the women's
the royal women's hospital

YOUR CARE OUR COMMUNITY

2008 Quality of Care Report

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

The RWH Quality of Care Report 2007-08 was made possibly by the invaluable contribution of over 70 staff members and consumers of the Women's, who contributed data, text, stories and photos. The report reflects on the work of staff across the Women's. 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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For over 150 years, the Women's has provided quality health services to women and babies and led the advocacy and advancement of women's health in Victoria. Last year was a very important year in the life of the Women's with our historical move to a brand new hospital in Parkville. This transition followed years of planning and marked the beginning of a new and exciting chapter for our staff and supporters of the Women's.

Some of the significant changes which have been implemented at the Women's include the introduction of new and innovative models of care such as our Maternity TeamCare and Neonatal Services family model of care. The Women's also has a brand new imaging centre, which includes the first Magnetic Resonance Imaging (MRI) machine dedicated to women's health in Australia. Our advocacy program has advanced the profile of important women's health issues such as women's mental health, prevention of violence against women and abortion law reform.

The Women's continues to meet the growing demand for our clinical services and in particular the increased demand for our maternity and neonatal services. In doing so we are working collaboratively with the Department of Human Services and other maternity services to implement strategies to ensure we are able to fulfill our tertiary role and provide specialist care to women and newborn babies.

The commitment and dedication of our staff and the community who supports us enables the Women's to continue its role as the largest independent specialist Women's hospital in Australia dedicated to improving the care of women and newborn babies.

Dr Rhonda Galbally AO
Chair, Royal Women's Board

Dale Fisher
Chief Executive

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WELCOME TO THE QUALITY OF CARE REPORT

We understand the importance of integrating the diverse, ever-changing needs, priorities, perspectives and experiences of women.

Welcome to the Quality of Care Report

WHAT DO WE MEAN BY QUALITY OF HEALTH CARE?

Quality in healthcare can be described as:

- doing the right thing (getting the health service you need)
- at the right time (when you need it)
- in the right way (doing the right procedure or test)
- to achieve the best possible outcome.

Safety of healthcare is part of quality and is about avoiding mistakes and errors. It is about dealing with them openly and honestly if they do happen, learning from them and making ongoing improvements to the way the hospital works together to prevent errors.

We write this report to inform consumers about what we are doing to improve our quality and safety of care. We assess our progress and how we compare with other hospitals. As consumers, you have an important role to play in the care you receive by being well informed about your health, providing information to us, taking part in decisions, raising queries or concerns and asking for a second opinion if you need to, bringing a relative or friend with you, and giving the hospital feedback about your experience.

BEING ACCOUNTABLE FOR QUALITY OF CARE

Being accountable for quality of care is about clinical governance. The information in this report is what we use to monitor and improve our clinical care, in line with our responsibility under government legislation.

The board, executive and clinical managers have final responsibility for the quality and safety of clinical care. The Board Quality Committee meets quarterly and the hospital's Quality and Safety Committee meets monthly to discuss quality and safety issues.

The clinical directors and managers are responsible for quality and safety in their areas of responsibility.

Clinicians have a responsibility to strive for excellence in clinical care, learn when something goes unexpectedly wrong, make improvements and communicate openly with women and their families.

WHO ARE WE?

Each year at the Women's, 200,000 appointments are made by women from 165 countries, who speak 60 different languages and follow 42 separate religious faiths. The Women's is committed to a holistic philosophy of health care and provides comprehensive services ranging from health promotion to clinical expertise. As a major teaching hospital and a leader in medical research, the Women's has played an important role in advocating for women's health care for over 150 years and provides a full range of services in the areas of:

- Maternity
- Gynaecology
- Neonatology (care of newborn babies)
- Women's cancer and
- Women's health services.

Increasing demand

Over the past five years the Women's has identified a steady increase in the numbers of women being cared for and the number of babies born at the Women's (Table 1). To address the increased demand and improve the quality of our services, we have implemented a range of strategies described throughout the report and developed services that better cater for groups of women including the Centre for Women's Mental Health and the Early Pregnancy Assessment Service (EPAS) for women with pain and bleeding in early pregnancy.

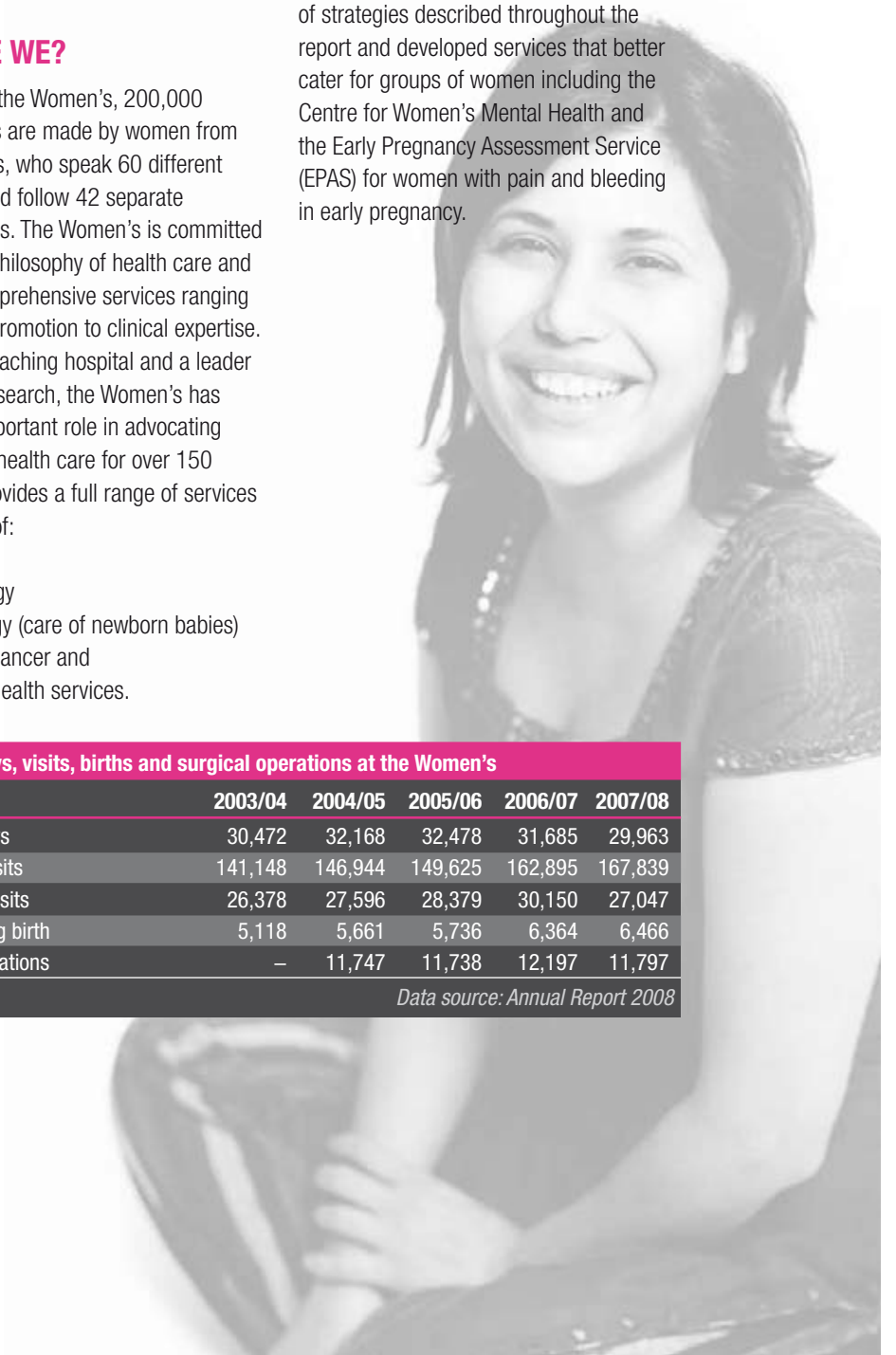


Table 1: Stays, visits, births and surgical operations at the Women's

	2003/04	2004/05	2005/06	2006/07	2007/08
Inpatient stays	30,472	32,168	32,478	31,685	29,963
Outpatient visits	141,148	146,944	149,625	162,895	167,839
Emergency visits	26,378	27,596	28,379	30,150	27,047
Women giving birth	5,118	5,661	5,736	6,364	6,466
Surgical operations	–	11,747	11,738	12,197	11,797

Data source: Annual Report 2008

OUR COMMUNITY

As a tertiary hospital, we have a local and statewide community. Women predominantly come to us from the inner city through to the northern and western suburbs of Melbourne. Our social model of care recognises that factors such as housing, income and stress can affect women's ability to care for themselves and their families. The Women's has been shaped over time by women's voices and we are an advocate for improvements in women's health and well-being.
In developing our services, we understand the importance of integrating the diverse, ever-changing needs, priorities, perspectives and experiences of women.

The diversity we care for

We provide services for a very diverse community, as identified in these figures:

- 23.8 percent of Victorians were born overseas
- 28.85 percent of women who were inpatients at the Women's were born overseas
- 46.54 percent of women who gave birth last year at the Women's were born overseas. The top five countries where these women were born were India, Vietnam, Lebanon, Somalia and Iraq.

OUR STAFF

Our workforce is large and diverse with many occupations and skills. Importantly, staffing costs are 76 percent of our budget.

Twenty two percent of our staff were born in a non-English speaking country, reflecting our multi-cultural population.

Table 2: Our staff

How many?	Who are they?	Full time or part time?	How long have they been here?	Their ages
2249 staff	46% are nurses or midwives	39% are part time	32% longer than 20 years	5% over 61 years
87% are women	32% are corporate and support staff	33% are full time	38% between 4 and 19 years	21% between 51 and 60 years
13% are men	15% are doctors	28% are casual	30% less than 3 years	55% between 31 and 50 years
	7% are other health professionals			19% less than 30 years

Data source: CHRIS 21

OUR NEW HOSPITAL

Community Consultation in 2001 – What did women want from the new hospital?

A separate specialist women's hospital based on community values and cultural and religious respect.

Quality staff, technology, teaching, training and research.

A hospital with **good access** to services, technology, expertise and research.

A balance in services, both critical and community care, general and specialist services.

Family-friendly patient care that responds to the needs of the whole patient and protects privacy and dignity.

Some features of the new hospital are:

- We are co-located next to the Royal Melbourne Hospital, but are a separate hospital. We work in partnership with the Royal Melbourne where we can provide a better service together, such as our Integrated Breast Service for people with breast cancer.
- Fifty per cent of rooms are single-bed rooms and the other rooms have no more than two beds with ensuite bathrooms. This creates a more restful environment and improves patient privacy.
- The neonatal unit is designed as the baby's first bedroom and is more spacious and attractive, with more room around each baby's cot.
- Easier access to theatres and critical care, with theatres closer to the Birth Centre and easy access to the Royal Melbourne Hospital. This means that we can look after women who may need access to adult intensive care.
- The Outpatient Clinics are all on the same floor and near other services that women may need to access, such as ultrasound, pharmacy, pathology, dietitians and physiotherapy.
- The new Pauline Gandel Imaging Centre provides ultrasound, radiology and a new MRI.
- The new Women's Research Centre is now part of a larger research precinct with the Royal Melbourne and Royal Children's Hospitals, the University of Melbourne and the Bio21 cluster, bringing science to improvements in women's health.

"NEW BEGINNINGS" CHANGE MANAGEMENT

The "New Beginnings" program was another important aspect of the transition process to support staff in dealing with the psychological and social aspects of the move to Parkville.

As it got closer to the move, additional communication forums, newsletters and committees were organised. Pivotal to the successful management of the move was additional support required to help equip staff and senior management with problem solving tools and techniques. Sessions were held to assist staff in adjusting to a brand new work environment. Coaching/ mentoring programs provided specific support to managers. New Beginnings Communicators played an active role across the entire hospital to assist staff with move related change and queries about their specific areas and department. This resulted in staff being well equipped and ready to deliver services when the doors opened in Parkville on 22 June 2008.

ACCREDITATION – MEETING NATIONAL STANDARDS

The Australian Council for Health Care Standards (ACHS) accredited the Women's in March 2007. The Women's received 21 higher-level ratings compared to three in 2005 and none in 2003. This included two outstanding achievements and 18 extensive achievements which was an outstanding result. The surveyors were particularly impressed by our work on health promotion, consumer involvement and research. We are working towards a midterm review in March 2009 and we want accreditation to be an incentive to improve services where required.

The Women's has also been re-accredited as a Baby Friendly Hospital and recognised as a Health Promoting Hospital by the World Health Organisation.

WOMEN AND OUR COMMUNITY

We inform, support and advocate for women, maintaining trust and confidence by working with community leaders and other service agencies.

In chapter one, we briefly discussed the diversity of women attending the Women's. In this chapter, we discuss some of the ways we are working to improve services for this diverse community of women.

WORKING WITH WOMEN FROM DIVERSE COMMUNITIES

In 2007, we conducted consultations with women from diverse communities to inform our Diversity Plan over the coming years. Our aim was to get a better understanding of women's experiences of the hospital and their views on quality in health care. We identified three groups as a priority: women who speak English as a second language, Aboriginal women and women with physical and sensory disabilities.

We received a small amount of philanthropic funding which enabled us to commission independent consultants to conduct focus groups. We worked with consultants with expertise in women's health and cultural diversity, and had an interpreter working alongside the facilitator in each of these groups. This meant we could invite women from non-English speaking backgrounds. The focus groups were held in December last year with Aboriginal women and with women who speak the following languages: Arabic, Mandarin, Cantonese, Turkish, Vietnamese, Somali, Italian and Greek. Common themes were found across all of the nine groups.

In 2007, the Women's Family and Reproductive Rights Education Program (FARREP) undertook a quality assurance project that involved interviewing eight women from Sudan, Ethiopia, Eritrea and Somalia. The project focused on women who had experienced female genital mutilation and their views about FARREP and other hospital services. The feedback highlighted the importance of FARREP in informing, supporting and advocating for these women and will contribute to improvements over the next twelve months.

Understanding clients and their needs

Women in every focus group expressed concerns about possible repercussions, for themselves or for staff, if they made a complaint. They were unsure about how to go about making a complaint and whether it would be worth the time and effort. One of the key challenges for the Women's over the coming years will be to promote the importance of women raising their concerns and to explain how the consumer advocate service works particularly with women from marginalised and disadvantaged groups.

Encouraging participation in decision-making

The Women's produces a wide range of fact sheets and, where possible, translates them into different languages. During consultations, women valued the fact sheets they were given saying they helped them make decisions and feel confident in their care and they used them to discuss their health issues with their family. Feedback from women also indicated they want more health information on a range of issues including women's anatomy and physiology, the roles of different health professionals, and the broader health system. A key focus will be promotion of the Women's Health Information Centre (WHIC) to women who speak English as a second language.

Partnerships with multicultural and ethno specific agencies

In October 2007, one of our Community Advisory Committee (CAC) members organised for women from the Ethnic Youth Council, at Spectrum Migrant Resource Centre, to come to a CAC meeting and talk to staff and the committee about sexual and reproductive health for young migrant and refugee women. One of the challenges in sexual and reproductive health is educating young people while maintaining trust and support from parents and communities. The discussion highlighted the importance of working with parents, community leaders and community agencies when providing health information that raises sensitive and taboo issues like intimate partner violence or sex before marriage.

In 2008, FARREP at the Women's revised their training package for health professionals working with communities who practice female genital mutilation. We have a role in supporting other health services to provide appropriate services for these women and will be providing training to FARREP workers across Victoria.

Using language services to best effect

The Language Services Department continues to meet the challenge of providing interpreters for an increasing number of women (see Figure 1). In 2007-2008, we participated in projects and forums with the Department of Human Services to improve language service provision and better understand the language needs of patients in hospitals.

Communication was a key issue identified by women in the focus groups. Women talked about the difference it made to have an interpreter who was skilled and knowledgeable in women's health when they were talking to the doctor about their diagnosis and treatment. Unfortunately as we are not able to provide a staff interpreter for every

appointment we asked women to tell us the critical points for using interpreters. This feedback will help us to refine the process for booking interpreters for appointments. When Language Services interpreters are unavailable (e.g. after hours) the hospital accesses the telephone interpreter service.

In Maternity Services, we were able to meet just over 70 percent of the demand for interpreters last year. One challenge for Language Services is meeting the needs of patients who speak rare and emerging languages (such as Nepali and some languages from the Indian sub-continent) and for whom it is difficult to provide interpreting services.

A culturally diverse workforce

Results from a recent survey [1] found that about 22 percent of our staff were born in a non-English speaking country, and that 30 percent of staff speak a language other than English at home. This language and cultural diversity reflects the diversity in the community using the hospital. We are looking at ways to take advantage of our knowledgeable workforce and expertise about cultural differences to improve our capacity to provide culturally safe healthcare.

Promoting the benefits of a multi-cultural Victoria

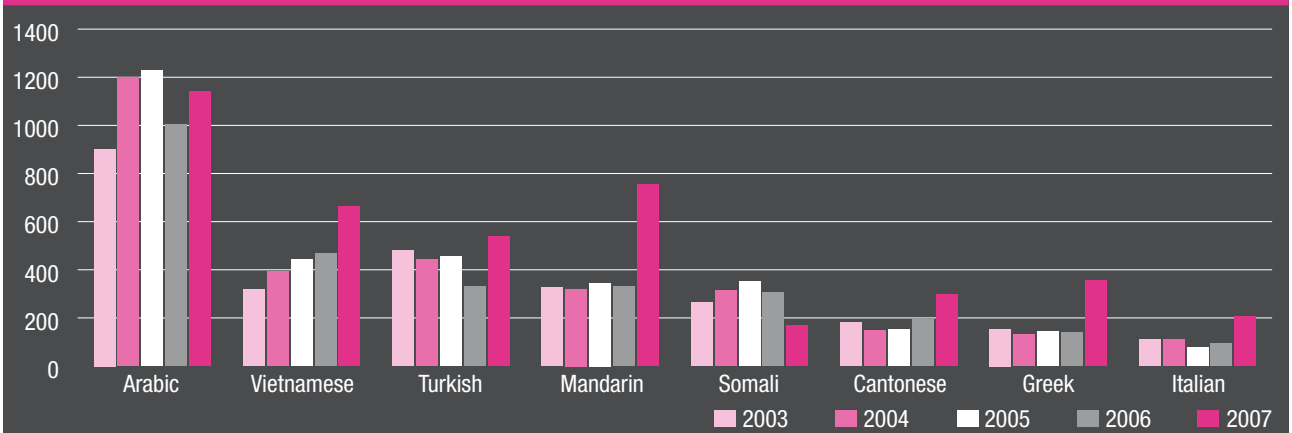
The Women's is on the land of the Kulin nations. One way of acknowledging and paying respect to the traditional owners of the land is to ask an Aboriginal elder to perform a welcoming ceremony at major public forums and events. Joy Wandin Murphy conducted a welcome to country, which included a smoking ceremony, at the spiritual farewell in Carlton to mark the end of an era and our new beginning at Parkville.

NEXT STEPS – WOMEN WITH DISABILITIES

The Women's has a specialist clinic for pregnant women who have a disability, the Women with Individual Needs (WIN) program. In 2007, the WIN social worker and the Pregnancy Advisory Service (PAS) undertook a project looking at the number of women with a disability who accessed the PAS. In response, the social worker and reference group have developed a Clinical Practice Guideline for staff and a health professional's information booklet

We do not know how many women with disabilities are using our services or which clinics they attend. One of the difficulties is that our patient information system does not include questions about physical or sensory disabilities. We are working with disability services in Melbourne and country Victoria to recruit women for focus groups. We will use their feedback to inform strategies to improve our knowledge about the health needs and preferences of this group of women.

Figure 1: Requests for interpreters and the top eight languages 2003 to 2007



Data source: Health Information Services

[1] 2008 people matter survey state services authority

APOLOGY TO THE STOLEN GENERATION

Each year, the Women's holds events to mark Sorry Day. This is in line with the recommendations of the *Bringing Them Home Report*, from the inquiry by the Human Rights and Equal Opportunity Commission into the separation of Aboriginal and Torres Strait Islander children from their families.

The Prime Minister's apology to the Stolen Generations in the federal parliament was a significant turning point in the reconciliation movement. This was the first time that a representative of the Federal Government had taken responsibility for the Commonwealth laws and policies that removed children from their parents because of their cultural identity.

In May 2008, as we prepared to move to the new site in Parkville, our Chief Executive, Dale Fisher, took the opportunity to say sorry to the Indigenous community for the role the hospital had played in implementing policies that had created the Stolen Generations. The apology was endorsed by the Board, which was represented at the Sorry Day ceremonies by the Chair of the Board, Rhonda Galbally.

'On behalf of staff, past and present, of the Royal Women's Hospital **I say sorry** for the suffering and hurt of the Stolen Generations, their descendents and the families left behind.

I make this apology to Aboriginal women and their children, their husbands, their partners, cousins, aunties and uncles, who suffered as a result of the policies and practices conducted at this hospital.

I apologise for the actions which caused needless anguish, guilt and confusion and has left a legacy of anger and pain, as well as distrust of the hospital.

There is no more fitting time, as we leave the site where these practices occurred, to acknowledge that whatever the intention of staff, the severing of that most deepest of bonds, between a mother and her baby, has had cruel and lasting consequences for Aboriginal women and their families.

I hope that this apology can be accepted by the Aboriginal community, that an honest reckoning can become the basis of a new relationship between the Women's and our Aboriginal community, which builds trust, confidence, health and wellbeing.'

– Dale Fisher, Chief Executive

TAMMY ANDERSON
Aboriginal artist and performer who worked on the Women's oral history project.

CREATING A WELCOMING ENVIRONMENT FOR ABORIGINAL WOMEN AND THEIR FAMILIES

The Women's is committed to making the hospital a comfortable and friendly experience for Aboriginal women and their families. This year we added an Acknowledgement of the Traditional Owners to the homepage of our website www.thewomens.org.au *'The Women's acknowledges and pays respect to the traditional owners of the land, the people of the Kulin Nations.'*

Each year we celebrate Sorry Day and NAIDOC week, with displays of Aboriginal art and performances by local artists. The Aboriginal Women's Health Business Unit (AWHBU) is working with hospital staff to ensure that there is Aboriginal artwork displayed in the hospital which is an important way to assist in creating a welcoming environment. In addition, the AWHBU is now located on the ground floor next to the front entrance in the new hospital. This increased visibility has led to an increase in the number of Aboriginal and Torres Strait Islander women coming to the Unit. Women have commented that this has assisted them in feeling more comfortable at the Women's.

Cross cultural training

Tammy Anderson is an Aboriginal artist and performer who worked on the Women's oral history project. The second stage of the oral history project involved the recording of interviews with Aboriginal women regarding their experiences at the hospital. The project was undertaken in partnership with the Koori Heritage Trust and was completed early in 2008. The DVD recording was shown during Sorry Day in 2008 and will be used as a resource for future cross-cultural training.

Culturally sensitive post acute care planning

A discharge planning steering committee has been developed that will incorporate post acute care. The manager of the AWHBU is a representative on this committee and culturally-sensitive practice is integral to the committee's work. Currently, staff are able to refer and consult with the AWHBU and Aboriginal Health Associates regarding safe and culturally sensitive discharge planning, including post acute care, for Aboriginal and Torres Strait Islander patients.

Setting up a referral base

The Women's has existing systems in place for effective referral of women, including the Aboriginal Health Associate program, the AWHBU, a protocol with the Victorian Aboriginal Health services, and the Aboriginal Women's Advisory Committee. In addition, scripts have been provided to staff in Outpatients to encourage and guide staff to 'ask the question' and allow women to identify if they are Aboriginal and/or Torres Strait Islander. This helps to refer women to the AWHBU and other services.

Reconciliation Plan

Developing the Reconciliation Plan is a priority for our Diversity Plan. This year we formalised the membership and terms of reference for the Reconciliation Steering Committee, including getting a representative from each of the departments in the hospital and identifying an executive sponsor who will lead the development of the plan across the hospital. The steering committee will look at the recommendations from the *Bringing Them Home Report* and the *Right of Ways Report* to inform the Action Plan. The committee has also reviewed all the recommendations of the *Right of Ways Report* to identify those that have been achieved, are ongoing, or yet to be achieved.

Table 3: Aboriginal and Torres Strait Islander women coming to the Women's

Financial year	Number of babies born	Number of women	Total inpatients
2005/06	49	131	180
2006/07	54	125	179
2007/08	49	132	181

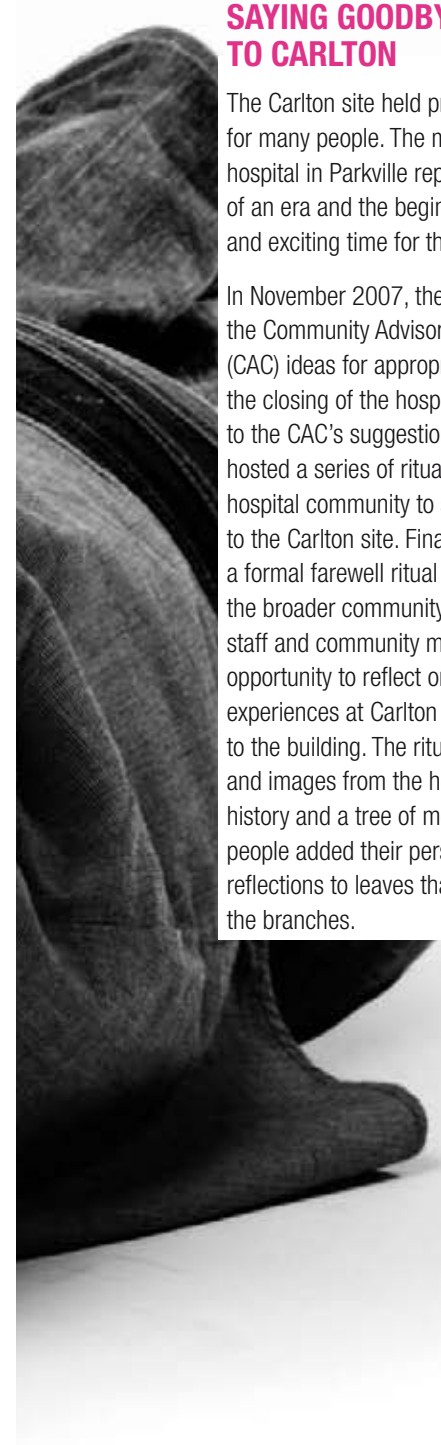
Data source: Health Information Services

‘We talk with women and involve them in planning and decision making.’

INVOLVING CONSUMERS

Involving consumers

In this chapter, we discuss some of the ways we engage with women and involve them in planning and decision making. Our Committee Advisory Committee advises the Board on ways to involve consumers and get feedback on ways to improve our services.



SAYING GOODBYE TO CARLTON

The Carlton site held precious memories for many people. The move to the new hospital in Parkville represented the end of an era and the beginning of a new and exciting time for the Women's.

In November 2007, the Women's sought the Community Advisory Committee's (CAC) ideas for appropriate ways to mark the closing of the hospital. In response to the CAC's suggestions, the Women's hosted a series of rituals to enable the hospital community to say goodbye to the Carlton site. Final events included a formal farewell ritual for both staff and the broader community. This provided staff and community members with an opportunity to reflect on their personal experiences at Carlton and to bid farewell to the building. The ritual included photos and images from the hospital's 150 year history and a tree of meaning where people added their personal wishes and reflections to leaves that were hung from the branches.

FINDING YOUR WAY AROUND THE NEW HOSPITAL

Attending clinics at Carlton was difficult for patients trying to find their way around the hospital. Outpatient services were spread across the ground and first floors, with staff often required to give women complicated directions.

There are no such problems in the new hospital as the clinics and associated services are all together on one floor. For example a woman coming to outpatients with heavy or irregular bleeding can see her gynaecologist, have an ultrasound and blood test and get her medication all without leaving the first floor.

In a focus group about way finding and signage in the new hospital, women from country Victoria talked about how they needed to know where they could get a map which showed where the clinics and wards were, but also about other services and facilities available at the hospital.

'After driving four hours to an appointment, information like - is there a cafeteria, where are the toilets – can make the day just that little bit easier.'

As a result of this feedback, our brochure *'Finding your way around the new Royal Women's Hospital'* is available at the information desk on the ground floor and includes information about parking arrangements, food and cafeterias, toilets and access to an ATM. This and more information about services and facilities in and near the hospital is also available on our website at www.thewomens.org.au

Our volunteers have played an important role helping people find their way around the new hospital.

Thanks to **Rhonda Brown**

In April, Rhonda Brown resigned from the CAC after seven years. This is what one of the CAC members said about Rhonda:

'…I admired her from the beginning as she seemed to have a handle on stuff I was seriously struggling with… I thought I'm just a mum – but over a coffee she gave me validation and value that I sincerely thank her for.

Rhonda hit the ground running highlighting same sex issues. When she first raised the issues facing lesbians and same sex couples, I believe it was challenging and confronting for the committee. In her lighthearted but thoroughly thorough way she took the members through stories of discrimination and the pain and heartache that this causes to women who may just want to have a baby, their partner acknowledged and their relationship treated as sound, and as entitled to procedures and quality care as the straight community.

During Rhonda's partner's pregnancy and subsequent delivery of their beautiful baby boy, Rhonda spoke of her own experience, the reality of being the un-pregnant partner and the unease this caused her even within the hospital. Attitudes are changing but we still have a way to go.

The CAC will truly miss Rhonda's considered moments, always speaking out, often taking the words out of my mouth, but also often seeing a different perspective that I had not thought of but very valid….'

COMMUNITY PARTICIPATION PERFORMANCE INDICATORS

We report the following set of performance indicators on consumer participation to the Department of Human Services (DHS). Performance indicators are measures to assess how well we do.

<table>
<tr><th>Indicator</th><th>How we perform</th></tr>
<tr><td>The governing body is committed to consumer, carer and community participation and meets the Australian Council in Healthcare Standards standard on consumer participation at least to the level of moderate achievement (MA).</td><td>In March 2007, the Australian Council in Healthcare Standards rated the hospital's work as Excellent Achievement, exceeding the requirement. This finding was confirmed in 2008, when Health Outcomes International evaluated the Women's CAC and found that the Women's was effective in engaging consumers in developing a Community Participation Plan that linked into the hospital's planning processes.</td></tr>
<tr><td>There is participation in higher level decision making and consumers, carers or community members on key committees.</td><td>The Women's has consumer membership written into the Terms of Reference of the Primary Care and Population Health Advisory Committee, the Quality Committee and the CAC. The CAC evaluation found that 'links with other committees i.e. the Quality Committee, have helped raise the CAC's profile within the hospital as well as bringing a consumer perspective to these committees' agenda. We increasingly involve consumers in committees that steer improvement in services, for example, the integrated Breast Service and better management of deteriorating patients.</td></tr>
<tr><td>The service reports openly to its communities on quality and safety and the participation in its processes.</td><td>Each year the Women's reports to the community through this quality of care report, and consults the CAC on how to make sure that the content and design of the report is interesting and informative for women and includes their advice in the report. CAC comments for the 2008 report include:
• The cover and title need to communicate clearly that this is a report for women, not staff.
• The stories are the strength of the report; they are both interesting and create confidence in the hospital's transparency.
• The language in the report should promote the social rather than medical model of health.
• The report needs to be distributed widely in the community, including a summary report and promoting it in migrant and refugee communities that use the hospital.</td></tr>
<tr><td>A Community Participation Plan has been developed and is being reported against annually to the DHS.</td><td>In 2007, we developed a new Community Participation Plan which we submitted to the Department of Human Services (DHS). This will guide our work until 2010. In January 2008, we were commended by DHS for our work with women from diverse communities, how we provide health information for women, how we involved women in the design of our website, our new early pregnancy assessment services and the evaluation of our language services.</td></tr>
<tr><td>There is consumer and, where appropriate, carer participation in clinical care and consumer participation in decision making about their care and treatment is assessed on the VPSM Consumer Participation sub-index.</td><td>This is calculated using three questions from the Victorian Patient Satisfaction Monitor as a score out of 100:
• The opportunity to ask questions about your condition or treatment
• The way staff involved you in decisions about your care
• The willingness of hospital staff to listen to your health concerns
<table>
<tr><th></th><th>2005</th><th>2005/06</th><th>2006</th><th>2006/07</th><th>2007</th></tr>
<tr><td>The Women's</td><td>81</td><td>81</td><td>80</td><td>80</td><td>79</td></tr>
<tr><td>Category 2 hospitals</td><td>80</td><td>78</td><td>77</td><td>78</td><td>78</td></tr>
<tr><td>All hospitals</td><td>81</td><td>81</td><td>80</td><td>80</td><td>80</td></tr>
</table></td></tr>
<tr><td>Appropriate information is available to enable all consumers and carers where appropriate to share in decision making about their care.</td><td>The Women's invests considerable resources in developing health information for women, to help them understand their health and make decisions about their care. Feedback from women about the information they want and how to improve the information we provide is crucial to making sure we are meeting their needs.

For example, in April 2007, the Women's began a four month trial of an early pregnancy assessment service (EPAS) for women with bleeding or pain in the first 16 weeks of their pregnancy. After three months, we conducted telephone interviews with women to evaluate the service, about their experiences, consistency of information, appropriateness of facilities and integration of EPAS with other areas of the hospital.</td></tr>
</table>

Indicator	How we perform
	One of the findings was that women valued the consumer health information developed for EPAS, but not all women received this information. Also, women who had suffered a miscarriage identified the need for specific information to prepare them for the process of miscarrying and information about options for medical or surgical intervention. In response, new consumer health information fact sheets were drafted and reviewed at a multidisciplinary workshop in November. Consumer involvement in this workshop ensured that feedback from women was integrated into the changes. These fact sheets are integrated into clinical care. See our website http://www.thewomens.org.au/atozfactsheets

We have been commended for our work with women from diverse communities, our health information for women, how we involved women in the design of our website and in the development of our new pregnancy assessment services.

CONSUMER ADVOCATE SERVICE

The Consumer Advocate Service is located on level one of the new hospital. It is more prominent and accessible than at the Carlton site and the use of the service by consumers has increased.

There were 530 complaints to the Consumer Advocate Service in 2007. This is a 38 percent increase from 2006 which we believe is due in part to the higher profile the service has in the hospital given the new brochure promoting the service and training and education undertaken by the Consumer Advocates throughout the hospital. The Consumer Advocates regularly present at monthly orientation sessions for new staff. In addition, they have provided education sessions on skills for managing complaints, the role of the Consumer Advocate and communication training in Emergency, Pregnancy Day Care, Ultrasound and a number of the maternity and gynaecology wards. This training will continue to be provided throughout 2008.

What are the complaints about?

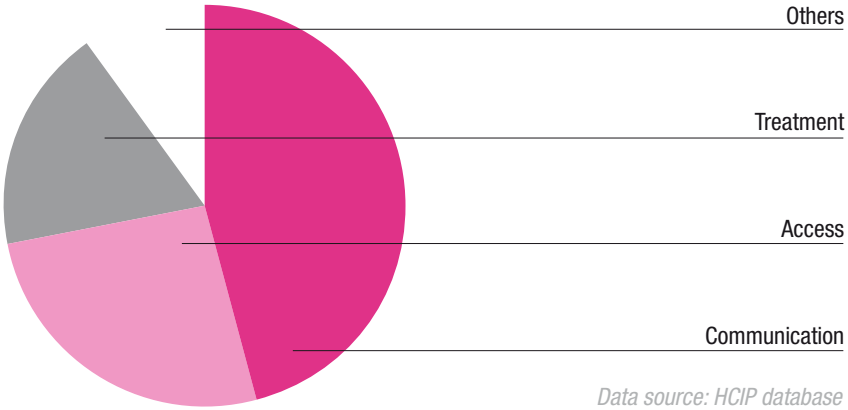
The most common issue which consumers complain about is poor communication. This is 46 percent of the total number of issues and is similar to past years. Access and treatment are the next most common issues at 26 percent and 18 percent respectively (Figure 2).

Treatment issues remained stable, however access issues increased during 2007. The majority of the access complaints were about access to maternity and ultrasound appointments and reflects the significant increase in maternity demand. In an effort to manage this high demand for our maternity services at the Women's, and be able to focus on our specialist tertiary role, the Women's refers women who are experiencing a low risk and straightforward pregnancy to their local maternity hospital for their care. We have formalised our maternity booking processes to ensure priority access to our maternity services for women who live in our local area and for women throughout Victoria who are experiencing a complicated or high-risk pregnancy. Some of the complaints received were about this referral process and, in recent months, we have increased communication about access to our maternity services among GPs and directly with women.

The Consumer Advocate Service plans to evaluate its complaints service during the next year. In preparation for this, a number of consumers were interviewed and a focus group was conducted to discuss expectations and experiences of the service. Questions were asked about accessibility, timeliness, process, communication and outcomes. This information will be used to develop an evaluation survey for users of the service.

We listen to women and take action to improve communication and access to services.

Figure 2: Breakdown of complaint issues



Data source: HCIP database

We encourage women to have an active say in decisions about their labour and birth.

How do we respond to complaints?

Our response is always planned with the person making the complaint so that it takes into account their needs and wishes. The medical file usually helps us establish what happened and who was involved. Conversations with staff and managers allow feedback to be given where appropriate, meetings with patients arranged, and improvements planned to prevent a reoccurrence of the issue. Many complaints are useful in alerting us to possibilities for quality improvements across the hospital.

For example, a woman who had attended our Reproductive Biology Unit had organised for a donor sperm sample to be donated. It was the woman's expectation that the sperm would be tested and stored for future use. There is a six month quarantine period and when she contacted the Women's after some months she discovered that no sperm had been stored.

The Consumer Advocate investigated this and found that not all sperm samples are intended for storage and there is a fee attached for storing semen. In this instance, the donor did not clarify that the sperm was for storage and no fees were paid. However there was no process for this arrangement to be checked with the recipient.

A commitment was made by the relevant departments to develop a process that would enable this checking between recipients to occur. A follow up system has been developed so that both donors and recipients are aware if sperm is not stored and storage fees are not paid. This should reduce the incidence of this kind of event occurring in the future.

FEEDBACK FROM WOMEN

We receive feedback from women in a number of ways including analysing complaints, letters from women telling us what they liked about our care, focus groups and the Victorian Patient Satisfaction Monitor (VPSM).

Our VPSM results for the last couple of years have been affected by the physical aspects of the old hospital, especially the lack of privacy and restfulness. We expect this will improve as a result of the new hospital's design which has focused on a more welcoming and resutful environment for our patients and visitors.

In addition to reviewing the results (see Table 4), we also look at the qualitative comments women make. Almost all positive comments refer to the courtesy, team work, caring and professionalism of hospital staff which shows that it is our staff women value most. Food and problems associated with shared rooms featured strongly in the negative comments including poor communication and lack of courtesy among a small number of staff.

Comments are provided back to staff and management to guide our improvements. The next set of results will tell us about women's experience of the new hospital.

We ask women about their experience of being involved in decisions about their labour and birth. Ninety-three percent said that they had an active say in decisions at least some of the time, and forty percent said they had an active say all of the time.

Table 4: Victorian Patient Satisfaction Monitor

Index Measure (20-100 Scale)	March to August 2006 Score	September 2006 to February 2007 Score	March to September 2007 Score	A2 hospitals Average Score
Overall care	75	75	74	74
Access and admission	76	74	72	71
General patient information	80	80	79	79
Treatment and related information	78	77	76	76
Complaints management	81	79	79	79
Physical environment	69	67	67	70
Discharge and follow-up	74	73	73	73

Data source: VPSM

A SAFE HOSPITAL

A Safe hospital

In this chapter, we discuss what we do to prevent harm to women and babies during their hospital stay. During the past year, we were particularly concerned about risks associated with moving to a new hospital and managing increased demand for maternity services. Even with the best intentions of our staff, errors will occasionally occur so our job is to put processes and systems in place which protect and minimize any harm to our patients and staff.

WHAT DO WE DO TO MAKE OUR HOSPITAL SAFER?

We promote an open and learning culture so that clinicians feel confident to discuss clinical complications and errors in care. Staff report things including events that have not gone to plan, circumstances that might lead to something going wrong or 'near misses' on occasion, and incidents that have been picked up quickly and corrected. By looking at incidents, medico-legal claims, complaints and reviews of clinical practice, we identify our risks and what we need to do to prevent harm. We measure our clinical performance and compare it to other hospitals. This is a high level activity which is led by the Chief Executive and is reported to our Quality and Safety Committee and the Board.

ENSURING SAFETY DURING AND AFTER THE MOVE

Prior to the move we consulted with staff, particularly clinicians, to identify the risks associated with moving the hospital and adjusting to the new hospital environment. We identified a range of potential risks which we planned for to ensure the move to Parkville was as smooth as possible particularly given we were undertaking the relocation during a period of high demand for maternity services and neonatal care at the Women's and across the State.

The Metropolitan Ambulance Service and Neonatal Emergency Transport Service (NETS) were involved in planning the move and successfully transported 55 neonatal and special care babies, 68 women and 47 post natal babies. This included transfers from Frances Perry House.

After the move, we continued to monitor all safety risks closely and made several adjustments. These included getting the hot water temperature for babies and mothers increased, adjusting air conditioning, ensuring new pieces of equipment (often electronically driven) functioned as we required, and ensuring staff became familiar with new equipment and systems such as the nurse call system.

We promote **an open and learning culture** for our clinicians.

What we did to reduce clinical risks?	What was the outcome?
We developed systems for managing clinical emergencies throughout the move.	Clinical emergency teams were on both sites during the move. The Parkville clinical emergency teams did several practice drills before the move to make sure that they were familiar with the new hospital.
We reduced the number of patients to be moved.	Elective surgery was reduced before the move and for a week afterwards. The hospital was not able to reduce the number of babies admitted to neonatal intensive and special care due to high demand across the state during that time.
We reduced staff leave before, during and after the move and rostered additional clinical staff.	Rosters were completed well in advance and there were no major staff shortages.
We had detailed plans for managing emergencies at both sites during the move.	A detailed emergency management plan was created for the move, including individual plans for Carlton and Parkville and communicated broadly to all staff.
We organised training and orientation to the new hospital.	Approximately 1800 staff attended training and orientation. We reduced surgery so that staff could attend and held sessions for staff on night duty. We trained staff to help orientate other staff to the new building. We also trained volunteers to help women and their families find their way around the new building.

PICKING UP ON THINGS THAT GO WRONG

Incident reporting is an important activity as it identifies things that have not gone to plan and increases awareness among staff of the need for increased vigilance regarding patient safety. We also find out about things that have gone wrong through the range of review processes including complaints. We are confident that we do find out about any adverse events, because these events show up through several processes we have in place.

When something does go wrong, we involve staff in the review process of what happened through a root cause analysis. This process can identify a chain of events rather than one single action of a staff member. We work out how to reduce the risk to ensure the same thing won't reoccur. We talk with women and their families, apologise and keep them well informed during the review process. Additional support is provided to our staff who can be very distressed when unexpected things happen.

Figure 3 shows our patient incident reporting over the last five financial years. We actively encourage staff to notify us about patient incidents. We look at our patterns of incidents and spend a lot of time reviewing them. Figure 4 shows that most incidents result in no harm. Incidents we rate as minor are where additional observations are undertaken as a precaution or where there may be a need for a dressing or minor treatment.

Figure 3: Patient incidents reported

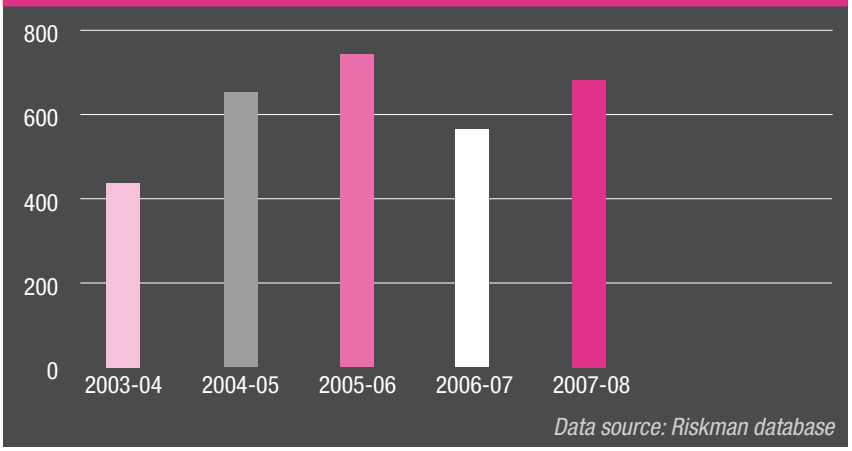
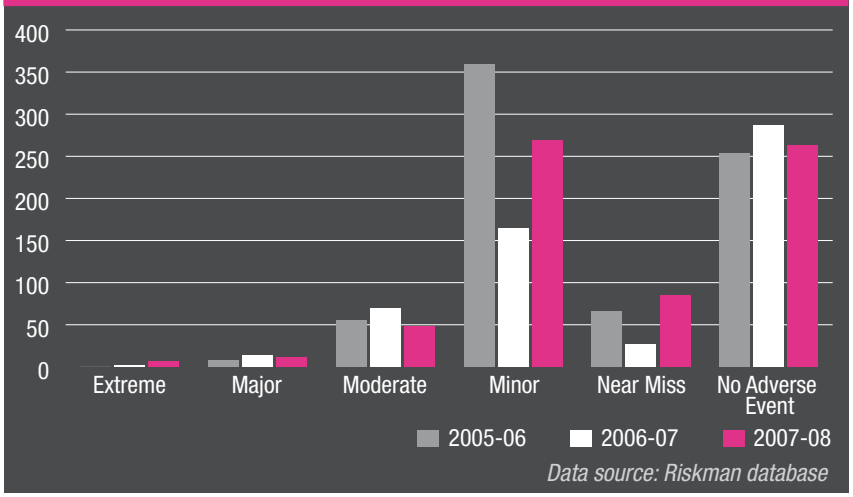


Figure 4: Clinical incidents by seriousness for the last three years



Some terms we use:

Sentinel events: unusual incidents that cause significant harm to patients and mostly arise from system problems, for example, leaving a pack or instrument in the patient, or operating on the wrong side

Root cause analysis (RCA): a method for reviewing very serious incidents and accidents to see what went wrong and look for improvements and ways to prevent it happening again. It is also used if an incident could have had serious results (a near miss).

Multidisciplinary: a team made up of different health professionals working together

Prophylaxis/prophylactic: measures taken to prevent disease or infection before they occur, such as vaccination or a dose of antibiotics

Audit: an examination of a selection of patient medical records to check the type of care provided

Issues and improvements

Key issues we identified during the year included:

- Delays in initiating treatment
- Patient identification issues such as mislabeled specimens, inconsistency between mother and baby identification, inconsistent identification systems
- Skin damage to newborns requiring long term breathing support from breathing tubes and sticky tapes
- Accurately identifying the well-being of the baby during labour
- Consistency of clinical documentation
- Inconsistent recognition of women who have psycho-social problems that have the potential to impact on care and treatment.

Clinical issues such as these are consistent nationally. We have taken a range of actions to address them as discussed below and in other chapters. We have:

- Established a clinical documentation working group to develop improvements in how we document a patient's treatment and care.
- Established education programs for clerical staff and clinicians to improve patient identification. We changed our policy to one of 'active identification' – asking the woman to say her name and other information.
- Improved our processes (escalation) for getting urgent assistance and treatment for the patient. The escalation protocols are particularly used in the Birth Centre and gynaecology and cancer wards.
- Reviewed mechanisms for fixing breathing apparatus to a baby's face and trialed a range of products. Decisions are currently being made in relation to the best product.
- Established a working group to identify the service gaps for women with psychosocial issues. Many improvements have been noticed such as improved referral of women to Centre for Women's Mental Health and Women's Social Support Service, better information sharing within the maternity teams and a more multidisciplinary focus to assessing and supporting women.

PROVIDING SAFE BIRTHING

As one of our review processes we closely monitor the care of mothers and babies. The care of women who give birth at the Women's is regularly reviewed by our Clinical Practice Improvement Unit which you can read in Chapter Five.

Every week, we also review deaths of babies born after 20 weeks gestation. This is part of the scientific effort to understand why these babies die and to direct research to understanding this. For example we conduct research into why some babies are born prematurely and as part of this research we look for any improvements we can make in the provision of care.

The safety of the hospital in delivering babies is measured through the Perinatal Mortality Ratio. When the number of premature babies is taken into account, the Women's Perinatal Mortality Ratio is one of the best in Victoria and is better than expected given the complexity of the women cared for by the Women's (see Chapter Five).

EARLY RECOGNITION OF WOMEN WHO ARE DETERIORATING

Nationally and internationally, recognition of the deteriorating patient has emerged as something hospitals need to do better. Research shows that if patients whose conditions worsened had been detected earlier they would have received prompt medical attention and the risk of further deterioration would have been reduced. We were concerned that we had a small number of women where there were delays in identifying their deteriorating condition.

We developed a joint project between the Women's, the Mercy Hospital for Women and the Victorian Managed Insurance Authority to focus on gynaecology patients and clinicians who work with them. We aim to improve the responses from clinicians to the early signs of a patient's worsening condition.

We undertook research at both hospitals and learned from projects in other hospitals about:

- handover of patients from one shift to the next
- how nurses alerted doctors about patients whose condition was worsening
- how doctors responded.

We found that we could improve the way that nurses communicated with junior doctors and about how urgently they needed to see the woman. We plan to trial a version of SBAR for communicating about the woman (Situation of the patient; Background of their condition; Assessment of their current state of health; Recommendation about what they want the doctor to do). We found that we could improve the information junior doctors had about patients by having a face-to-face handover on each shift. We looked at how signs that might tell you a patient was deteriorating were documented and how this could be improved. We are planning to pilot an 'early warning score' as part of the patient observation chart to see if this improves recognition of patients at risk of deteriorating.

SAFE USE OF MEDICINES

Medicine related errors continue to be a high-risk area for all hospitals. This year, we appointed a pharmacist to focus on the safe use of medicines. The job of Rowena Fary (pictured above), the Quality Use of Medicines pharmacist is to:

- analyse medication incidents and trends from daily pharmacist ward rounds to work out when and where problems occur
- coordinate an assessment of our safe medicines processes
- use this information to improve processes and systems to reduce medicine errors.

Preventing medicines being given by the wrong route

We expect to give the right medicine, to the right patient, at the right time and in the right way. Sometimes, despite all precautions and the best intentions, a mistake can occur. Giving an oral medicine in the wrong way, such as giving a liquid oral medicine intravenously, is a high risk mistake. When we had such a mistake, the clinician who made the mistake realised immediately and alerted the team that assistance was urgently required. The mistake was rectified successfully. We acknowledged the clinician's courageous admission and we undertook a review to see what went wrong.

When this happened, we were in the middle of introducing a new approach to oral medicines:

- we introduced 'orange' oral liquid dispensers throughout the hospital
- we designed a hospital-wide campaign to highlight the importance of oral dispensers – 'orange for oral'
- we developed a separate oral liquid medicines guideline to add to our Medicines Management procedure
- we changed the way doctors prescribe oral medicines for babies so that the doses are the same amount as the dispensers available.

Pharmacists' role in quality and safety

- During the pharmacists' ward rounds, the pharmacist checks all medicines prescribed for women or babies. Pharmacists frequently make changes in consultation with the doctor who initially prescribed the medicine.
- When patients are admitted and discharged, they review previous medicines women are taking alongside new medicines, and make sure they are consistent.
- They label medicines with clear instructions and provide consumer information and advice to women about their medicines and answer any questions they may have.
- They ensure prescribers' intentions are clear particularly with unusual orders.

Working with manufacturers

One of the basic safety features for medicines is the clear labeling of the product. Pharmacists and clinicians were concerned when caffeine citrate injections for premature babies from a new supplier arrived with a label that could have been misleading. It was felt the label did not state clearly the contents of the vial and that nurses who would administer the injection could be easily confused and unsure of exactly what the medicine was. The pharmacy department contacted the manufacturer immediately and we discussed more appropriate ways to express the contents on the label while maintaining the legal requirements of the Code of Good Manufacturing Practice. The manufacturer reassured us of a change in the next batch of labels.

SAFE MANAGEMENT OF FRAGILE SKIN FOR HIGH RISK PATIENTS

The Women's has a strong program for the safe management of the skin of women and newborns. There are a range of issues concerned with looking after skin injury, including pressure ulcers and skin injuries related to intravenous tubes. The risk of pressure ulcers is very small given most of our women and newborns are healthy. Sicker women and newborns, especially newborns in intensive care, are more at risk.

Staff routinely complete skin assessments daily and document changes in the progress notes and observation charts of babies in Intensive and Special Care, particularly babies on respiratory support who have tape and tubes attached to their skin. In the operating theatres, staff use a range of pressure relieving devices for women who have had a long procedure.

Over the last year we have been more active in monitoring the incidence of pressure-related events and have recently implemented a set of pressure ulcer guidelines aimed at further reducing the risk of pressure ulcers for women and babies.

Table 5 and Table 6 show incidents involving all forms of skin damage. None of the major or moderate incidents were from pressure ulcers.

Table 5: Reported Incidents related to skin damage for the last three years

	2005/06	2006/07	2007/08
Major	1	1	0
Moderate	1	1	2
Minor	9	13	7
No adverse event	0	0	4
Total	11	15	13

Data source: Riskman database

Table 6: Types of skin damage

	2005/06	2006/07	2007/08
Pressure related	3	7	9
Other	8	8	4
Total	11	15	13

Data source: Riskman database

We participate in the quarterly statewide pressure injury monitoring program organised by the Department of Human Services.

REDUCING RISK OF INJURY FROM FALLING IN HOSPITAL

The risk of a woman or newborn falling at the Women's is minimal and quite different from the risk and incidence rates identified in a general hospital. Our falls relate to women fainting after childbirth (38 percent of reported falls), partners of women fainting during the birth, babies slipping from the bed, or being dropped unintentionally. During 2008, there have been 34 incidents of falls reported and no mother or baby received any significant injury related to a fall.

During the year we have:

- updated falls risk management policy and guideline
- developed resources to assist staff to assess and manage risks of falling
- developed information brochures for women with a falls risk
- identified falls risk alerts (i.e. arm bands and bed signs).

Figure 5: Incidence of falls by seriousness for last three years

Data source: Riskman database

PREVENTING HOSPITAL ACQUIRED INFECTIONS

The Infection Control team works with clinicians to reduce hospital infections. They identify and give advice about prevention and treatment for patients with, or at risk of, infections. They review all infection control issues and provide education for staff on infection control. They look after staff health, for example, vaccinating staff and preventing needle stick injuries. They review compliance with infection control procedures and feed results back to staff along with areas for improvement.

Infection prevention and the move

The Infection Control team undertook microbiological air sampling at the new hospital site in the highest risk areas. While most areas yielded very good results, an unexpectedly high fungal spore count in two rooms within the Operating Suite identified a design issue with the filtered air supply to those rooms. This problem was rectified before the new hospital opened.

Reducing the risk of infections

There are situations where the risk of infection is high for example sick or very premature babies and women having emergency surgery. The Infection Control team identifies women and babies most at risk, collects data on infections and compares this information to other hospitals nationally and internationally. This data is provided back to clinicians with recommendations from research about preventing infections. Our infections rates are reported in Chapter Seven for surgery and Chapter Eight for babies.

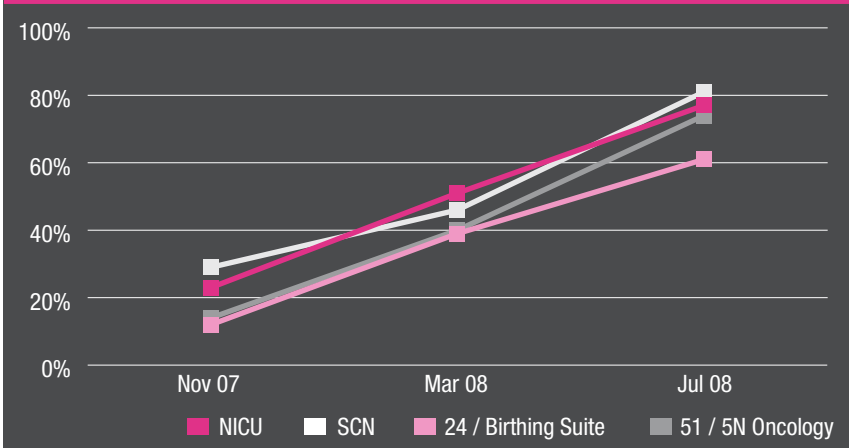
Clean hands reduce infection risks

Clean hands reduce the spread of infections in hospitals. Clinicians are used to washing their hands, but do not do this all the time. We were concerned to see this confirmed in an audit in November 2007 (see Figure 6). As part of a state-wide hand hygiene program of audits and one-on-one staff education there was significant improvement (Figure 6). The overall compliance target set by the World Health Organisation and the Department of Human Services is 55 percent. We exceeded this target in the last audit, but the challenge will be to sustain this over time. We have strategies in place to achieve this.

Preventing transmission of infection

Laboratory surveillance is undertaken to identify clusters of infection. Our highest risk area is Newborn Intensive and Special Care. In 2008, babies have been admitted with parainfluenza virus, Serratia marcescens and Staphylococcus aureus infections. Early detection, rapid treatment and additional precautions to prevent transmission limited spread to other babies. Periodically, we have some babies with a resistant bowel organism. These babies carry the organism but are not sick because of it. We nurse these babies separately. Hand hygiene is important in reducing spread.

Figure 6: Compliance with hand hygiene opportunities at the Women's



Data source: Infection Control Surveillance

Table 7: The percentage of women who receive prophylactic antibiotics before caesarean section and hysterectomy

2001	2002	2003	2004	2005	2006	2007	2008
93.6	92.8		96.7	98.4	99.2	97.4	
		86.4		80.9	94	86.3	90

Data source: Infection Control Surveillance/VICNISS

Table 8: Cleaning standards

	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
Our score	90	89	94.7	92.8	91.9	94.4
DHS cleaning standard	80	80	85	85	85	85

Data source: RWH auditing records

Antibiotic prophylaxis before surgery reduces infection risk

Prophylactic antibiotics given at the time of surgery more than halves the risk of infection. Table 7 shows our rates for caesarean section and hysterectomy. We plan to improve the rate for hysterectomy by having the anaesthetists give the antibiotic routinely. They do this for caesarean section and our rates have improved.

Having a clean hospital

We audit our cleaning standards against the cleaning standards for Victorian hospitals, as shown in Table 8. The Victorian standard we have to meet is 85. Our score for our highest risk areas such as theatres was 96.5.

REDUCING RISKS FOR STAFF

Making sure the move and the new hospital was safe for staff and patients in our care, was of paramount importance in the last year. We planned our approach to Occupational Health and Safety (OH&S) for all three campuses before and during the move. We aimed, and achieved, zero staff work-related injury, illness or disease during the move.

In 2007-2008, we implemented our policy on the prevention and management of workplace aggression and violence. Hospital staff can experience aggression and potential violence from patients or their families and visitors. Staff need to know how to protect themselves and manage situations so they do not result in violence and disruption to other patients. One hour education sessions have been completed for many staff, including all staff in departments where risks are higher.

HAVING A BABY AT THE NEW HOSPITAL

We provide **family friendly care** that responds to the needs of the woman, baby and their family.

Having a baby at the new hospital

WHAT'S NEW AT PARKVILLE?

In the new hospital, the Birth Centre on level three has been designed with homely birthing rooms and easier access to theatres if a caesarean birth is urgently required. After their birth women either stay in a single or a two-bed room. There is Newborn Intensive and Special Care on the same floor for mothers who need to visit with their baby. Pregnancy care is located on the first floor with most other outpatient services.

DEMAND FOR MATERNITY SERVICES

There has been an unprecedented growth in the number of women giving birth at the Women's. Over the past three years, the number of women having a baby in metropolitan Melbourne rose by 15.5 percent, while the number of women having a baby at the Women's increased by 24.1 percent, as shown in Figure 7.This has presented a number of challenges for maternity service providers.

Last year, the Victorian State Government announced a range of measures to address this unexpected increase in demand to ensure all women can access the right care, in the right place, at the right time. These initiatives aim to help the three specialist maternity hospitals fulfill their specialist role by giving priority to women with complex and high-risk pregnancies.

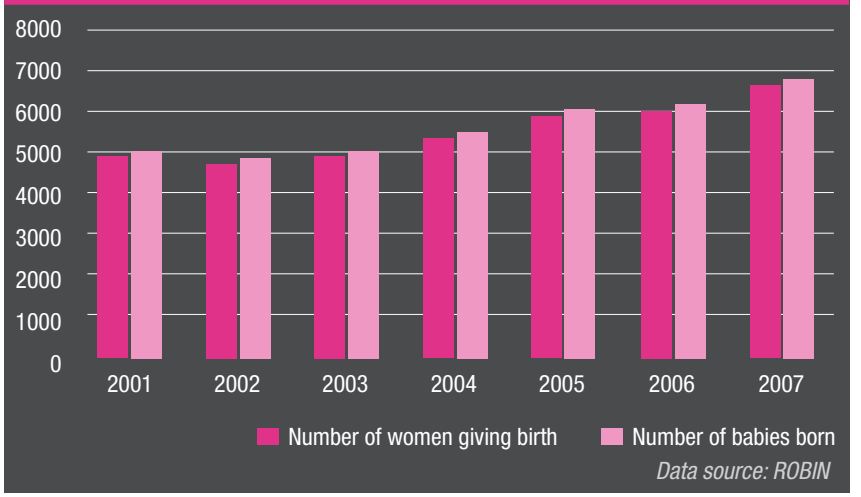
The majority of pregnancies and births are low risk and straight forward. To ensure all women can access the level of maternity care they require, women with low-risk pregnancies are encouraged to attend their local maternity hospital for their maternity care.

The Women's subsequently formalised maternity booking advice to give priority access for:

- All women who live within the Women's local area; and
- Women require specialist tertiary care during their pregnancy.

Women from outside our local area can be referred to the Women's or another specialist hospital, if at any time a woman's pregnancy becomes complicated, or is considered to be high risk.

Figure 7: Number of women giving birth and babies born at the Women's



Data source: ROBIN

TEAMCARE FOR WOMEN

At the Women's, we encourage women, their partners and support people, to be actively involved in a woman's care to feel confident and ready for their baby's birth.

Tanya Farrell and Dr Louise Kornman, the Directors of Maternity Services, explain the new team approach we started in February this year.

What are the changes in TeamCare?

In the last twelve months, we changed the way we organise care during pregnancy and birth. Research and experience tells us that women are more satisfied if they feel that there is a consistent team of staff looking after them. With this in mind, we organised our staff into four teams (blue, green, yellow and red). We assign women to a team based on where they live. This means that women will be cared for throughout their pregnancy and birth by the same group of doctors, midwives and allied health staff.

Why do you think this will be better?

We expect that care will be more personalised, as women are likely to see the same midwives and doctors throughout their pregnancy, birth, recovery and return home. We believe that women will feel a greater sense of belonging, and that our maternity staff will become more involved with individual women. Over time, each team will develop stronger links with its community, local GPs, community-based support groups and so on.

What about women who need specialist care?

We have a range of specialist services, including staff with expertise in maternal fetal medicine and medical specialties including kidney disease, blood disorders and infectious diseases, and in physiotherapy, mental wellbeing, counseling, diet, peer support and social support. Women with the most complicated pregnancies go to clinics for expert care such as for diabetes, multiple pregnancy, fetal abnormality, preterm labour, alcohol and drug problems and physical and intellectual disabilities. This occurs while under the care of their team.

There is also a dedicated genetics counselling service, which provides advice to women about genetic conditions like cystic fibrosis, down syndrome and cleft palate. Counsellors talk with women about the tests which are available and support women and their families with their decisions.

We have specialist clinics for women with recurrent miscarriage or previous pregnancy loss or complications where they can get counseling and advice before their next pregnancy.

MANAGING CLINICAL RISKS FROM HIGH DEMAND

We were concerned that high demand for maternity services would reduce our ability to care for women requiring specialist maternity care. We needed to take a number of steps as follows:

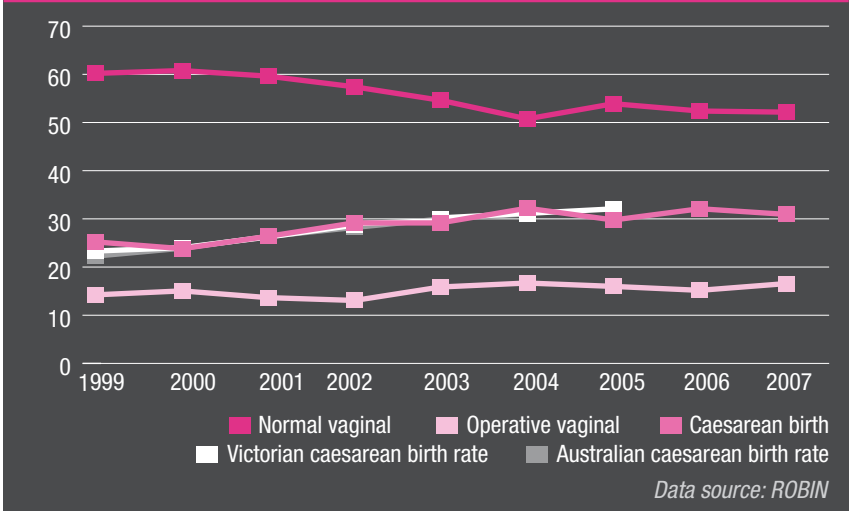
What we did to reduce clinical risks?	What was the outcome?
Access to theatre after hours	Communication has been improved with theatre and Birth Centre staff to better plan on work after hours. An evening theatre opens when it is busy so that access to theatres for emergencies is improved overnight.
Clarity about monitoring the wellbeing of the baby during labour	We developed and implemented an evidence-based guideline and improved documentation to guide the interpretation of CTGs (an external monitor which traces the baby's heart rate to give an indication, although not a perfect one, of how the baby is going). We are also reviewing the evidence from research for the use of measuring lactate, a blood test taken from the baby's scalp. Fetal scalp lactates are done to provide more information about the welfare of the baby during labour. This evidence will provide better guidance about when to take a lactate and how to interpret results. We are working to increase consultant presence in the Birth Centre to provide support for midwives, registrars and residents. In particular, consultants are expected to be present for more difficult and caesarean births.
Timely expert advice after hours	A new system which is planned to commence in May 2009, will enable consultants on call to look at information about the wellbeing of the mother and baby during labour (e.g. CTG partogram) from outside the hospital. This system will further assist consultants to support our junior medical staff and midwives with key decisions when caring for women.

LOOKING AFTER THE HEALTH OF THE MOTHER AND BABY

Why worry about the caesarean birth rate?

Although caesarean birth rates have increased, our rate is now stable and similar to Victorian and Australian rates as shown in Figure 8. The decision to do a caesarean section is taken in the best interests of the mother and/or the baby. Howevever caesarean birth increases the chances of morbidity for women and results in increased length of stay and additional cost for hospitals. For mothers, the experience of an emergency caesarean birth is unexpected and may affect the mother during the early weeks post labour. For those women who have had caesareans in previous pregnancies, of most concern is the risk of the placenta growing into the scar tissue, which puts the health of the mother and baby at risk during birth.

Figure 8: Women giving birth vaginally and by caesarean (data in %)



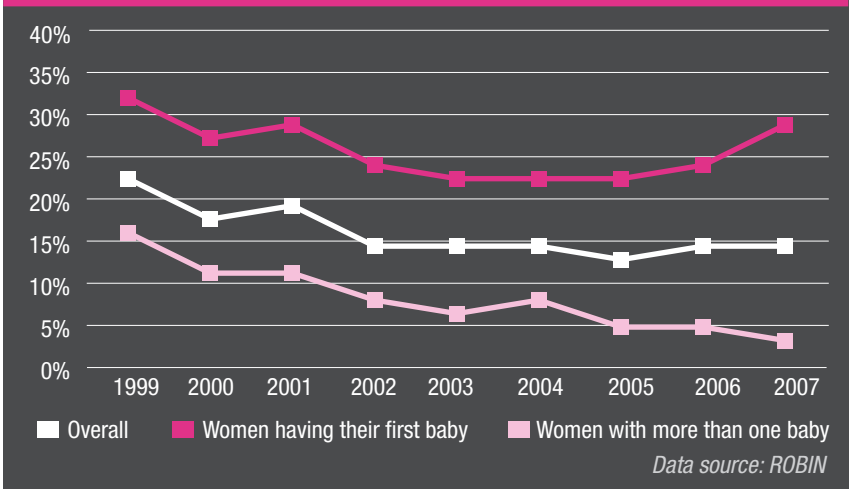
Why is the rate rising?

High risk pregnancies are not driving the rising caesarean birth rates at the Women's. The elective caesarean birth rate at the Women's is stable. The rising overall caesarean birth rate is due to emergency caesarean births. Analysis of our data shows this clearly and emphasises the need to focus on women who are having a baby for the first time, to ensure the appropriateness of their caesarean birth.

What have we done so far?

- We have developed an evidence-based Clinical Practice Guideline for normal labour and birth which is being updated.
- We developed and implemented an evidence-based Clinical Practice Guideline for induction of labour and changed our procedures. Our aim is to reduce unnecessary inductions and to better manage inductions because there is often a cascade from induction to caesarean birth, especially in first births.
- We revised the resources for Vaginal Birth after Caesarean Birth (VBAC), including better assessment of women and developed a decision aid for women considering VBAC.
- We started fortnightly case reviews with junior medical staff of selected emergency caesarean births following induction of labour.
- We have compared our data with two other tertiary hospitals in Melbourne as well as two hospitals overseas.

Figure 9: Induction of labour rates



What is the next step?

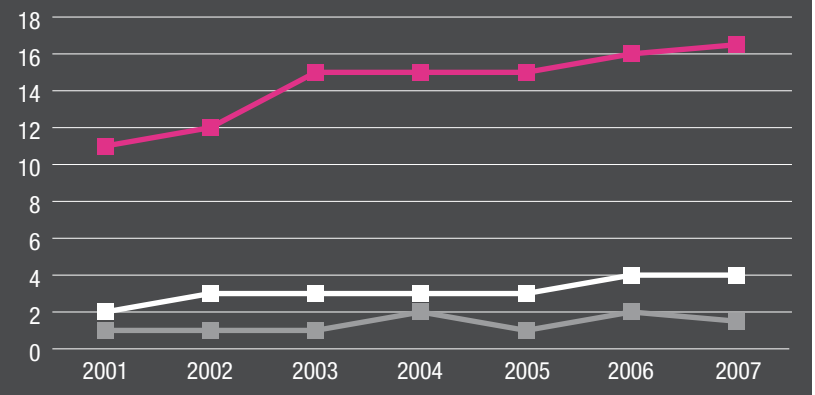
- We are working to ensure better support of junior medical staff in making decisions regarding the need for an emergency caesarean birth.
- The strategies we have currently implemented have not yet created a shift in the rates but we are continuing to monitor them closely and will revise them if necessary.

Blood loss after birth

We monitor the main complications for women and their babies as part of our quality and safety program. Postpartum haemorrhage (PPH) is defined as a woman losing more than 500mL (half a litre) of blood after birth. This blood loss can have an impact on the wellbeing of mother and baby and can lead to decreased energy and difficulties with breastfeeding. A large PPH (over 1500mL - one and a half litres) is an anxious experience for women and their partner. A very large PPH can result in the need for a blood transfusion, admission to intensive care, and significant morbidities such as hysterectomy and in rare cases, death.

We cannot prevent all PPHs, but we put a lot of effort into managing them quickly before they become a major bleed. Figure 10 (next page) shows our overall rate as a percentage, as well as the rate for more serious loss of blood. A number of our previous strategies have not reduced our overall rate. We now review the care provided to women who have a blood loss more than 1500mL following vaginal birth. An area for improvement is junior medical staff involving consultants earlier in managing cases of PPH.

Figure 10: Post partum haemorrhage rates 2001 to 2007



Data source: ROBIN

Table 9: Rate of third and fourth degree tears (percentage of women giving birth)

	2001	2002	2003	2004	2005	2006	2007
Third degree tears	1.7	2.7	1.9	1.8	2.4	3.3	3.1
Fourth degree tears	0	0.2	0.2	0.2	0	0.3	0.1

Data source: VAED

Pelvic floor injury in childbirth

A very small number of women giving birth will have a major tear to the vagina and the surrounding area – defined as 'third or fourth degree tears'. This can lead to later problems with incontinence, difficulties with sexual relationships or pelvic floor problems. Our perineal clinic follows up women to prevent these complications. A clinical nurse consultant visits women on the ward to discuss the tear, its healing and to arrange follow up appointments in the perineal clinic. The clinic has a team made up of an urogynaecologist, colorectal specialist, physiotherapist, continence midwife, dietician and sexual counsellor.

We are working on ways to prevent these and review each of these more serious tears to see if we can improve the way birth is managed.

HOW DOES THE WOMEN'S COMPARE WITH OTHER HOSPITALS?

Table 10: The Women's Maternity Service Performance Indicators

	2003/04 RWH	2004/05 RWH	2005/06 RWH	2006/07 RWH	2006/07 VIC average
For a woman aged between 20 and 34 with no complication of her health or her pregnancy having her first baby at term					
The chances of having the baby induced %	21.5	8.8	6.8	9.0	**15.2**
The chance of having a caesarean section %	23.7	18.8	14.7	17.9	**19.1**
The rate of 3rd/4th degree tears for women having her baby vaginally %	3.1	2.9	4.3	6.0	**4.6**
For women with one previous caesarean section having their next birth					
Rate of Vaginal Birth After Caesarean Section (VBAC) among women who planned for VBAC %	41.5	50.0	51.2	42.0	**51.4**
For all women					
Rate of women referred to postnatal domiciliary care or Hospital-In-The-Home %	88.0	93.0	94.4	91.0	**90.6**
Number of WHO Ten steps to successful breastfeeding achieved	10/10	10/10	10/10	8/10	**9/10**
Rate of women who wait more than 30 minutes for hospital antenatal clinics %	34.0	36.4	31.4	29.4	**12.3**
For women assessed as needing an interpreter					
Rate of women who get an interpreter %	60.0	73.7	79.4	71.1	**86.2**

Data source: Department of Human Services Maternity Services Indicator Reports

This is the first year that we have reported less than 10 out of 10 for the World Health Organisation ten steps for breast feeding. We were unable to meet the step *'Place babies in skin to skin contact with their mothers immediately following the birth for at least one hour.'* We were not able to meet this for women who had caesarean births, because we were not always able to have a midwife with a woman in the hour following birth. We are working through ways to increase the amount of time babies spend skin to skin with their mother immediately after birth.

The second step that we did not meet was the exclusive breastfeeding rate for 75 percent of women. To meet this criteria of 'exclusive' breastfeeding, newborns cannot receive 'food or drink' other than breast milk unless medically indicated. We are continuing to work with staff to increase our exclusive breastfeeding rate and achieve this target in future.

RESEARCH ON MATERNITY CARE

One to one midwifery care

The Women's and La Trobe University are evaluating a caseload (one-to-one) midwifery model of care in a randomised controlled trial for women who are experiencing low risk pregnancies. Currently there is evidence that many women like this kind of care and that some midwives want to work this way. However there is limited rigorous evaluation of this model of care in particular how it compares with a woman's usual options for pregnancy care, the cost and organisation of one-to-one care and its impact in a large specialist hospital such as the Women's. We aim to recruit 2008 women to the trial of which half will receive one-to-one care. In the first year, we have recruited 734 women and of these women, 400 have had their babies. We collect information about the birth and send each woman a survey two and six months later post birth.

If a woman develops any obstetric or medical problems during their pregnancy, the one-to-one midwife consults with and involves an obstetrician but continues to provide support for the woman.

For the ten midwives involved in providing the one-to-one care, the close bond that develops between the midwife and her client has been complex. There have been hard work and tears combined with laughter and desire to make it work. The support and acceptance from other midwives who understand the unseen workload of the one-to-one midwives has been crucial including the acceptance of the one-to-one midwives as part of the broader team.

An alternative approach to postnatal care: a pilot study

The aim of the Postnatal Individualised Care (PINC) pilot study was to explore a new approach to early postnatal care. This is where women are offered early discharge with extra home visits at times to suit them including during pregnancy to assist them to prepare. The study explored the ability of the hospital to meet this new model, the views and experiences of women and midwives providing early postnatal care, at home and in hospital, and the financial cost of this approach.

One hundred and eight women took part in the study who were low risk without any known medical problems. 70 percent of the women were having their first baby and 74 percent of women in the study had a vaginal birth. Of these, 62 percent stayed in hospital longer than planned. Women's views were received by survey two months after the birth. Three quarters of the women felt their length of stay was 'about right' and 74 percent of women felt that the number of home visits was right for them.

Midwives who provide domiciliary or postnatal care were generally positive about the model of care but concerned about workload and resource issues. Further work is being done about how individualized postnatal care could work better in a large tertiary hospital.

Women were generally positive about the model of care and 83 percent said they would choose the PINC model in future. However, overall only 44 percent of women thought that post natal care in hospital was 'very good' while 61 percent felt the care at home was 'very good'. This shows there is room to improve early postnatal care within the hospital and at home.

WHEN THE UNEXPECTED HAPPENS

Not all pregnancies end happily and some pregnancies miscarry at an early stage. A small proportion of babies die from complications of pregnancy or prematurity. Some women make difficult decisions to have an abortion. These are all difficult times for women and their families. 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.

Many staff support women and their families through these difficult times – obstetricians, midwives, neonatologists, neonatal nurses, geneticists, anaesthetists, physicians, pathologists, bereavement counsellors and other allied health professionals.

During the year, the Perinatal Mortality and Morbidity Committee considered the care provided to women and babies for every one of the 157 perinatal deaths (79 stillbirths and 78 neonatal deaths) by looking at the pathology and the medical record. Cases with educational or practice improvement opportunities were presented at a monthly health professionals' forum.

The data are consistent with a high standard of maternity and neonatal care. Half of the perinatal deaths occurred for women who had been transferred to the Women's because of problems with their pregnancy. In 51 percent of these circumstances, a termination of pregnancy was undertaken.

The data shows that 50.3 percent of all deaths were babies with congenital abnormalities. In three quarters of these, the pregnancy was terminated.

Most perinatal deaths were preterm – 85 percent were babies less than 37 weeks and 70 percent were less than 28 weeks. There were two cases of hypoxic peripartum death at term, both of which were reviewed to look for practice improvement issues.

Figure 11 shows our perinatal mortality rate, adjusted for congenital abnormalities, which is lower than the Victorian average and reflects good maternity and neonatal care.

Table 11: Perinatal deaths, The Royal Women's Hospital 2004 to 2007 and Victoria 2006

	2004	2005	2006	2007	Victoria 2006
Livebirths	5390	5931	5984	6663	69229
Stillbirths	81	72	84	79	607
Neonatal deaths	58	73	68	78	227
Perinatal deaths	139	145	152	157	834

Data source: Perinatal mortality database

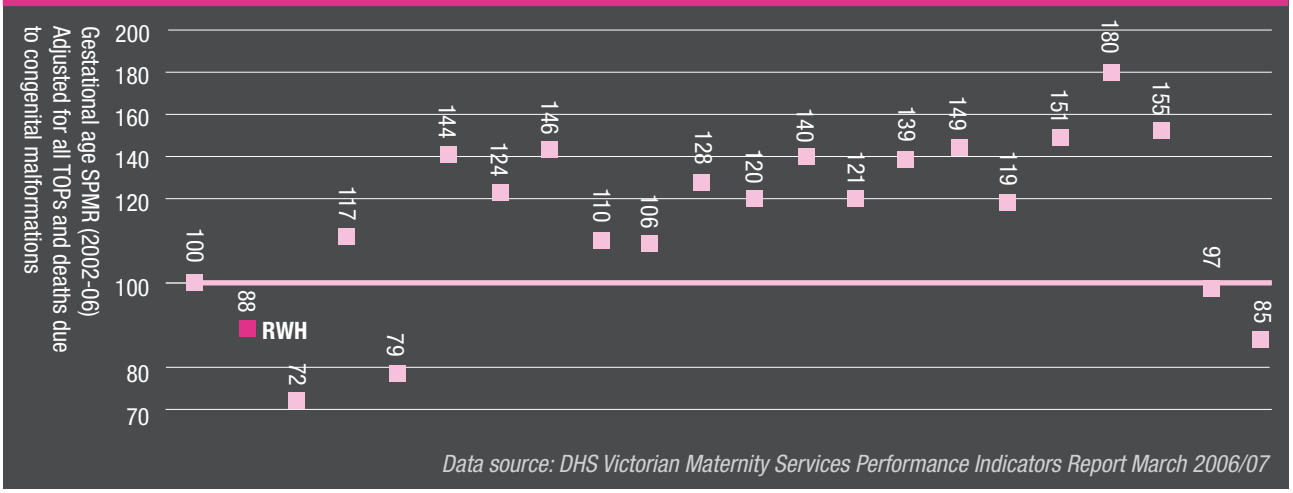
Table 12: Perinatal deaths at the Women's 2007, by cause and gestational age

	Gestational age									
Cause of death	20-27 weeks		28-31 weeks		32-36 weeks		37+ weeks		Total	
PSANZ PDC	n	%	n	%	n	%	n	%	n	%
Congenital abnormality	59	54.1	1	10	9	64.3	10	41.7	79	50.3
Infection	5	4.6	0	0	0	0	3	12.5	8	5.1
Hypertension	5	4.6	0	0	0	0	0	0	5	3.2
Ante partum haemorrhage	10	9.2	3	30	2	14.3	0	0	15	9.6
Maternal conditions	2	1.8	0	0	0	0	1	4.2	3	1.9
Specific perinatal conditions	1	0.9	1	10	0	0	2	8.3	4	2.5
Hypoxic peripartum death	0	0	1	10	0	0	2	8.3	3	1.9
Fetal growth restriction	2	1.8	1	10	2	14.3	0	0	5	3.2
Spontaneous preterm	18	16.5	1	10	0	0	0	0	19	12.1
Unexplained antepartum death	7	6.4	2	20	1	7.1	3	12.5	13	8.3
No obstetric antecedent	0	0	0	0	0	0	3	12.5	3	1.9
Total	109	100	10	100	14	100	24	100	157	100

Data source: Perinatal mortality database

We talk through a number of difficult decisions and consult closely with families who say they value the opportunity to discuss the death of their baby.

Figure 11: Gestation standardised perinatal mortality ratios Victorian Hospitals 2002 to 2006



Data source: DHS Victorian Maternity Services Performance Indicators Report March 2006/07

Terms we use

Stillbirth: the baby dies in the womb after 20 weeks

Neonatal death: the baby dies before 28 days old

Perinatal deaths: stillbirths and neonatal deaths added together

Congenital abnormality: an abnormality present at birth

Hypertension: high blood pressure

Antepartum haemorrhage: when a woman looses blood vaginally before her baby is born

Antepartum: before birth

Post partum: after birth

Hypoxic peripartum death: the baby dies from lack of oxygen during labour

Fetal growth restriction: the baby is smaller than expected for its gestation (weeks of pregnancy)

Morbidity: the incidence of a disease or condition, or adverse effects, which may be caused by a treatment

WHAT DO FAMILIES THINK?

After a baby dies, despite the family's grief, they still have to make a number of difficult decisions. One of those is whether or not to have a post mortem (or autopsy). Over the last decade, hospitals were criticised for their lack of consultation with families about post mortem.

In 2000, we worked with families to develop a family information booklet and a procedure so that senior consultants obtained consent after talking families through their options. Over 2006 and 2007, we sought the views of 52 families who had lost a baby at the Women's in 2005 to evaluate whether the information we provided them was too much or too little.

We found that the choice to have or not to conduct a post mortem on a baby was not influenced by age, social, educational, cultural or familial factors or whether there were other children. When families chose no post mortem, it was usually because the cause of death was known or they wanted to protect the baby from further harm. Families chose autopsy to find the cause of death, to understand the risk for further pregnancies or because it was the 'right thing to do'. For example, to assist humankind and scientific research to help other families.

Generally families believed they had made an informed decision. Significantly, the research found that it is not the amount of detail that concerned them but the emphasis placed on post mortem, which families saw as only one decision they had to make.

Clinicians were described as informative, helpful and caring. Families said they value the opportunity to discuss the death of their baby and do not want to be 'protected' from information and decisions. They value talking with the senior doctors, although some thought it would be valuable to have a midwife they knew, or who had been involved in their care, to 'translate' the doctor's information to them.

Families suggested a new booklet to bring together all aspects of their decisions from the diagnosis of death, birthing choices, bereavement loss support, post mortem choices, necessary paperwork and options after leaving the hospital.

THE SACRED SPACE: A SHARED SPACE BETWEEN THE WOMEN'S AND ROYAL MELBOURNE HOSPITALS

The new Sacred Space, situated off the corridor between the two hospitals is being further developed to reflect the diverse and multi-cultural community within the Women's and Royal Melbourne hospitals. The Sacred Space is a place for quiet reflection, meditation and prayer for all people and is welcoming and respectful to all faiths and traditions. There are two rooms available which offer access to a prayer journal, prayer mats, religious symbols and holy books from a number of traditions.

The Sacred Space is a place for quiet reflection meditation and prayer for all people, and is welcoming of all faiths and traditions.

WOMEN'S SERVICES

We provide evidence based care at the forefront of our practice.

WHAT'S NEW AT PARKVILLE?

The Women's Health Information Centre is located on the left hand side when you enter the new hospital on the ground floor. This is where a wide selection of literature and information about women's health and pregnancy is available.

Women's Services, which includes women's cancer, gynaecology, urogynaecology, mental health and information services have reviewed their services and established strategies to better meet women's health needs. We believe it is important that our commitment as a professional tertiary organisation is maintained and that clinical governance and evidence-based care is at the forefront of our practice. We are continually evaluating our services and seeking to improve services that address women's needs.

The location of these services has improved with most women's health clinics together on level one enabling greater access and more multidisciplinary care. The inpatient wards for gynaecology and oncology patients are located on level five.

HEALTH INFORMATION FOR WOMEN

Health information is central to how we provide health services at the Women's. Two services, the Women's Health Information Centre and the Women's Consumer Health Information, work in tandem to develop a comprehensive program of improving access to quality consumer health information for women.

The Women's plays an important role in developing health literacy around women's health issues. The term 'health literacy' is the degree to which individuals are able to obtain and understand basic health information and services required to make decisions about their health. Poor health literacy has been shown to cause poorer health, less use of preventative services, overuse of hospitals and emergency departments, and increased health costs.

There are any number of reasons as to why this is the case including language and cultural issues, levels of education, social isolation, basic literacy and numeracy skills and increasing demand on consumers to self manage and sort through high volumes of information.

At the Women's the notion of health literacy has helped us to reframe the way we produce and deliver information to women. We work collaboratively with patients, health professionals and women in the community. We consider the variety of ways in which information can be produced and how women may be able to access it through their GP, community health centres and in the hospital. We ensure that information is integrated into care and we are seeking other ways in which they can access information or be provided with appropriate support to access information. For example we plan to trial an 'information prescription'.

'This is my third baby at the Women's, the first baby I had no information, the second baby a little bit more, but this time it's improved greatly.'

THE WOMEN'S HEALTH INFORMATION CENTRE

The Women's Health Information Centre offers a telephone, drop in and email service. The centre, which is located in the main foyer, offers a welcoming environment where women can be assisted to find the information they need. In the three months since we have been at Parkville, we have seen just over 1000 women and been contacted by 2762 women by phone and 144 emails.

To contact us you can ring 03 8345 3045 or email on whic@thewomens.org.au. You can find consumer information on our website www.thewomens.org.au which has a dedicated section for health information including information in languages other than English.

WORKING TOGETHER AS A TEAM – ALLIED HEALTH

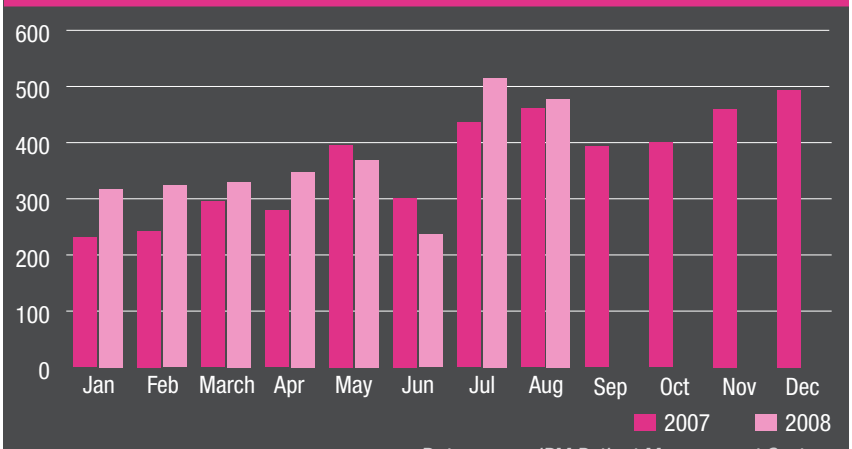
There has been sustained work across the hospital to create more multidisciplinary teams. Services such as physiotherapy, social work, dietitians and mental health clinicians have been integrated into teams in maternity, gynaecology, cancer services and neonatal intensive and special care. This approach improves our ability to recognise the broad range of issues that might affect women's health and wellbeing.

Physiotherapy

Physiotherapy is an important aspect of women's health. Each year our physiotherapists see over 4000 women and we are steadily increasing the services we offer.

We have integrated physiotherapy, social work, dieticians and mental health clinicians into teams in maternity, gynaecology, cancer services and neonatal care.

Figure 12: Physiotherapy attendance January to September 2008



Data source: iPM Patient Management System

A significant improvement to Physiotherapy's clinical service has been the integration of physiotherapists into the new maternity TeamCare model in February 2008. This new development has had a significant impact on the quality and timeliness of care we offer pregnant women. The number of appointments has also doubled in specialist gynaecology clinics during this year.

Another improvement is the increase in the number of exercise classes for maternity and gynaecology patients. We now offer four types of exercise and education classes for pregnant and postnatal women - fitness, Pilates, pelvic floor and abdominals, and TENS classes. We also offer pelvic floor exercise classes for gynaecology patients, and lead the fitness classes for the 'Big Girls Group'. In 2009, we will begin a 'Mums and Bubs' exercise and education class for postnatal women who are at risk of postnatal depression.

We are keen to undertake physiotherapy research on women's health. In 2008, two staff completed their PhD and two will complete their Masters Degrees by the end of the year.

Nutrition and Dietetics

Nutrition and Dietetics has experienced significant changes over the past twelve months, with the introduction of maternity TeamCare 2008 and the great new space which is shared with Physiotherapy. Working in the TeamCare model is a step forward, with dieticians present in all the four team clinics and appointments fully booked.

Establishing a presence in a multidisciplinary team sets us apart from other hospitals and has enabled better communication between the different health professionals, and better identification of women who would benefit from nutrition and dietetics consultation.

Another area of growth for Nutrition and Dietetics has been within the Urogynaecology team, in managing bowel incontinence through diet. This is a relatively new area of work for dieticians and Nutrition and Dietetics at the Women's is recognised nationally as a leader.

Nutrition and Dietetics are working in collaboration with Physiotherapy to develop a multidisciplinary program to help women manage their weight and fitness.

Women's Social Support Services

Women's Social Support Services (WSSS) provides a range of social work services to women with psychosocial issues. Each year, we see over 6,000 women across maternity, gynaecology, neonatal and cancer services. We are located off the front foyer in the new hospital, so access is easy.

In 2008, social workers were integrated into the maternity TeamCare model with a social worker in each team including in Young Mums clinic and the Fetal Management Unit. This led us to improve our intake and crisis care arrangements.

WSSS has worked with other departments to improve the quality of care for women. This includes working with the Pregnancy Advisory Service to look at the needs of women with a cognitive impairment with an unplanned pregnancy and with CASA House on the Violence Against Women Strategy. We provided training and education within the Women's and externally on issues such as child protection, self care, bereavement, and violence against women.

We also contribute to social work research with three staff working on Masters Degrees and one on a PhD.

CENTRE FOR WOMEN'S MENTAL HEALTH

In 2006, the Women's received generous funding from the Pratt Foundation and from the Department of Human Services to establish a Centre for Women's Mental Health. We think that women's mental health problems need an approach specifically designed for women because:

- Women as a group experience social, psychological, cultural and economic inequalities.

- There are characteristics of the assessment, treatment and management of mental health problems specific to women.

Our initial focus has been on building up a mental health service. The mental health team has expanded and includes consultant psychiatrists and psychiatry registrars, clinical psychologists, mental health nurses and a consultant infant mental health clinician.

Mental Health services

Mental health assessment and treatment is provided for women who are both inpatients and outpatients and we have a partnership with the Royal Melbourne Hospital after hours. Table 13 shows mental health services are increasing. The main reason for referral of women is depression.

We provide education around mental health issues to other departments within the hospital and telephone consultation advice and educational sessions to General Practitioners.

Maternity

A psychiatrist or psychiatry registrar is attached to each of the four TeamCare maternity teams including the Young Mums, Women's Alcohol and Drugs Service, Fetal Management Unit and Diabetes clinics. This allows mental health care to be integrated into maternity care. Regular contact between mental health and other team members improves communication and is part of identifying mental health issues for individual women. Strong links have been developed with the three mother-baby units in Melbourne and other services to improve ongoing care for women with major mental health problems.

Newborn Intensive and Special Care

A consultant psychiatrist and the consultant infant mental health clinician work with parents and infants in Newborn Intensive and Special Care. Parents with mental health problems are supported and work may be undertaken to strengthen the parent-infant bond.

Outpatient follow up for these women and their families may also be provided for a period of time. The infant mental health clinician is also available to other mothers identified either antenatally or postnatally as at risk of experiencing difficulties with their babies.

Cancer and other services

A dedicated consultant psychiatrist and clinical psychologist works with the gynaecological cancer unit and the Women's-Royal Melbourne Integrated Breast Service as part of the support for women's psychosocial issues. A dedicated consultant psychiatrist works with our menopause service and will shortly be joined by a clinical psychologist.

Table 13: New referrals to mental health services

	Jan to June 2007	July to Dec 2007	Jan to June 2008
All new referrals	199	217	272
Fetal Management Unit	13	11	12
Maternity	100	96	132
Alcohol and Drugs	35	18	15
Young Mums	3	19	13
Cancer	10	27	30
Neonates	–	–	15

Date source: Mental Health database

We have improved our ability to recognise the broad range of issues affecting women's health and wellbeing.

There is such a big difference between how I was and how I feel now. The experience was as positive as it could be.

Interview with Jess

Jess is 25 years old. When she was 24, she found a lump in her breast and came to the Women's. Jess was treated within the Integrated Breast Services of the Women's and Royal Melbourne Hospital. This is her story.

'The doctors decided to take the lump out as a precaution. I was young. I had no family history. It came as a complete shock when they asked me to come in three days later and I met a team of people. I was told I had DCIS (abnormal cells) in the margins. I don't remember a lot about that first appointment.

I met with the team a couple of times and discussed what the options were for me. They were recommending a mastectomy. When they discussed my options with me, they spent time thinking and talking to me about what it would mean for me.

At first I seemed to take it really well. Then I started bursting into tears at work. I became really anxious about how I would feel afterwards. I worried about my body image and what it would mean for my sexuality as a young woman without a current boy friend. I wanted to pull out of the surgery.

That's when they asked me to see a psychologist. I didn't want to see her at first. I felt like that meant I was crazy. I saw her lots of times and I still see her. Because of how anxious I was, I also saw the psychiatrist. The best thing was having the chance to talk to them and that it was OK to feel the way I felt. The psychologist was like having a support person who was thinking about how I would feel. When I had the surgery, she organised for me to stay five days and organised a single room for me with a double bed so that my mother who came down from Queensland could stay with me. People kept checking up on me. I felt like I was treated as a person.

One of the greatest parts has been having the same team all the time. They know my name. When I see new people, they are always prepared for me. I had my surgery at the Women's. I had tests at Royal Melbourne and I am having plastic surgery there.

I like the way the new hospital looks. The volunteers to show you where to go were good. The new hospital seems more professional and personal – it's more girly! In the ward, when it's clean and comfortable, you feel much better.

The care was comprehensive and looked from all different angles, not just medical. There are a couple of things that could be better. The pictures they showed me about what my breast would look like were very confronting and not like surgery these days. I told my surgeon about this and she is taking new photographs, including ones of me. I talked to one of the nurse about the impact on my sexuality. It was a big issue for me as a young woman. I thought that this could have been specifically raised with me.

There is such a big difference between how I was and how I feel now. The experience was as positive as it could be.'

WOMEN'S EMERGENCY CENTRE

For some women, the Women's Emergency Centre (WEC) is their first contact with the hospital. The WEC is on the lower ground floor of the new hospital and provides emergency care and assessment of early labour.

Dr Melinda Truesdale, an Emergency Medicine Physician, **Dr Anna Rogers**, an Obstetrician and Gynaecologist and the nursing manager, **Caroline Looney**, were interviewed about women's emergency care in the new hospital.

Tell me about your space in the new hospital

We are really happy with the hospital - our environment is spacious, bright and clean.

There are more interview rooms and more useable cubicles which let us bring women inside waiting for assessment rather than sitting outside in the waiting room.

The working conditions for doctors are better and you get a better overall view about what's going on.

There is a new triage and assessment area.

We wanted to provide better neonatal access and care and we are able to put these babies and their families in an area where they are very visible and we can keep a better check on the baby.

We have an isolation room so that if women come with an infectious disease, we can keep them separate so that other women are not at risk.

There is much better access to the sexual assault clinical area, which is now within Women's Emergency Care.

The move went well. There was lots of preparation to make sure we had the right staff and the right equipment over the move.

What improvements have been made in the last year?

The biggest improvement is that the Women's Emergency Care has been reaccredited with the College of Emergency Medicine. This means that we are able to recruit more qualified doctors and trainees, so that the standards of medical care have improved.

We have also been able to recruit more nurses, so that 95 percent of the time, we are staffed to the number of nurses we are required to have in industrial agreements.

We have better links with the Emergency Department at the Royal Melbourne Hospital, which is particularly important now that we are so close together, and this will mean better transfers of women between the two emergency departments according to the treatment they need.

Credentialing of doctors to undertake ultrasound has been done.

EARLY PREGNANCY ASSESSMENT SERVICE

Pain and bleeding early in pregnancy doesn't always mean there is a problem. For those women for whom it means they are having a miscarriage, this is often a very difficult time. We wanted to improve our services so that we could offer a more streamlined and supportive service. The Early Pregnancy Assessment Service (EPAS) was established in April 2007 to provide a 'one-stop' care for women with pain and bleeding in the first sixteen weeks of pregnancy. It is situated near the Women's Emergency Centre and women who are acutely unwell are managed within the Centre.

EPAS is held on weekday mornings and Monday afternoons, and women are referred from the community or may self-refer. Midwives assess and follow-up women and arrange investigations in accordance with Clinical Practice Guidelines (CPGs) which were developed to support and guide the service. We see around 300 women each month.

A recent improvement has been the development of a process for training, supervision and credentialing of doctors working with EPAS in early pregnancy ultrasound.

If a miscarriage is diagnosed, when appropriate, women are offered the alternatives of waiting for the miscarriage to happen naturally or surgical management. In February 2008, miscarriage theatre lists were increased from three times weekly to daily Monday to Friday, so waiting times could be reduced for women choosing surgical management. The process for booking has been streamlined reducing the number of different doctors a woman will see.

If a continuing pregnancy is diagnosed, the woman is referred to an antenatal clinic at the Women's or her local hospital.

If an ectopic pregnancy is diagnosed, the woman is referred to a gynaecology team for clinical management. Our CPG has recently been revised to improve clinical review where a woman's ectopic pregnancy is managed medically with methotrexate. A register of women with ectopic pregnancies has been established to assist follow-up of women.

As EPAS developed, we interviewed women about their experience and worked with consumers to develop information for women (see Chapter Three). Fact sheets on miscarriage and ectopic pregnancy are available on our website http://www.thewomens.org.au/atozfactsheets

Table 14: EPAS presentations: Monthly visit data January to June 2008

	Jan 2008	Feb 2008	Mar 2008	Apr 2008	May 2008	Jun 2008
Presentations	363	300	286	290	318	229
First visit	209	175	175	182	205	156
Ultrasound exams	255	184	203	211	236	181

Data source: EPAS database

EPAS has collaborated with Women's Hospitals Australasia to develop an audit tool for diagnosis and management of ectopic pregnancy. We collect data on all women who present which will allow us to audit how effective the service is over the next twelve months.

WOMEN'S HEALTH CLINICS

Since the move to Parkville, there have been many positive changes within the outpatient Women's Health Clinics, with all women's health specialties now being located together. All the clinics are held in the Women's Health pod on the first floor, except for the Menopause Clinic and Reproductive Services which are on level two. Sexual counselling will join the first floor from November 2008.

These are our Women's Health Clinics:

Adolescent
Breast
Cancer
Choices
Communicable Disease
Continence Advice
Dysplasia
Gynaecology Assessment Clinic
Gynaecology 1 (bleeding)
Gynaecology 2 (pain)
Gynaecology 3 (prolapse)
Menopause
Mental Health
Perineal
Sexual Counselling
Surgical Pre-admission
Urodynamics
Urogynaecology
Vulval / Dermatology Disorders
Well Women's Clinics

Combining the outpatient clinics has improved multidisciplinary care, as clinicians can talk over clinical care with colleagues from other disciplines. Other advantages since the move include improved access to consulting rooms and facilities.

The move has been a major change for everyone and with the new facilities and equipment, the service needs to match women's expectations of us. High demand for specialist gynaecology and cancer care with current workforce shortages has had an impact on service delivery. The time women wait for specialist clinic appointments is increasing and anecdotal evidence suggests updating and streamlining our intake process will improve this which is one of the hospital's main priorities.

CHOICES

Choices Clinic was established in 1998 by combining the Family Planning and Pregnancy Advisory Service Clinics. Combining the two services meant better access for women to both clinics.

Choices Clinic provides all aspects of women's sexual and reproductive health care, including contraception options and surgical sterilisation. The clinic offers outpatient IUD (Intrauterine Device) insertion and women are also able to have contraceptive implants (Implanon) inserted or removed. Women who are requesting pregnancy termination attend Choices Clinic. Women come to the service by contacting the Pregnancy Advisory Service counselors or the Genetics clinic.

Women are also referred to the clinic from the community, from within the hospital or can self-refer.

Many of the women have high risk pregnancies or high risk medical histories which is why the service we offer is at a tertiary level. Outside health services also refer women with complex medical histories to the Choices Clinic for sexual and reproductive health advice.

Since the move to Parkville, Choices Clinic services have improved. The clinic is now conducted on Tuesday, Wednesday and Thursday mornings. The operating theatre list is conducted in the afternoons of the clinic days and means that rural women or socially disadvantaged women can be seen in clinic in the morning and can go to Day Surgery on the afternoon of the same day.

Choices Clinic has also been a partner in Australia-wide research with the contraceptive implant (Implanon) and analysis of this research is currently underway.

Work practices have also changed and women are now seen as they arrive which has reduced some of the longer waiting times in clinic. Sharing the work space with other staff from differing specialities in women's health has made it easier to consult with other medical and nursing experts.

Choices Clinic has always had a good cooperative and collaborative team work ethic with nursing, medical and clerical staff working effectively together.

ADVOCACY – ABORTION LAW REFORM

One of the most significant improvements in the quality and safety of health care for women in the last forty years followed from the Menhennit ruling in 1969. Once the circumstances in which an abortion was not unlawful were clarified, women stopped dying of complications from desperate efforts to end a pregnancy they could not keep.

Prior to the Menhennit ruling, the Women's provided care for many women who died or were damaged by unsafe abortion. After this ruling, the Women's developed counselling and abortion services for women who needed them, in keeping with our commitment to provide comprehensive sexual and reproductive health care. The many doctors, nurses, midwives and counsellors who have participated in this work over the last forty years have contributed to a body of experience which has informed delivery of the best possible care and enabled us to advocate for broader improvements to health care, including law reform.

It is estimated that around one third of Australian women will have an abortion at some stage in their lives. International and local data confirm that abortion, when performed by qualified health professionals, is among the safest medical procedures.

Despite the Menhennit ruling determining when an abortion was not unlawful, abortion remained a crime in Victoria under the *Crimes Act 1958* that could lead to ten years imprisonment. This created uncertainty for women and the doctors who cared for them. Since 2005 the Women's has publicly supported efforts to regulate abortion in health law, rather than criminal law.

In November 2007, the Women's wrote a submission to the Victorian Law Reform Commission's inquiry into the law of abortion, describing the benefits of removing abortion from the *Crimes Act*. Staff from the Women's provided the Commission with expert advice on clinical practice and answered questions about the rare but complex circumstances that lead women to consider the option of abortion after 24 weeks. Ongoing advocacy included providing Ministers and parliamentarians with briefings, once the Bill to reform the law of abortion was tabled, and writing articles clarifying misunderstandings about the impact on women's health if the Bill became law.

The Women's believes that the new legislation regulating abortion in Victoria will foster greater community confidence in the law and in the health services available to women. Women experiencing an unplanned or untenable pregnancy, and their health care team, can now consider the option of abortion free of the threat of prosecution. We are confident that these reforms will improve the quality and safety of health care for women. Treating abortion as a health issue creates a framework which supports training and succession planning, research directed to health outcomes and prevention activities, as well as continuous service improvement.

MIFEPRISTONE

The Women's introduced use of mifepristone for medical termination of pregnancy in December 2007. Following a debate in the Federal Parliament about the regulation and use of mifepristone, we successfully obtained Therapeutic Goods Administration (TGA) approval to use mifepristone in particular clinical circumstances. Our staff looked closely at Scotland's longstanding mifepristone processes, and established contact with services in New Zealand. As a result, the Women's developed a procedure guideline and patient information and consent form based on information obtained from Scotland, New Zealand and local TGA requirements.

The Women's ensured the use of the drug was properly recorded and reported to TGA and for research. The Women's was the first hospital in Australia to introduce this treatment. Since implementation of mifepristone, a woman's stay in hospital following a medical termination of pregnancy has reduced from around three days to ten hours. The experience is safe and generally easier for women.

COMPLEX CARE SERVICE

As one of three tertiary women's hospitals in Victoria, we increasingly care for women with complex care needs alongside their maternity or gynaecological treatment. To meet the demand for specialised complex care, in the new hospital we have established a separate Complex Care Service with six beds. A Clinical Nurse Consultant (CNC) position has been created to provide clinical expertise, education and liaison.

Women who have more complex health needs are nursed within the complex care unit or within the Birth Centre. The Complex Care Service will offer an outreach service to the wards to support staff in assessing a woman's condition. We have reviewed the education and training for nurses and midwives and re-launched a complex care course for nurses.

Two complex care beds in the Birth Centre will be staffed by midwives who have completed the Complex Care Specialty Nursing Course or who have high dependency nursing experience. Nursing these women in the Birth Centre means the women receive the appropriate level of midwifery/nursing care and will avoid unnecessary separation of mother and baby.

CANCER SERVICE – CHEMOTHERAPY

Drugs used for chemotherapy in women with cancer have good and bad effects. We call the bad effects toxicity. One of our key measures to assess the quality of the treatment and care for women having chemotherapy is women's experience of toxicity and associated treatment delays and alterations.

Women's quality of life when on chemotherapy is improved by controlling nausea and vomiting. Based on international recommendations, we changed from two days of anti nausea medication after chemotherapy to one day only and evaluated whether this controlled vomiting while minimising a side effect - constipation. The results showed that one or two days was comparable in reducing nausea, while constipation was significantly reduced on the one day treatment.

BREAST SERVICES

For women, a diagnosis of breast cancer impacts their whole life affecting their physical and emotional wellbeing and network of responsibilities they have towards other people including their partners, children, parents, grandchildren and friends. Women want the best available treatment based on research evidence including help with treatment side effects, and support for their emotional, social, practical and sometimes spiritual needs (psychosocial care). A small number of men are also diagnosed with breast cancer.

In February 2007, the Women's and the Royal Melbourne Hospital launched a combined Breast Service which integrated our two breast services into one comprehensive service to improve breast cancer care. We wanted to build on the strengths of both units, be a centre of excellence for teaching and research, and address gaps in the services. In October 2008, Premier John Brumby presented the two hospitals with the inaugural *Premier's Award for Excellence for improving cancer care in Victoria* at the Victorian Public Healthcare Awards.

'At a time when patients and their families are at their most vulnerable, this service is offering better help and more hope.' – Premier John Brumby, October 2008.

Within the integrated Breast Services, there is a steering group involving representatives from both hospitals and working groups, all with consumer representation. Focus groups and one-on-one interviews were conducted with staff and consumers, to develop the model of psychosocial care, and to identify the best ways to disseminate information about the service.

A Director works across both hospitals, coordinating a highly dedicated multidisciplinary team. An innovative model of care was developed to ensure a smooth process for women between the two hospitals. It encompasses the entire patient experience from the booking of the first appointment to the lifetime follow-up care. There are weekly meetings of all health professionals involved with a woman to discuss the best approaches for her.

As shown below, the Breast Service has significantly improved access to care, coordination of care, and addressed the often neglected psychosocial elements of care. In its first year, the research profile has also increased. With the research intimately linked to the clinical care this helps translate research findings into clinical care.

Evaluating the psycho-social model of care

We developed tools to identify women's psychosocial needs which we trialed, introduced and adapted for gynaecology cancers. We evaluated staff perceptions of this screening tool and found that it was viewed as a way of having women's psychosocial concerns documented and assisted discussions with the Breast Care Nurse. However, we found that not all staff referred to the completed screening tool and work is underway to improve this.

We conducted focus groups with women, and found they were satisfied with the Breast Service and level of support, but also identified areas for improvement. These consumer perspectives were pivotal in our decision to include reconstructive breast surgery as part of the service:

Improved access	535 additional outpatient appointments per year 165 additional surgical procedures per year
Improved multidisciplinary care	100% of patients following breast cancer have an agreed multidisciplinary management plan included in their medical record Improved identification of patients who require supportive/psychosocial care
More research	2 significant research grants received 12 research studies are currently recruiting patients to take part in research to improve treatment

'I would particularly like to commend the Breast Care Nurse team. They really did make a difference from the time of my initial diagnosis and continue to do so now. Seeing a friendly, caring and thoroughly knowledgeable nurse/friend greatly eased all transition points in what has been very accurately described by others as a 'journey'. Despite the obvious workload on clinic days, they seem to find time for everyone. That continuity is very important to a patient in otherwise very uncertain times, as is the knowledge that there is someone just a telephone call away for support or advice between visits if needed.

I was also pleased (and somewhat surprised), that in such a major teaching hospital, there was a high degree of continuity with treating medical specialists. I understand the combining of the Breast Units of the Women's and the Melbourne (around the time of my first admission) was probably, in part, directed towards this end. It has obviously succeeded.

The only area where some discontinuity appears is where treatment requires reconstructive plastic surgery following completion of post-surgical medical oncology treatments. Maybe this is an area for potential future integration.'

CARING FOR WOMEN REQUIRING SURGERY AT THE WOMEN'S

Caring for women
requiring surgery at the Women's

WHAT'S NEW AT PARKVILLE?

For women having surgery, the new hospital has been designed to improve patient comfort, privacy and waiting areas as well as having the latest state-of-the art equipment and technology.

Each year over 11,700 surgical procedures are performed at the Women's, including almost 2,000 caesarean births. The great majority of surgical procedures are of a minor nature and treated in the day surgery department. Of the major surgical procedures, the three most common remain advanced laparoscopic surgery for ovarian problems and endometriosis, hysterectomy for benign and malignancy reasons and operations for prolapse and incontinence of urine.

THE PATIENT'S JOURNEY – BEFORE SURGERY

After the woman and her doctor have decided on surgery and the doctor has indicated a need for a pre-admission visit or otherwise, a team of nurses and clerks make a further assessment to ensure women are both medically and socially prepared for surgery.

Women are placed on the Elective Surgery Waiting List according to the urgency of their surgery. A nurse conducts a Health Questionnaire by phone to reduce the number of visits a woman has to make to hospital and to check if any further investigations are required before surgery. When their surgery date has been allocated, women receive a letter and, if required, an appointment at the Surgical Preadmission Clinic. Each woman is assigned a nurse so that women can ring them at any time before their surgery.

When a woman comes to pre-admission clinic, they are seen by a registrar, anaesthetist and pre-admission nurse, who make sure women are well informed about their procedure, their stay in hospital and are medically fit for surgery. Some women requiring major surgery are seen again by a team of surgeons. This benefits the women as it puts a safeguard in place to ensure they understand the surgery and that the appropriate tests and treatments are undertaken. It also reduces the number of surgeries cancelled on the planned day of admission.

HOW LONG DO WOMEN WAIT FOR THEIR SURGERY?

The Women's does very well on waiting times for surgery and meets all its targets. Doctors assess the need for surgery and how quickly it needs to be done. They rate it as urgent (category 1), semi-urgent (category 2) or less urgent (category 3). Table 15 shows that most women will have had their surgery within three months.

With the advances in surgical and anaesthetic techniques and the development of new anaesthetic and pain relieving drugs, more patients have surgery on a day basis including complex procedures. The benefits include shorter surgical times, reduced time in hospital and increased family involvement.

Most women are admitted on the day of their surgery and admission times are staggered to reduce women's waiting time. Since moving to our new hospital, women can now stay with their husband, partner or friend until just prior to surgery.

A safety procedure called 'Time Out' has been introduced into the surgical unit as a routine practice. This requires the surgeon, nurse and patient to make a final check on the nature of a women's surgery just before anaesthesia is commenced. There is good evidence that this procedure ensures that the right patient has the right operation in the right area of the body. We are currently planning an observational audit of this procedure.

Table 15: Waiting times for surgery (figures are percentages)

RWH elective surgery performance 2002-2007	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
Category 1 patients admitted within 30 days	100	100	100	100	100	100
Category 2 patients admitted within 90 days	100	100	100	100	100	100
Average days wait for category 2 patients	25	24	29	28	34	36
Average days wait for category 3 patients	114	75	116	95	76	83
% Hospital Initiated Postponements (HIP) – State target 8%	2.8	0.4	0.9	3.3	4.2	3.6

Data source: Elective Surgery Information System

HAVING SURGERY

The Surgery Unit operates Monday to Friday from 6.45am to 8.30pm for minor and major surgery and 24 hours a day for emergencies.

AFTER SURGERY AND DISCHARGE HOME

Women recover from the anaesthetic in the Post Anaesthetic Care Unit (PACU). Some women will then go to the ward. Day stay patients go from PACU, to second stage recovery, to recliner chairs and home.

Prior to the surgery we give women information about their recovery and what to look out for as studies have shown that patients retain this information better when they receive it before surgery.

The Home Based Services department has brought together services that provide support for hospital discharge or care in the home to improve these services. We aim to improve all areas of the service. The Home Based Services team will soon move from a five day to a seven day service. The team are in the process of ensuring that all our procedures and guidelines reflect current evidence based practice and that patient information brochures are widely available.

Discharge planning

We work across the hospital to improve early planning for discharge. We are mapping the journeys of women in the gynaecology wards from pre-admission to discharge to identify ways to improve discharge planning.

Hospital in the Home (HITH)

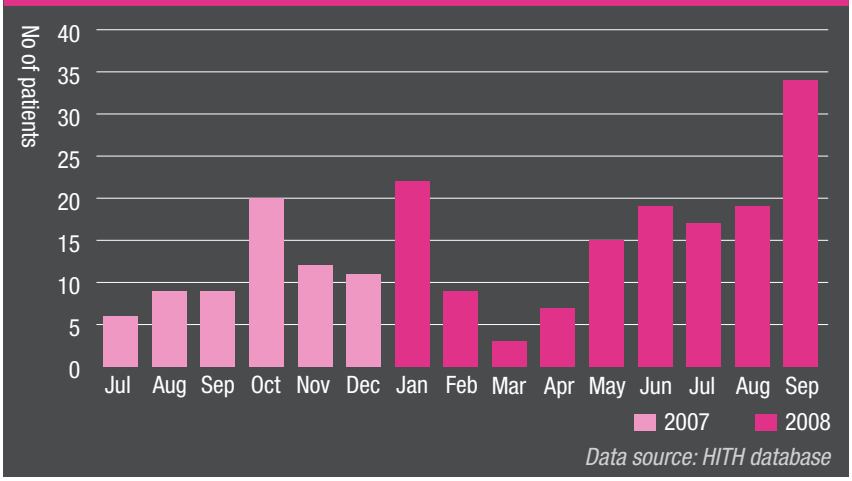
HITH is hospital care in the woman's own home, provided by nurses and midwives for women with various conditions. Patients remain under the care of their hospital doctor. They receive the same treatment that they would have received in hospital. Hospital in the Home may avoid a hospital admission altogether.

HITH nurses undertake:

- Complex wound dressings
- Intravenous antibiotics
- Intravenous fluid replacement for severe nausea and vomiting in pregnancy
- Post operative anticoagulant injections
- Trial of void following bladder trauma or surgery

The number of HITH visits has steadily increased in the last year as the profile of the service has been raised.

Figure 13: Number of HITH visits July 2007 to September 2008



Future directions

Recent audits found that the number of electronic discharge summaries routinely sent to GP's steadily declined in the last year which also coincided with our new patient information system and complex computer software related issues. This is important for continuity of care back to the community and we have put in place a range of short term measures to improve this manually until longer term computer software solutions are in place. This has resulted in improved figures.

MANAGING PAIN AFTER SURGERY

Managing pain is important, not only for women's comfort, but also because it promotes healing. The Acute Pain Service is connected to the Department of Anaesthesia. It is staffed by clinical nurse consultants and anaesthetists.

Pain management following surgery

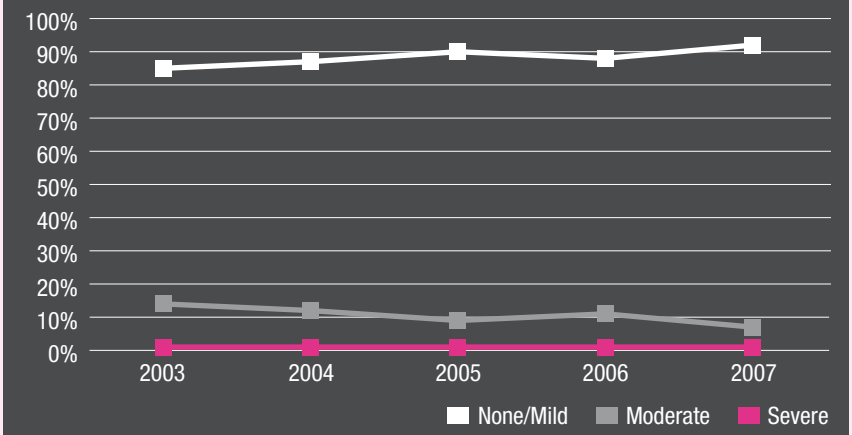
The Pain Service reviews women following major surgery and the number of reviews has steadily increased each year as shown in Table 16.

Table 16: Summary of patient reviews for pain management 2003 to 2007

	2003	2004	2005	2006	2007
Total reviews	1920	2181	2270	2412	2555

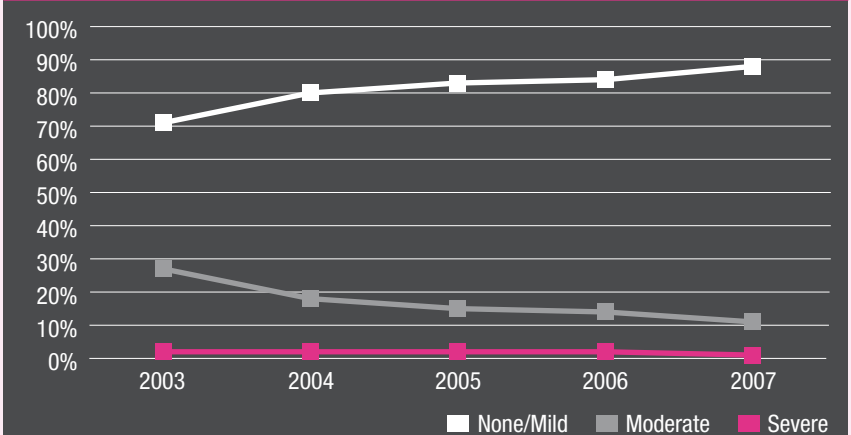
Data source: ORMIS (Operating Room Management Information System)

Figure 14: Improvement in pain control – day 1 post caesarean section



Data source: ORMIS (Operating Room Management Information System)

Figure 15: Improvement in pain control – day 1 major gynaecology/oncology surgery



Data source: ORMIS (Operating Room Management Information System)

Postoperative pain ratings on day one

During a typical 'pain round' the Clinical Nurse Consultant assesses the woman's pain and whether further analgesia is required. Information collected includes women's pain ratings, analgesic requirements and side effects. This information is entered in a database which is used to follow up patients and audit quality of care. Reviews of women continue until their pain is under control. Figure 14 and Figure 15 show improved pain control by the first day after surgery.

Research on pain

As we have one of the first acute pain services established in a Victorian hospital, we are dedicated to keeping abreast of the latest approaches to pain management such as Transversus Abdominis Plane (TAP) blocks. This block aims to reduce pain caused by cutting into the abdomen. The aim is to improve overall pain relief, reduce the amount of morphine type analgesics required (which reduces their side effects) and improve patients' satisfaction with their pain management.

The Acute Pain Service is currently participating in a clinical trial which is looking at the effectiveness of TAP blocks. The trial is headed by a staff anaesthetist, and involves women having major cancer surgery to determine if the TAP block has had any effect on pain relief after the operation. We are looking forward to seeing the results.

WHAT ARE WE DOING TO KEEP SURGERY SAFE?

Complications are not always preventable and in monthly meetings, we review complications to see if we could have avoided them. This might be through better surgical techniques or access to other types of surgeons. These meetings are an important quality improvement activity and help improve the skills of younger surgeons.

Complications of surgery – wound infections

Preventing infections is an important part of surgery. Surgery puts women at risk of wound infections and also urinary tract infections if they need a urinary catheter for a short period afterwards. Infection rates are monitored and submitted to the Victorian Nosocomial Infection Surveillance (VICNISS) program for comparison as discussed in Chapter Four. We work on reducing infections through measures such as hand hygiene, giving preventative antibiotics (antibiotic prophylaxis) just prior to surgery, good surgical technique and improving urinary catheter care.

Hysterectomy

In 2008, our overall infection rate decreased to 6.2 percent, as shown in Table 17. Although there were more superficial wound infections compared to last year, the more serious deep organ space infections were less common. Our rates are consistent with other hospitals. We can improve our antibiotic prophylaxis rate further and are reviewing the most appropriate antibiotics for this.

Our rates for urinary tract infections associated with catheters are consistently less than the United States Centres for Disease Control (CDC – NISS) rate of 5 percent. We work on catheter care and removing catheters as soon as possible.

Caesarean section – wound infections

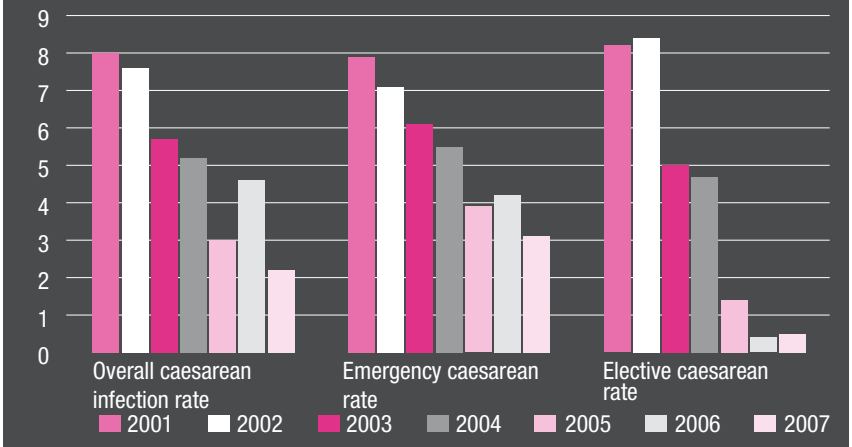
We continue to reduce all our caesarean section infection rates, which are shown in Figure 16. Our results compare well internationally. Our rate for elective caesarean sections is very low and the challenge is to further reduce the rate for women having emergency caesareans.

Table 17: Hysterectomy wound infections 2006 to 2008

	Jan-June 2006	Jan-June 2007	Jan-June 2008
Total number of hysterectomies	221	182	179
Number of wound infections (SSI)	4	1	4
Number of organ space infections	8	9	2
Number of urinary tract infections (UTI)	12	9	5
UTI rate as percentage	4.7	3.8	1.7
Surgical site infection rate as percentage	1.8	0.6	2.2
Overall infection rate as percentage	9.9	10.4	6.2

Data source: Infection Control Surveillance

Figure 16: Caesarean section wound infection rates 2001 to 2007



Data source: Infection Control Surveillance

WHAT DO WOMEN THINK?

Women having surgery are encouraged to participate in the Victorian Patient Satisfaction Monitor as this gives them the opportunity to provide feedback. Their feedback is provided to the unit every six months and is shared with staff and management to help work out where we can improve. Table 18 shows how satisfied women who had elective surgery were with particular aspects of their experience. Results highlighted are where we did better than other Victorian hospitals.

What women value

Women made comments about their experience, such as the ones below:

The best thing was:

The friendliness/ professionalism of staff. Ensuring you understood the procedure, checking they had the right personal details and treatment plan, made me feel reassured. Explaining what was happening and why was good.

One particular nurse I believe saved my life in helping me be strong.

Something to improve

Last minute, just before I entered the theatre, discussions by doctors that I may have to have a larger cut (instead of a key hole). Up until then I felt confident and that I knew what to expect. All went as planned in the end, but I felt scared and teary because this had not been mentioned as an option before this.

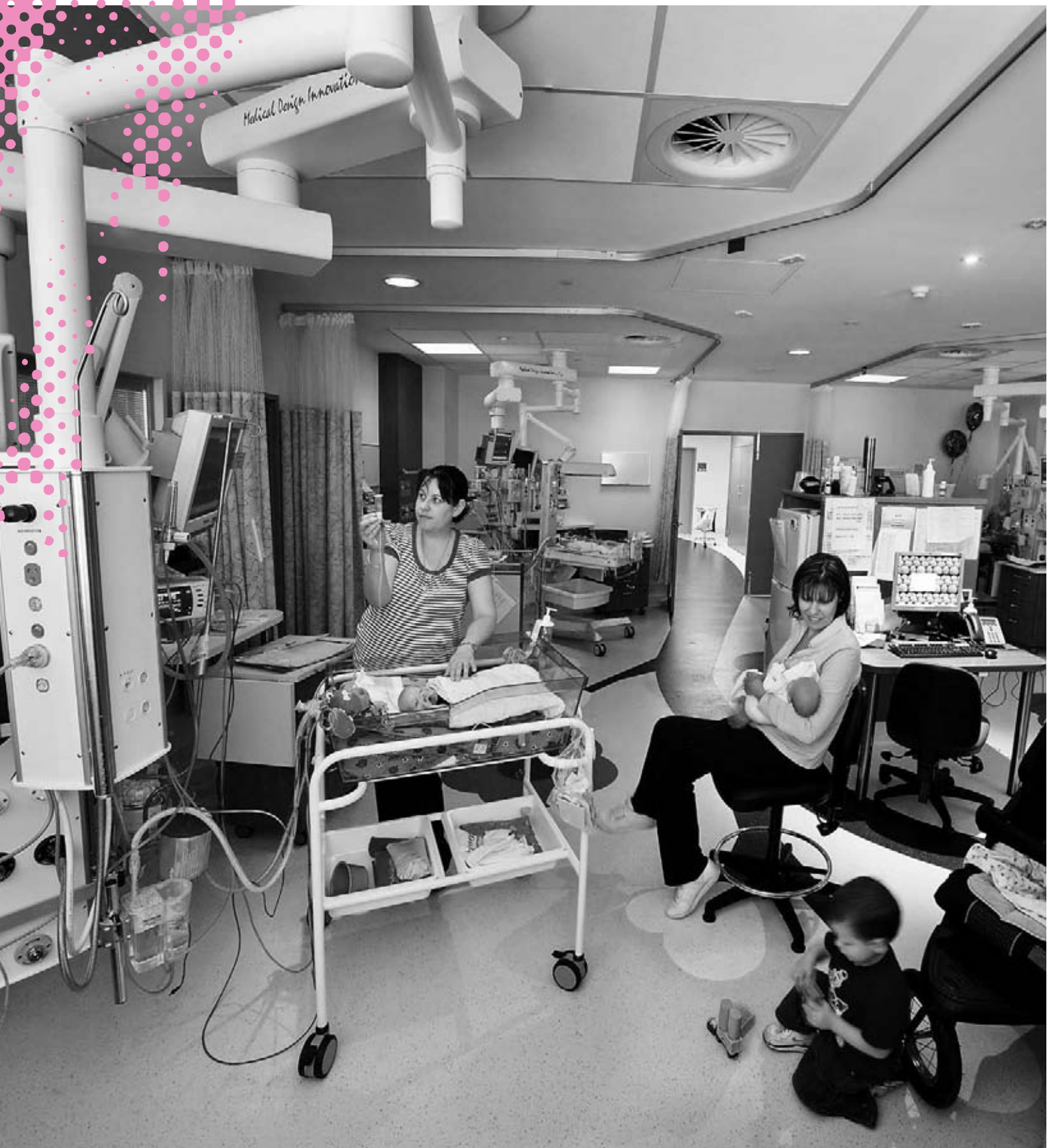
Table 18: Victorian Patient Satisfaction Survey March to August 2007 (percentages)

Satisfaction Item	Elective Surgery	Same Day Surgery
Courtesy of nurses	100	97
Helpfulness of staff in general	100	99
Responsiveness of nurses	99	95
Being treated with respect	99	96
Explanation of medicines needed post-hospital	98	96
Cleanliness of room in which you spent the most time	97	97
Respect of culture or religious needs	96	92
Help received for your pain	95	94
Way staff involved you in decisions	95	91
Written information received about managing condition	90	93
Courtesy of doctors	89	92
Explanation of treatment	89	90
Respect for privacy	88	85
Willingness of staff to listen	88	89
Explanation of routine & procedures	84	77

Data source: VPSM

OUR SPECIAL CARE FOR BABIES

We provide family-friendly spaces for parents and their babies.



WHAT'S NEW AT PARKVILLE?

There is a great deal that has changed in Newborn Intensive and Special Care over the past twelve months. If you walk into the new Newborn Intensive and Special Care as a parent, you will immediately notice the sense of space and the quietness of the unit. We have a vastly improved physical environment and we have also changed the way we look after babies and their families. We call this the 'model of care'.

Over the past eight years, Neonatal Services has gone through a process of cultural change to improve its ability to care for babies and their families, working with our staff to implement multidisciplinary collaborative care and improve the working environment. The aim was to provide more consistent care, better continuity of staff and to engage with families better.

CREATING CULTURAL CHANGE AMONGST STAFF

This has been a long journey. Back in 2001, issues were identified with how staff related to each other, both within their clinical groups and between clinical groups. Although this is not uncommon in demanding neonatal environments, this impacts on recruitment and retention of staff and industrial unrest.

The process involved listening to and valuing all staff as members of the multidisciplinary team. Unspoken beliefs, values and unwritten rules that had an effect on workplace relationships were openly explored. Change started in 2003-2004, with forums, particularly around communication, workplace violence, managing difficult/angry situations, grief and loss, supporting team resolution of issues, a code of conduct on workplace bullying and leadership and management development.

Staff benefited with improved morale and reduced sick leave, improved retention of nurses and a staff waiting list, and regular multidisciplinary forums and case reviews. From this, we started work on the new model of care.

Developing the new model

The new neonatal model of care is based on a collaborative multi disciplinary team approach that acknowledges how families and whole teams contribute to their baby's care. Newborn Intensive and Special Care at Parkville was designed so that it would be an environment that supports babies' development and gives them the best start. There is research evidence that points to how important this is in how babies develop in the longer term.

All members of staff and a consumer representative were invited to be involved. Staff and current families were surveyed about the existing 'model of care'. Focus groups, interviews and process mapping of care provided feedback on how consistency and continuity of care and involvement of families could be improved. Staff undertook literature reviews and consulted with services within the Women's and other Victorian hospitals, visiting other hospitals in Australia and overseas. This research and consultation informed the new model of care.

THE NEW NEONATAL MODEL OF CARE

In the new neonatal unit babies are admitted to a cot within a pod, with one of the two multidisciplinary teams responsible for care throughout the baby's stay. The baby remains in that pod throughout their admission wherever possible and staff skill mix is adapted for the baby. Each cot space includes a family area, with storage for the baby's and family's belongings, a display area and communication board. This provides privacy for the family with their baby and makes the cot-side their 'baby's first bedroom', allowing mothers to express milk at their baby's cot-side. Lactation consultant support is available to support these mothers.

Multidisciplinary care teams allow joint planning, sharing of knowledge and expertise to achieve better continuity and consistency of care, and provide staff with a greater sense of belonging. At the weekly team meetings, a management plan for each baby and family is documented to ensure consistency.

Implementing the new model of care and the relocation to Parkville

We implemented this new model of care in January 2008 prior to the move to Parkville. Admitting babies to a pod has decreased the number of times we move a baby irrespective of whether the unit is busy, with staff finding the process simpler and easier to work with. The pods are much quieter with less people traffic, which benefits babies, families and staff.

We have started to evaluate the new model of care from the point of view of parents and staff and will report on this next year.

WHAT DO CLINICIANS THINK ABOUT THE NEW MODEL OF CARE?

Interview with **Sue Jacobs** our Director of Neonatal Nurseries

What difference to you think the changes to the model of care have made?

It is providing a much more collaborative and cohesive approach to caring for babies and their families. It also provides a simpler, more straight-forward and transparent structure for staff to work in.

Why does that matter?

It means that we are more able to see the baby within the family, engage with the family and meet the family's needs. It means that we have a group of staff who know all about the baby and the family – the same doctors, the same nurse etc. The difference in neonatal care is that many babies are Newborn Intensive and Special Care for weeks to months, so it is important that there is a group of people who know the baby and its family well. It is important for families to know who is looking after their baby and who to talk to about their baby and to get consistent advice.

What is your evidence that the new model of care is working better?

As a clinician, it is wonderful to get to know the families over their stay and great to have ongoing relationships with these families. For staff, they know who is caring for the baby. The unit is so much quieter, with reduced traffic of people in and out.

NEONATAL CARE AT THE NEW HOSPITAL – PARENTS' EXPERIENCES

Interview with **Christine Nardella**

Christine and Rick know our Neonatal Intensive Care Unit (NICU) and our Special Care Nursery very well. Their triplets, Monique, Chloe and James, were born on 2nd June 2008 at 26 weeks and 6 days. They all weighed between 600 and 900 grams and all went straight to NICU at our Carlton site.

What was it like for you at our Carlton site?

It was good, but now it's better. At Carlton there was not enough space and it was really quite cramped. It was also noisy as NICU was one big room with all the babies and machines in together. It felt quite daunting. Also in Carlton our babies were mostly not together in the same room. As one became stronger she had to move to the next room because she needed less intensive care. This was great in terms of her growth but it was difficult to divide our time between two rooms and three babies. We also had to wash our hands every time we went in and out of each room.

What about the care you have received?

The care we received from the nurses has always been fantastic, both in Carlton and Parkville. If not for the nurses, our babies wouldn't have survived and really I can't say enough about them. They have always been there for us any time of the day or night and they have cared for our three babies as if they were their own. We have never felt like a number here. We have really felt cared for, both us and our babies.

How was the move from Carlton to Parkville?

I hadn't had time to look at the new hospital, even though I had been offered a tour, so I didn't really know what to expect. The nurses would describe it to me when they had been on a tour and I was actually looking forward to the move. I was rung when my babies were leaving Carlton and rung again when they had arrived at Parkville. Chloe was actually the last baby to leave Carlton and I was told she was given a standing ovation as she left!

Is it very different at Parkville?

The care from the staff is no different but the environment is very different. I remember the first time I came here. It was very special. All three of my babies were together in what came to be known as the Nardella Suite. I can now see how all three of them are all of the time. It is much more spacious, there are comfortable chairs and there seem to be more people around. It's lively and friendly and really feels like a second home to me. There'll be part of me that will actually feel sad to leave.

Continuity of care

The Access Coordinator has created a single 'director of traffic and communication' who liaises with the maternity teams within the Women's, NETS/PERS and other nurseries to coordinate access to the Intensive and Special Care and improve discharge links to home, community based supports and regional hospitals. This allows other nurse managers to support clinical care at the cot-side.

"We were told we could set up our space as we liked and so the space has slowly evolved as we've brought in books, soft toys, photos and other things."

Interview with **Jen and Andrew Williams**

Jen and Andrew's son, Tom, was born on 8th June 2008. Tom was only 29 weeks when he was born and weighed just 953 grams. His home has been the NICU since birth and he was 10 weeks old at the time of this interview.

What was it like having Tom in NICU at our Carlton site?

The staff were wonderful and the level of care was sensational however it felt very crowded and noisy. There was just so little room. We worried about being in the way, even though the staff did everything they could to make us feel welcome. When I wanted to express milk I had to leave Tom and shut myself in another room. I hated leaving Tom to do this.

How was the move from Carlton to Parkville?

It was so easy and not stressful at all. We were kept totally informed all along. We had a tour of the new hospital before the move so we knew where Tom was going. The weekend of the move we weren't allowed to visit during the day however we were called before and after the move as promised. We knew Tom was in safe hands all the time.

How is NICU different in the new hospital?

It's much better here. This is like our home, and the staff are like our extended family. We really feel part of a community. We have a whole team raising Tom and we are part of that team. We never feel like outsiders and the staff really value our input.

We were told we could set up our space as we liked and so the space has slowly evolved as we've brought in books, soft toys, photos and other things. We like to read to Tom so our book collection keeps getting bigger. When I came in one morning a nurse told me that it had been quiet through the night so she had read to Tom. Those little things are so important to us.

I can express breast milk here beside Tom without having to leave, shut myself in a little room and just look at a photo of him. Looking at my son as I express feels so different, and so important. We're not worried about being in the way anymore. There is so much more room.

We can close the curtain here and have time to ourselves with Tom. We can just be a family.

PROVIDING SAFE GOOD QUALITY CARE

The Women's has one of the busiest neonatal units in Victoria. We have 52 intensive and special care cots of which 18 are respiratory support intensive care cots, another two intensive care cots and 32 special care cots. We also can "flex" up to support a further two respiratory support intensive cots when demand for respiratory support requires. Our unit at Parkville has been built with the space to care for up to 60 babies when required and is more spacious than our Carlton site. Our average daily occupancy of the 52 cots across the year 2007 to 2008, as shown in Table 19 was 100 percent (51.9). This required us to flex (increase) the total number of our cots at times to meet the demand for care and to make sure that care was safe for the babies. Managing this is one of our most important quality and safety activities.

In NICU, using sucrose for pain by a nurse improved from 0 percent to 75 percent and now sucrose has been added as a prompt to the new neonatal medication chart. The use of analgesia in ventilated babies increased from 24 percent in 2006 to 43 percent in 2007.

Improving our quality and safety processes

We established a process to review our care of all babies who had an unexpected deterioration in condition to see if we needed to improve any aspects of our care.

A national neonatal medication chart

We implemented a new neonatal medication chart based upon the national paediatric medication chart and adapted it for newborn babies.

OUTCOMES FOR VERY PREMATURE BABIES

Approximately eight percent of babies born in Australia are preterm (before 37 weeks' gestation); less than two percent are born before 32 weeks. These babies make up the majority of babies admitted to our neonatal intensive care and special care nursery.

Changes over the past 30 years have led to a dramatic increase in survival of preterm babies. Now, most babies born as early as 24 weeks' gestation who are admitted to a neonatal intensive care unit soon after birth will survive to go home with their families. Figure 17 (next page) shows data from the Women's for these babies.

Table 19: How many of our 52 cots were occupied on average throughout the year?

Total Occupied Cots	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Year
Average Daily Occupancy	53.6	54.1	51.4	52.5	52.6	51.4	49.4	48.8	52	52.4	52	52.7	51.9

Data source: VicPic database

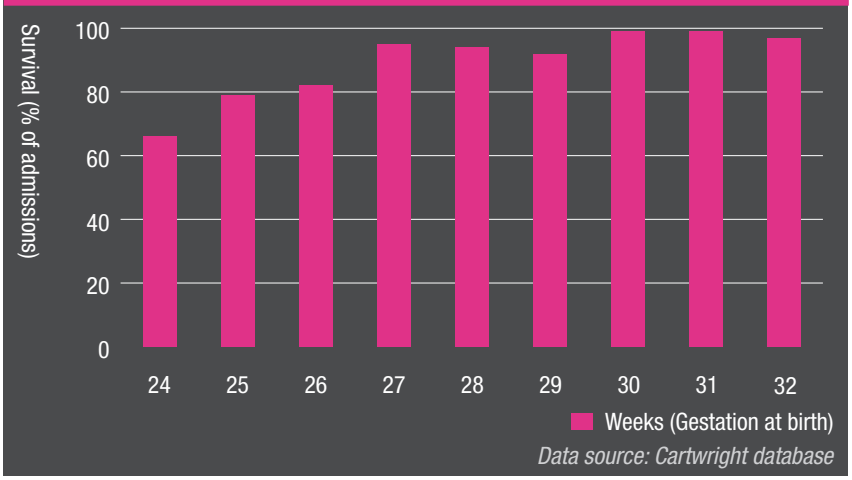
Treating pain in babies

During 2006-07, the unit participated in a national project to improve how we manage pain in newborn babies. We did an audit of what usually happened to manage pain when babies have procedures or are on ventilators and then provided an educational program for clinicians about pain management in newborn babies.

Improving management of babies who withdraw from narcotics

The Women's Alcohol and Drugs Service works with parents who are dependent on alcohol or drugs. One of our paediatricians led a state-wide project to implement a Clinical Practice Guideline for management of neonatal abstinence syndrome (withdrawing from narcotics) and to increase homebased withdrawal. The number of our babies being treated to withdraw at home increased from nine in 2005 to more than 28 in 2008.

Figure 17: Survival of preterm infants 2003 to 2005



However, despite increasing chances of survival, babies born very early are more at risk of long-term problems with their development. Babies born prematurely are more likely than babies born at term to have longterm disabilities such as difficulty with thinking (intellectual disability), walking (cerebral palsy), talking (communication), seeing (blindness) or hearing (deafness). Of surviving babies born at 24 weeks, one in three will have at least one of these problems. With increasing gestational age at birth, these rates of disability decrease (one in four at 25 weeks, one in five at 26 weeks, one in eight at 27 weeks, one in ten at 29 weeks). For babies born at 24 weeks, the decision about whether to treat is very much one made between parents and clinicians. The rates of these types of disability in children who are not born prematurely are four percent. Much of the research we now do at the Women's is aimed at reducing these disabilities.

INFECTION SURVEILLANCE

Bloodstream infections related to central lines in babies carry significant risk of death and illness in very vulnerable babies. NICU staff work very hard to keep these rates as low as possible.

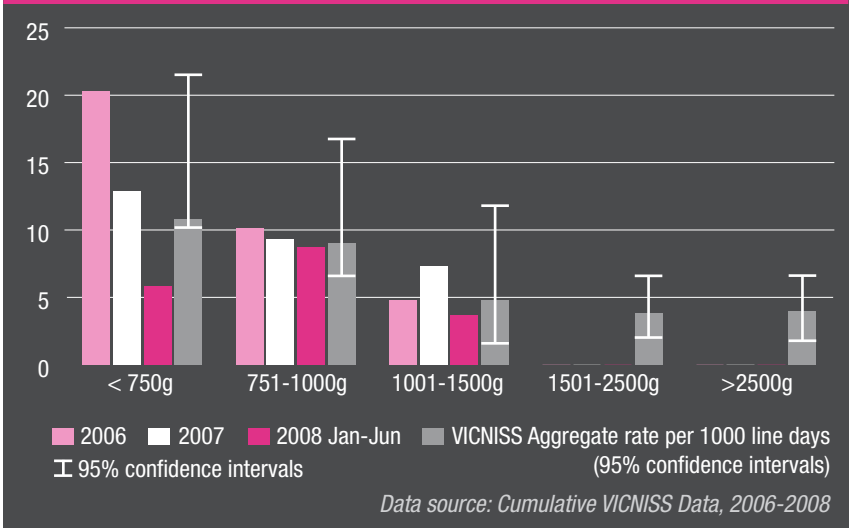
Babies admitted to the new Newborn Intensive and Special Care Unit have a greater risk of infection for many reasons. Central venous lines are used to administer essential medications and nutrition, but also provide a portal of entry for infection. We monitor bacterial infection rates related to these lines. We compare our rates with other hospitals in Victoria (VICNISS) and the United States (CDC-NNIS) because this helps us to reduce our rate.

How to read this graph

Figure 18 shows that over the last three years there has been a reduction in infection rates, even in the highest risk babies, those with very low birth weights. The grey columns are Victorian data from VICNISS, Victoria's Infection Control Surveillance Centre. The white lines show 'confidence intervals'. 'Confidence interval' is a statistical way of getting a valid comparison. Any results outside these lines are significant. So our results for 2008 for babies less than 750gms and babies over 1501gms are significantly better than the Victorian result. All our results are within US CDC confidence intervals; so we compare well internationally.

There is not one intervention that has worked to reduce these infections but rather a 'bundle' of things. We have improved aseptic technique and skin antisepsis (the way we insert central lines), hand hygiene, and have had an ongoing emphasis on removing lines early and keeping antibiotic courses short. Our aim is to reduce infections further.

Figure 18: Central venous lines bacterial infection rates in newborn babies 2006-2008



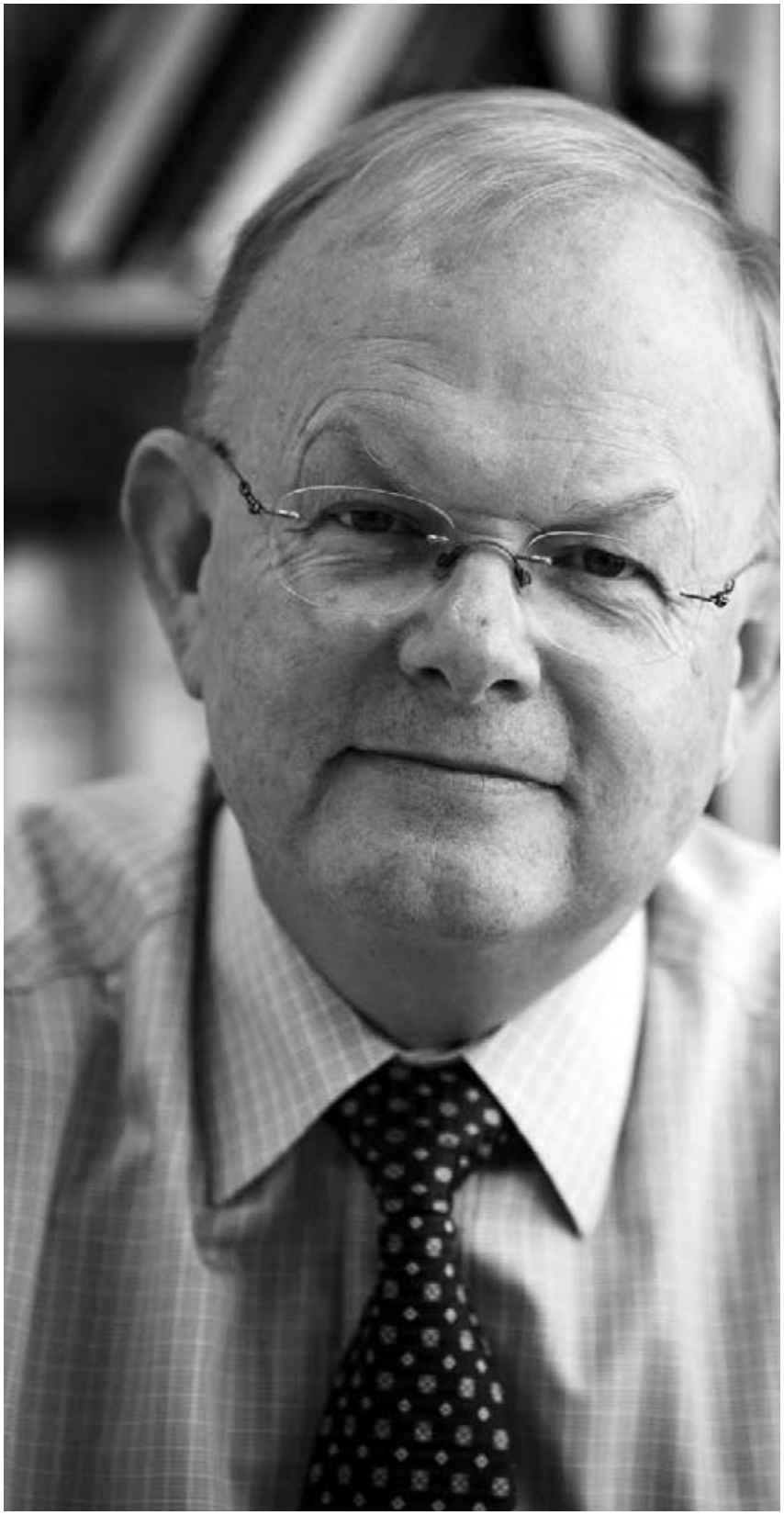
COLIN MORLEY: 'MAKING THE BABIES BETTER'

Professor Colin Morley, who joined the Women's in 1997 as Professor-Director of Neonatal Medicine, retired in 2008.

In his early career in England, Colin developed particular expertise in understanding lung problems in babies, as well as investigating artificial ventilation techniques in newborn babies. In 1984, he was named 'Doctor of the Year' by the British United Provident Association. More recently, much of Colin's research work has focused on helping babies manage the transition to life outside the womb in the first few minutes after birth.

Colin has been an enthusiastic collaborator with research groups within Melbourne, wider Australia, and internationally, and his reputation as a mentor for young researchers has led to a large number of trainee neonatologists coming to Melbourne to undertake research and clinical work at the Women's. He has been eager to pass on his extensive knowledge to medical, nursing, and allied health staff, as well as parents. He will be fondly remembered by the multitude of families whose babies he has looked after.

With Colin has come an enormous amount of enthusiasm, good humour, and a critical eye that has questioned clinical practices with a view to providing the best care possible. His legacy has been to establish a leading reputation for neonatal research at the Women's. His mantra of 'making the babies better' will be ringing in our ears for years to come.



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