QUALITY OF CARE REPORT 2009

SAFE CARE, YOUR RIGHT, OUR RESPONSIBILITY

the women's
the royal women's hospital
victoria australia

OUR VISION
OUR MISSION

OUR VISION

To be the leading provider of health care that improves the health and wellbeing of women and newborn babies.

OUR MISSION

To provide quality health services that meet the needs of women and newborn babies especially those requiring specialist care.

These services are informed by research and are provided within our environment of innovation, education and advocacy. The contributions of our employees, consumers, diverse communities and other agencies that share our goals are fundamental to our success. Our resources are committed to health services that are ethically, socially and financially responsible.

STRATEGIC DIRECTIONS

The Royal Women's Hospital strategic plan 2005-2010 identifies six strategic directions including:

> Delivering improved clinical outcomes and service performance;

> Improving our consumers' experience

> Optimising access to our health services;

> Developing our workforce;

> Building our future; and

> Strengthening our leadership, research and advocacy role.

STATEMENT OF PRIORITIES 2008-09

The Statement of Priorities is an annual commitment for all heath services and is the key accountability framework between the hospital and the Minister for Health. For the 2008-09 financial year the Women's concentrated on transitioning its operations to the new site in Parkville. The focus was on:

> Ensuring the transition year is safe reliable and sustainable;

> Supporting our staff during the transition year;

> Improving our financial position and performance;

> Strengthening community and stakeholder engagement;

> Developing research culture and strengthening research at the Women's;

> Improving and developing new services;

> Utilising reliable contemporary technologies to support health service delivery.

CONTENTS

WELCOME TO THE 2008-2009 QUALITY OF CARE REPORT

SAFE CARE, YOUR RIGHT, OUR RESPONSIBILITY

It is with great pleasure that we present to you the Royal Women's Hospital's 2008-09 Quality of Care Report.

The past year has been another one of outstanding achievements for the Royal Women's Hospital.

As an international centre of excellence in women's health, and the largest independent specialist women's hospital in Australia, we are dedicated to improving the care of women and newborn babies.

Demonstrating our leadership in innovation and technology, this year we opened a Magnetic Resonance guided Focused Ultrasound service at our Pauline Gandel Women's Imaging Centre, which provides treatment for uterine fibroids. We are the first hospital in Australia to do so.

Advocacy for women and social welfare is what differentiates the Women's from other hospitals. Today we care for our patients' complex psycho-social needs by addressing issues of mental health, drug and alcohol dependence, violence and sexual assault. Our advocacy influenced Victoria's abortion law reform that removed abortion from the Crimes Act. Our Centre for Women's Mental Health, the first gender-based centre for women's mental health in Australia, continues to grow. Our Sexual Assault Prevention Program in Secondary Schools (SAPPSS), developed by the Women's CASA House, is to be implemented in Canberra schools using Federal Government funding.

Our research leadership has resulted in outstanding success in the areas of preventative medicine, oncology and gynaecological surgery. We have been awarded National Health and Medical Research Counsel funding of $2.5 million for the Centre for Clinical Research Excellence to look at brain and lung research of premature babies.

The dedication of our staff and our cooperative relationship with the Department of Health ensures that the Women's continues to deliver world-leading clinical care, research, health promotion and advocacy to women and newborns throughout Victoria.

Our accreditation results ranked the Women's amongst the top performing hospitals in Australia. The results included two Outstanding Achievements for research and health promotion.

We would like to thank you for your support over the past 12 months and we trust that you will enjoy reading of our achievements in our Quality of Care Report for 2008-2009 – Safe care, your right, our responsibility.

Dale Fisher,
Chief Executive

Rhonda Galbally,
Board Chair

Our 2008-2009 Quality of Care Report – Safe care, your right, our responsibility provides you with a detailed insight into how we are improving your care. Through patient stories and evidence based information we are demonstrating our commitment to you as follows:

CHAPTER 1 promotes our approach to working with our multicultural community and workforce. We discuss our Diversity Plan to highlight how we use language services and our culturally diverse workforce to best care for women. This section also outlines our work on the state government's Improving Care for Aboriginal People (ICAP) program.

In *chapters 2 and 3* we also discuss our partnerships with multicultural agencies and our engagement with diverse communities. We detail how we encourage women's participation to better understand women and their needs.

CHAPTER 2 talks about our workforce to give you an understanding of how we ensure our staff provide the best care, through training, credentialing and mentoring. In this chapter we demonstrate how we work to improve communication between staff and our patients, such as in our newborn intensive and special care unit.

CHAPTER 3 focuses on community participation to improve the quality of care we provide. In line with the Department of Health's Community Participation performance indicators we highlight the role of our Community Advisory Committee, our commitment to our Community Participation Plan and how consumer information and feedback helps meet the needs of women and their families.

Through examples we demonstrate how we provide quality information to patients and the improvements we are making to ensure our community receives high quality care.

CHAPTER 4 highlights our approach to clinical governance and our commitment to ensuring quality and safety. This includes preventing and controlling infections, medication safety, meeting cleaning standards, and preventing and monitoring falls and pressure injuries. We also look at how we manage risk and respond to consumer complaints. Our recent high standard Accreditation results from the Australian Council of Healthcare Standards further demonstrate our achievements in this area.

CHAPTER 5 looks at our high quality, clinical care and shows how research underpins this care. We highlight new technologies that have been adopted to provide better care to women and their newborn babies. We report on many exciting research projects that improve clinical care for our patients. We also look at how our teams in ambulatory care are working collaboratively to improve care through initiatives such as our new chronic pelvic pain clinic, maternal weight management program, our diabetes pre-pregnancy groups and our new continence clinics. In this chapter we also look at how we evaluate clinical performance in maternity and neonatal care.

OUR COMMUNITY: SHAPING OUR IDENTITY

OUR COMMUNITY: SHAPING OUR IDENTITY

The Women's is renowned as a major teaching and research hospital that provides the highest standards of care to women and newborn babies in the areas of gynaecology, women's cancers, pregnancy and birth, women's mental health, newborn care (neonatology), research, health promotion and social support.

Each year at the Women's approximately 200,000 appointments are made by women from 165 countries who speak 60 different languages and follow 42 separate religious faiths.

At the Women's:

- 29 percent of women who were inpatients at the Women's were born overseas.
- 42 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 China.

In comparison to the state benchmark of 24 percent of Victorians born overseas, this shows our hospital provides care for a significantly diverse group of women and their families.

To respond to the needs of our diverse community, hospital services are informed by community principles and designed according to the 'social model of health'. These aim to address the social, cultural and economic circumstances of women to provide access to high quality healthcare and provide and advocate for women's particular healthcare and diverse needs.

RECOGNISING OUR DIVERSITY

*Halimo** has been in Australia for almost two years. She arrived as a refugee from Somalia with her son who was 12 years old. Her husband is still in Somalia and she had two other sons who were both killed in the war.

I had been seeing a doctor near where I live and had some 'women's problems'. My doctor suggested I go to the Women's where they have experts in this area. I had seen the Women's but had never been there. I was happy to be going to a women's hospital. In Somalia I went to a hospital just for women and children and I feel most comfortable that these hospitals will understand my problems. I prefer to see a female doctor but it's OK for me to see a male if necessary.

At my first visit I saw a nurse practitioner who asked me all about my history since I was a child. She was very kind and I felt that she really cared about me. She gave me lots of information and she explained to me what she would do. She told me I should let her know if I was not comfortable at any time and she would stop. It was all good. Telling me she would stop if I wanted her to made a big difference.

For my next appointment I have asked for an interpreter. Even though I understand most things, I want to make sure everything I am told about my problem is very clear to me.

**Halimo's name has been changed upon request for the purpose of sharing this story.*

QUALITY OF CARE REPORT

OUR COMMUNITY:
SHAPING OUR IDENTITY

In 2008-09, the Women's continued to experience strong demand as demonstrated in Table 1.

TABLE 1: STAYS, VISITS AND BIRTHS AT THE WOMEN'S

	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
Inpatient stays	30,472	32,168	32,478	31,687	29,956	28,371
Outpatient visits	141,148	146,944	149,625	162,895	167,871	147,588
Emergency visits	26,378	27,596	28,379	30,150	26,497	24,755
Women giving birth	5,118	5,661	5,736	6,360	6,466	6,589
Surgical operations	–	11,747	11,738	12,197	11,797	11,911

Data Source: Annual Report 2009

Graph 1 shows the most common languages spoken by women who are inpatients and required interpreter services during 2008-09.

GRAPH 1: INPATIENT INTERPRETER SERVICES 2008 - 2009

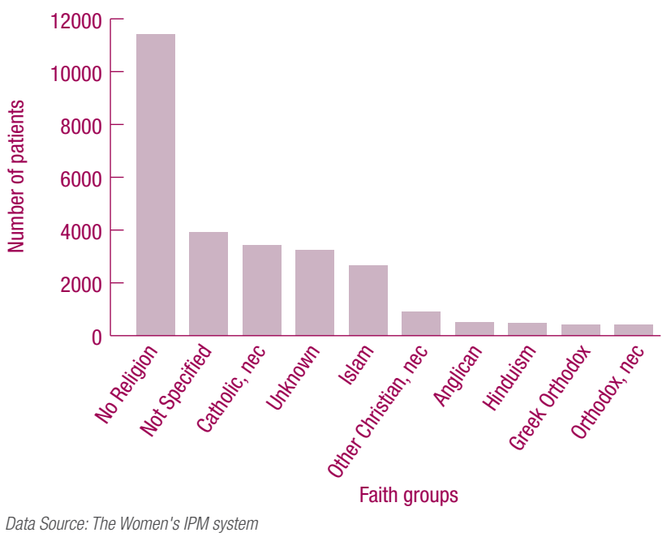
Data Source: The Women's IPM system

The Women's Language Service experiences high demand to meet the needs of women who have little or no understanding of English. Each day the department receives up to 100 inpatient and outpatient requests for interpreters and in the past year has provided services for 30,702 appointments. Our interpreters provide in-house support across the 12 most requested languages and telephone services.

The Women's Maternity Service Performance Indicator results show that 80.3 percent of women who requested an interpreter for their maternity appointment were provided with one. This is still less than the state average of 84.3 percent and we are working to improve this further. However we have improved by 10.3 percent on our previous record which is excellent progress in this area.

At the Women's we care for women from a wide range of backgrounds, cultures, and religious faiths. Graph 2 shows the diversity that we experience at our hospital.

GRAPH 2: MAJOR FAITH GROUPS 2008 - 2009



Data Source: The Women's IPM system

One of the most commonly requested languages for the Women's Interpreter Service is Vietnamese. Panya, one of the Women's ten in-house interpreters, attends appointments throughout the day, provides telephone interpreting services, and responds to paged requests from departments such as the Women's Emergency Care.

OUR HOSPITAL IS INFORMED BY OUR COMMUNITY

The Women's consults with our community to inform the quality and direction of our services. We consulted with 1000 women in 2001 to establish clear community principles and to shape the development and planning of our new hospital. During this consultation the following community principles were adopted and are used by our staff to guide our care for women today.

These community principles are:

- Women value a separate specialist women's hospital based on community values and cultural and religious respect.
- Women value quality in staff, technology, teaching, training and research.
- Women want the hospital to have good access to technology, expertise and research.
- Women value a balance in services, both critical care and community care, general and specialist services, and obstetrics and gynaecology.
- Women value family-friendly care, which responds to the needs of the whole woman and protects privacy and dignity.

QUALITY OF CARE REPORT

OUR COMMUNITY:
SHAPING OUR IDENTITY

Artwork by Aboriginal artist, Kylie Bird

AUNTY DOREEN AT OUR 2009 SORRY DAY CELEBRATIONS

To mark the first Sorry Day held at our new hospital in May 2009, Aunty Doreen Wandin-Garvey, senior elder of the Wurundjeri people, performed a Smoking Ceremony at the Women's, addressing the audience of staff and visitors with the following words:

"Yama, ngarrang. Let the spirits of the land hear. This is the land of the Wandoon / Wurundjeri.

As the smoke rises, so will the spirits of mischief rise and depart.

In this land, the people are equal, as the leaves are equal to the tree. Where the people come together, "gaayip", is a place of understanding and healing.

So the smoke disappears, woi ngarrang, and let there be peace among the people.

In Wandoon / Wurundjeri ways, it is good manners to hear what others have to say, and in the Wandoon / Wurundjeri ways, respect is earned by those who know when they speak and what to say.

May the words that are spoken, the feelings shown, the ideas inspired, the truths told, and let us find, that as the smoke cleanses this place for "gaayip", we are also cleansed.

Womin je ka mooroop. Let only the spirits of the land, who bring peace and harmony, truth and trust, repentance and forgiveness, understanding and healing, be here in this place. This is a place of "gaayip".

In Wandoon / Wurundjeri ways, when people come together to resolve conflict, to reconcile, to seek forgiveness and to move on, there is necessarily recognition, that each and every person belongs to the land, and like the leaves on the trees, though held by many branches, are equal in the land.

When this fire has turned to ashes, it will be scattered here on this land, so that we complete the cycle of life, and return the spirits of the land, back to the land. "

SUPPORTING AND RESPONDING TO THE NEEDS OF OUR COMMUNITY

The hospital has engaged women from a wide range of communities to better understand their experiences of healthcare. Women provide their advice on the changing needs of our culturally and linguistically diverse community.

This consultation informed the Women's Diversity Plan which was developed as part of the hospital's commitment to the community principle of providing services based on community values and cultural and religious respect.

The Diversity Plan is comprised of three key components – a Reconciliation Action Plan, a Disability Action Plan and a Cultural and Linguistic Diversity Plan. All hospitals have Key Result Areas (KRA) as part of the *Improving Care for Aboriginal People* (ICAP) program which has been set by the Department of Health. Our achievements against the ICAP KRA will be highlighted throughout the report.

Indigenous artwork unveiling

In line with the KRAs of building relationships with the Aboriginal community, creating a warm and welcoming environment and establishing culturally sensitive service planning, the Women's Reconciliation Action Plan was finalised in 2009. It details the hospital's commitment to improving the health and wellbeing of Aboriginal and Torres Strait Islander women, by building community trust in the quality and safety of the health services provided at the Women's.

The Victorian Public Healthcare Awards are held annually to recognise dedicated people striving to improve public health. In 2009, the team at the Aboriginal Women's Health Business Unit (AWHBU) was selected as a finalist. Our staff were highly commended for their work on a project to develop *A new relationship between the Women's and our Aboriginal community.* This was submitted as part of the Department of Health's Secretary's Award – *Improving the Health and Wellbeing of Aboriginal People in Victoria.*

One of the commitments in the hospital Reconciliation Action Plan is to create a warm and welcoming environment for Aboriginal and Torres Strait Islander women and their families. As part of this, the Women's commissioned Aboriginal artist Kylie Bird to create a unique Indigenous artwork for the atrium area of our hospital as featured on the previous page.

The artwork symbolises a united people and their journey toward reconciliation and was unveiled at a celebration hosted by the Women's with the Indigenous community in March 2009. The inclusion of the Welcome to Country in the artwork, is reflective of the Women's hospital-wide commitment to acknowledge the traditional owners of the land at all hospital events and functions.

Improving the referral process for Aboriginal women

In line with the ICAP KRA of establishing referral arrangements that meet the needs of Aboriginal women, the Aboriginal Women's Health Business Unit has updated the directory of Aboriginal health programs and workers in both mainstream and community controlled services. This information is provided to staff to enable them to provide information and referrals to women who need follow up services and support.

Bilingual Staff at the Women's project

A significant focus of the Diversity Plan is to build workforce capacity to care for women from non-English speaking backgrounds. In line with this, the *Bilingual Staff at the Women's project* commenced in 2009. This project is funded by the Victorian Multicultural Commission and aims to use existing bilingual skills within the hospital workforce, to improve the communication and care provided to women who come from non-English speaking backgrounds.

A survey of staff shows that 36 percent speak a language other than English and 19 percent speak three or more languages.

As part of this project, up to twenty staff will receive accreditation and training to use their language skills as an aid to communication outside of clinical settings with women who speak English as a second language.

These staff will support areas of the hospital working with women who come from linguistically diverse backgrounds to help them:

- > make or reschedule appointments;
- > provide information about, and receive direction to, clinics, wards and support services; and
- > contribute to a welcoming and reassuring presence in an unfamiliar environment, to improve the hospital experience for women speaking languages other than English.

RECOGNISING OUR STAFF

I underwent minor elective surgery at the Women's hospital. The care and attention shown to me by all of the staff I met was fantastic. I had a worry-free and very comfortable experience from start to finish, thanks to your wonderful staff. I just wanted to pass on my gratitude and admiration for all the people who looked after me during my short stay there.

Elise Bolza (patient at the Women's)

The Comfort Momoh lecture series

Providing women affected by Female Genital Mutilation (FGM) with high quality care involves expertise in the clinical, legal, social and cultural aspects of this harmful practice.

The Women's has developed clinical expertise in caring for women affected by FGM and is committed to strengthening the global movement to eliminate the practice.

To improve the ability of healthcare professionals to provide appropriate, high quality care to women affected by FGM, the Women's hosted the Comfort Momoh Lecture Series in April.

Dr Comfort Momoh, an internationally recognised expert in FGM, was invited by the Women's from the UK to educate our health professionals, here and across Victoria, about best practice in the clinical management of FGM.

This forum included an analysis of the cultural and human rights context for FGM and its harmful effects on women's health. It also included the sharing of information and resources including how to use the hospital's Clinical Practice Guidelines when providing pregnancy care to women affected by FGM.

The lectures and workshops were attended by more than 250 health professionals and students from across Victoria. The main objective of these was to improve the quality of care and education provided to women in our community affected by FGM.

Volunteering at the Women's

The Women's has been developing its Volunteer Program. Over the past year we have recruited 25 new members, bringing the membership of our program to 69 vibrant and dedicated men and women who are aged between 20 and 82 years and who come from a range of diverse backgrounds.

To support the initial transition period at our new hospital, the program recruited more than 50 volunteers to guide patients and the public coming to the new facility. This program was so successful that a core group of 28 volunteers continue to guide and support patients coming to the Women's every day.

Our volunteers provide invaluable support in the areas of outpatient's clinics, oncology research, medical records, archives and fundraising. In the past year, the volunteer program has become so successful and their contribution so well recognised that now any area of our hospital can seek assistance from any one of our volunteers.

OUR PEOPLE: CREATING HEALTHCARE LEADERS

OUR PEOPLE: CREATING HEALTHCARE LEADERS

At the Women's our key strength is our staff who we attract locally, nationally and internationally. The high-quality healthcare provided across gynaecology, oncology, women's mental health, maternity, social support and newborn services is underpinned by the specialist expertise and dedication of the 2,379 members of our workforce and the training we provide in developing our clinicians of the future.

TABLE 2: WHAT OUR WORKFORCE LOOKS LIKE

Our Staff – 2379 in total				
Gender	88% are women	12% are men		
Age	17% are younger than 30 years	52% are between 30 and 49 years	23% are between 50 and 59 years	8% are over 60 years
Employment Status	30% are full time	40% are part time	30% are casual	
Occupational Group	52% are nurses or midwives	24% are corporate and support staff	18% are doctors	6% are other health professionals
Years of Service at the Women's	7% have worked more than 21 years	36% have worked between 4 and 20 years	38% have worked between 1 and 3 years	19% have worked less than 1 year

Data source: CHRIS 21

QUALITY OF CARE REPORT

OUR PEOPLE:
CREATING HEALTHCARE LEADERS

The Women's has a number of strategies and programs in place to recruit, train and retain highly skilled people in essential clinical and supporting staff roles. This demonstrates the community principle of having high quality staff as follows:

ATTRACTING THE VERY BEST PEOPLE (RECRUITING)

A number of initiatives have been implemented during the year to attract and recruit new staff members with the right skills needed to provide high quality care to women:

Overseas recruitment

The Women's facilitated visits from 63 overseas medical staff, including medical specialists, who worked at the Women's to gain specialist skills, knowledge and training. An additional 37 nurses and midwives from overseas were assisted with visa and Nurse Board applications during 2008-09.

Student Midwife Facilitated Employment Model

As a specialist maternity centre, the Women's has a large midwifery workforce. The sustained global shortage of midwives has presented a significant challenge in recruiting midwives to work at our hospital. In response to this, the Student Midwife Facilitated Employment Model was launched to provide final year midwifery students with a unique employment opportunity to work with us in their final year of studies, enabling them to take up graduate positions at the Women's.

Using the Student Midwife Facilitated Employment Model, high achieving midwifery students (registered in Division Two with the Nurses Board of Victoria) are mentored and supervised by experienced midwives from the Women's to provide postnatal care to well women and newborn babies.

ENSURING OUR STAFF PROVIDE THE VERY BEST CARE (TRAINING)

As the largest independent provider of care to women and newborn babies in Australia, the Women's is an accredited training provider for doctors specialising in obstetrics and gynaecology, neonatal paediatrics, anaesthetics, psychiatry, emergency medicine, endocrinology and general practice. As a hospital that values the importance of teaching and training we ensure the following is in place:

Appropriate qualifications and credentials

We have robust processes to ensure medical staff hold the appropriate qualifications and experience for their role. This means that registration with the Medical Practitioner's Board of Victoria is checked regularly. Other credentials such as the Fellowship of learned Colleges are checked at intervals of five years or less, in accordance with the Standard of the Australian Council for Quality and Safety in Healthcare.

The hospital requires medical staff to participate in training courses and encourages attendance at national and international conferences to maintain their skills, knowledge and networking ability.

Cross-cultural Training

As part of the Improving Care for Aboriginal Women Project (ICAP), the Aboriginal Women's Health Business Unit (AWHBU) has conducted eight training sessions with staff from across the hospital.

This training which is in line with the Women's commitment to achieving the Key Result Area (KRA) of providing cross cultural training includes: how to ask women if they are Aboriginal and Torres Strait Islander in a sensitive and appropriate manner; how to work effectively with women and families from these communities; and providing them with information about the role of the AWHBU and what the government is doing to improve Aboriginal healthcare in Victoria.

In recognition of our high standard of training, AWHBU staff were asked to deliver this training to staff at the Royal Melbourne Hospital and midwives at the Australian Catholic University.

FARREP training

The hospital's Family and Reproductive Rights Education Program (FARREP) also provide cultural training and education to healthcare workers working with communities affected by Female Genital Mutilation. The training provided by the FARREP team assists healthcare professionals in providing culturally safe care to women from these communities.

Feedback from the training sessions has found both external and internal participants benefited from increased cultural awareness; they felt empowered to provide services; and have gained information about resources and services available to women.

INITIATIVES IN NEWBORN INTENSIVE AND SPECIAL CARE (NISC)

Over the past 12 months the Newborn Intensive and Special Care unit has introduced several new initiatives to improve the care of premature and sick babies by developing the expertise of staff and improving communication and collaboration between health professionals. We have:

> improved the way staff work with each other across their different clinical areas. Through the provision of this multidisciplinary approach, we are also able to ensure the family is more involved in the care of their baby(s). This has also created opportunities for clinical education at the cot side which is more relevant to our staff because their learning is evidence based. This further improves the care provided to the baby and their families (see chapter 5);

> set up regular team meetings with staff from their different clinical areas which has improved their ability to learn from each other's professional expertise;

> commenced a New Starters Program which supports nursing staff who want to enrol in a Masters course at La Trobe University. This assists in developing their professional expertise and networks with other clinical professionals;

> changed our orientation practices so new staff now receive a CD information pack prior to starting work. This assists them in understanding their workplace and environment before their first shift;

> desktop learning packages available to enable staff to participate from all computers within the NISC unit;

> introduced special focus weeks such as Medication Safety, Documentation and Developmental Care weeks to assist staff in learning more about important clinical issues;

> formed working groups such as The Continuous Positive Airway Pressure (CPAP), Developmental Care and Nursing Clinical Practice working groups for nurses to critically review their practice. Our staff are benchmarked against other hospitals and change their practice to provide the very best care.

As a result of these new initiatives we have identified improvements to staff morale and retention within the NISC unit. Staff sick leave has fallen from 12 percent to 5 percent during 2008-09 which is an excellent achievement.

DEVELOPING AND INVESTING IN OUR PEOPLE (RETAINING)

We support our staff by creating a work environment that encourages and listens to feedback, provides unique opportunities for our staff to develop their skills and knowledge and prioritises health and wellbeing within the workplace. This also has a direct impact on the standard of care our patients receive and the following initiatives have been implemented in the past year as follows:

Staff Benefits Program

The Women's implemented *thewomens@work* staff benefits program to promote a positive, safe and productive work place. Through this program staff can access a range of lifestyle services that support working life at the Women's and ensure a more relaxed and welcoming environment for staff and visitors to our hospital.

Gathering Staff Feedback

Each year, the Women's participates in the State Services Authority People Matter Survey which measures employees' perceptions of how well the public sector values and employment principles are applied within the workplace.

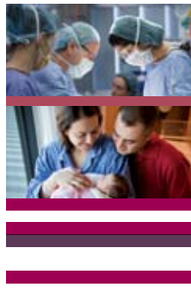
During 2008-09 the Women's scored well in the following categories:

> Responsiveness – providing the best standards of service and advice.

> Human Rights – respecting, promoting and supporting human rights and responsibilities.

> Equal employment opportunity – providing a fair go for all.

> Workplace health and safety.



MISS ORLA MCNALLY

Miss Orla McNally and her family recently relocated from south-west England to take up the position of Director, Oncology/Dysplasia at the Women's.

"I was very lucky to have worked at the 'Old Women's' as a fellow eleven years ago. This time had a huge influence on me and introduced me to leading cancer specialists working at the Women's.

The opportunity to work with these people in my new role was a huge attraction. Also, the fact that the Women's is now located next to the Royal Melbourne Hospital is fantastic. I am passionate about multidisciplinary team working and the physical links with the Royal Melbourne and the future Parkville Comprehensive Cancer Centre will add to this, which we know makes one of the biggest differences in cancer outcomes for women.

I now wish to use my experience setting up a gynaecological cancer centre in the UK to make what is a good gynae-cancer service at the Women's a *great* cancer service for women - we have the skills and importantly the people to make this happen. One of the biggest challenges in this role is to raise awareness about gynaegological cancer and to streamline the route women take to reach our team with initiatives such as one-stop clinics.

The Women's is renowned in the world of obstetrics and gynaecology for its high standards of care and research record. This profile is due to expand as one of the three hospitals in the Parkville Comprehensive Cancer Centre. To be here involved in this development at this time is tremendously exciting and I feel very privileged to be part of it."

The Women's rated 78 percent for leadership, which was 6 percent higher than other organisations; and 94 percent for responsiveness which was five percent higher respectively. In other areas the Women's rated 78 percent for reasonable avenues of redress and 91 percent for workplace health and safety.

Our safe working environment

Over the last 12 months, the Women's has completed further work on the Prevention and Management of Workplace Aggression and Violence, including training and completing a comprehensive risk management framework.

A multidisciplinary group has been set up to develop a hospital-wide approach to managing behavioural emergencies (such as threatening or violent behaviour) from an occupational health and safety and clinical care perspective.

This multidisciplinary group will assess resources and training required to ensure behavioural emergencies are managed appropriately and in a timely way without causing harm to staff, patients, relatives and visitors.

Mentoring staff

A series of workshops were delivered to nurses and midwives to improve their ability to act as preceptors (mentors) to less experienced staff (learners).

Preceptoring partnerships have been shown to reduce anxieties in learners and enhance their professional experience.

Participants developed skills in giving effective feedback, encouraging two-way communication and approaching difficult conversations while gaining a greater awareness of how individual diversity in personality, backgrounds and learning styles affect the way people learn.

QUALITY OF CARE REPORT

OUR PEOPLE:
CREATING HEALTHCARE LEADERS

Nursing Exchange Program 2009

A nursing exchange program has been established between the Women's Newborn Intensive and Special Care unit (NISC) and the Neonatal Unit at the Auckland's Women's and Children's Hospital to provide staff with a challenging and supportive environment to further their careers and share knowledge between hospitals.

For the inaugural exchange, one nurse from each unit is participating in the program. The nurses on exchange were encouraged to participate fully in the units' hosting them, so they could share what they had learned with their colleagues back home. The focus of the exchange was to communicate differences in nursing practices.

The success of this year's exchange has meant the program will continue in 2010 with the potential to expand to sister hospitals in Canada.

Flexible and efficient staff training

Busy environments, increased complexity and rapid changes in the workplace require creative ways of delivering staff education to ensure staff have the appropriate skills required to provide high quality healthcare. Ensuring education is flexible to meet our staff's individual needs, the Women's has launched the new competency assessment tool.

This tool allows staff to log onto a single website for training assessment and competency testing. The results of all training and assessment are captured so that staff and managers can access results and analyse trends.

To date, assessments including emergency management; hand hygiene; epidural management; drug competency; storage, collection and administration of blood products and intravenous cannulation (the giving of liquid substances directly into a vein), are available on this system.

This system helps ensure staff have essential clinical skills and is accessible twenty four hours a day, seven days a week.

IMPROVING YOUR EXPERIENCE AT OUR HOSPITAL

IMPROVING YOUR EXPERIENCE AT OUR HOSPITAL

Women help us shape their care by providing us with feedback, consulting with us and providing input to the community principles and values that guide the way we work. These community principles are consistent with the Department of Health's performance indicators for community participation.

INVOLVING WOMEN AND FAMILIES IN IMPROVING OUR HOSPITAL

At the Women's we involve women and families in the decision making process to ensure the care we provide is safe, responsible and accessible. We involve consumers in the decision making process by listening to your concerns, learning when something goes unexpectedly wrong and communicating openly with you and your families. Our commitment to improving the quality and standard of care provided to you is demonstrated by our staff as follows:

Commitment to consumer participation:

In March 2009 the Australian Council in Healthcare Standards (ACHS) conducted a periodic review as part of its Evaluation and Quality Improvement Program. This review assessed mandatory criteria including clinical care which demonstrated that the hospital ensures consumers are involved in developing care plans and evaluating their clinical care. Evidence to support this includes the evaluation of the Integrated Breast Service and Breast-feeding Education and Support Services. These areas were commended for their ongoing improvements and for receiving a standard of excellent achievement. This was previously received in March 2007.

Consumer participation in high level decision making

Consumers and carers are represented throughout the hospital on our monthly committees such as the Community Advisory Committee, the Primary Care and Population Health Advisory Committee, the Quality Committee and many others. Consumers reported that bringing the consumer's perspective to the table provided a reality check to the discussions and enabled "a layperson's viewpoint on sensitive issues".

Community Participation Plan

The Women's continues to implement the Community Participation Plan developed for the 2007-2010 period. Some of the key initiatives implemented during the past year have included:

> regular monthly parent involvement in the Newborn Intensive and Special Care (NISC) family and baby care group, where approaches to family and baby care are advised and discussed; and

> gathering feedback from women about our Individualised Postnatal Care Program, a program tailored to their needs through consultation and discussion with the woman and medical support team.

Consumer participation in decision making about their care

We continue to work to improve the information provided to women and their families. Women have identified they want to be better informed and educated about their right to informed consent. Later in the chapter we discuss our work on consumer health information which relates to this particular area of work.

CAC MEMBER, ANNA MOO

The Women's Community Advisory Committee (CAC) acts as an advisory committee to the hospital Board ensuring that consumer participation occurs not only at a high level, but right across the organisation. Anna Moo is a member of our Community Advisory Committee.

"As a first generation immigrant woman, I am very much aware of the importance of health services to be culturally relevant and responsive to women's needs. The CAC provides the opportunity for women's voices to be heard and feedback provided on health issues that are important to all women. Women on the CAC are as diverse as the women who attend the hospital and bring to the discussion their expertise, knowledge and experiences and a great deal of wisdom and humour. Feedback and advice are provided on important policy issues and plans such as consumer information, the Parkville Comprehensive Cancer Centre, waiting lists, community consultations and the Diversity Plan. Women on the CAC have many opportunities to attend forums to provide a community voice and insight. "

QUALITY OF CARE REPORT

IMPROVING YOUR EXPERIENCE
AT OUR HOSPITAL

Our score last year on the Victorian Consumer Participation Sub-index was 77, the average for similar hospitals. However in 2006, the first year it was measured, our score was 80, so the hospital remains committed to making further improvements in this area by talking to women and their families and seeking their advice on ways we can improve their involvement when making decisions.

A HOLISTIC APPROACH TO CARE

Women told us they wanted family-friendly care so that the needs of the whole patient were considered and to ensure their privacy and dignity is protected. We report on the recent projects which are improving the experience of women and their families in our care as follows:

Caring for women experiencing anxiety and depression

The Centre for Women's Mental Health has introduced two significant projects relating to anxiety and depression in women. These projects support women with newly diagnosed breast and gynaecologic cancer and women experiencing postnatal anxiety and depression.

Women with cancer

Psychological distress is thought to be very common in women with newly diagnosed breast or gynaecologic cancers, but only 5-10 percent are referred for psychological care. This suggests that improvements are required by our staff in better understanding and identifying when a woman needs to be treated for anxiety and depression.

Identifying and managing psychological distress is very important as it can affect a woman's treatment for cancer and her overall quality of life.

The Women's has implemented a pilot program where routine screening for symptoms of anxiety and depression at the time of diagnosis followed by every eight weeks is completed. A woman may be referred to the Centre for Women's Mental Health or another appropriate mental health service.

These projects have been very successful in increasing recognition of clinically significant psychological distress and providing appropriate services to women. Women in focus groups told us that psychological screening as part of routine clinical practice was beneficial.

Women at risk of postnatal depression and anxiety

Postnatal depression and anxiety can have a devastating effect on a woman. It can reduce her ability to care for and interact with her child, with many women feeling a sense of inadequacy and a failure as a mother.

In response, the Perinatal Anxiety and Depression Prevention and Treatment Program provides assessment and preventive interventions for women at risk of developing postnatal anxiety or depression.

This program aims to prevent early mother-infant interaction problems, which can have longer term detrimental effects on the child's development. The program complements current mental health services provided in maternity clinics.

As part of the program women receive psychiatric assessment and treatment and are seen by the clinical psychologist for individual or group therapy. Where appropriate, further follow up is provided for women for a determined period of time after the birth of their baby.

When the Centre for Women's Mental Health was established in 2007, it was the first gender based

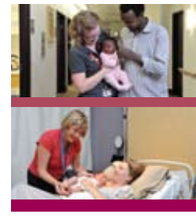


TABLE 3: NEW REFERRALS TO THE WOMEN'S CENTRE FOR MENTAL HEALTH

	Jan-June 07	July - Dec 07	Jan - June 08	July - Dec 08	Jan - June 09
maternity	152	144	182	164	184
neonatal	0	0	17	17	12
gynae/cancer	22	42	48	52	72
reproductive biology unit	2	7	18	25	21
Other	24	25	7	10	27
Total	200	218	272	268	316

Data source: The Women's Mental Health Database

service for women suffering mental health issues in Australia. The centre was established to focus on the provision of care for pregnant women experiencing mental health problems. During 2008-09 additional resources were provided to enable the Centre to better meet the needs of women with gynaecological problems, cancer, fertility concerns and for mothers of infants requiring care in our Newborn Intensive Special Care unit.

The growth of services to outpatients as shown in Table 3 demonstrates the significant progress we are making to address mental health problems among women which has previously gone unrecognised and untreated in society.

Oncology Sexuality project

When providing care for a woman with gynaecological or breast cancer, it is very important to consider the impact this has on her sexuality. Although there are a wide range of resources available, we have found many women do not access them.

With funding provided by the Western and Central Melbourne Integrated Cancer Service, a twelve month quality assurance project has started to identify the barriers that nurses and doctors face when working with women with sexuality and body image issues. The project aims to incorporate sexuality and body image as an essential dimension of cancer care.

This project is managed by two nurses from the oncology unit who have a keen interest in sexual health. It is supported by a multidisciplinary clinical advisory group and is informed by consumer participation.

Birth Reflections

The Birth Reflections Service started in mid 2008 for women who feel their birth experience was traumatic in some way. Some women who have some discussion about the birth of their baby in hospital report that it is too soon for them to really formulate questions about their experience and understand answers.

The service received 75 referrals in its first nine months. These came from midwives, doctors, social support staff, consumer advocate, shared care GPs, physiotherapy, maternal and child health nurses, community centres, mental health services and a number of women who self-referred. The variety of different referral sources emphasises the need for the service.

During an appointment, the woman's labour and birth are discussed. Diagrams are often used to assist in the discussion. The purpose of reviewing and discussing a woman's labour and birth with her and her partner is to give them a better understanding of what specifically happened during their birth and to answer any questions they may have. This also assists in determining if anything could have been done differently during pregnancy. The lessons we learn from these discussions enable us to improve the care of others.

During the year many women were referred to other clinics and support services within the hospital. These included referrals to the Consumer Advocate, Child Birth Education, General Practitioner, Maternal and Child Health Nursing Service, Women's Social Support Services (Social Work), Mental Health, Anaesthetic Review Clinic, a lactation consultant, physiotherapist and sexual counselling clinic. This is all part of ensuring women in our care receive clinical expertise during their pregnancy and post birth.

Women were sent evaluation forms on how they had found the Birth Reflections discussion. With over 80 percent of evaluation forms returned, the overall feedback of the service has been overwhelmingly positive.

The Journey through the Newborn and Intensive Special Care unit

The Family Centred model of care in the Newborn Intensive and Special Care unit (NISC) was directly informed by families who have had a baby in NISC. The unit's new design has significantly improved the experience of parents with premature and sick babies. They are now provided with more space at the baby's cot side with the design of the area set out like a baby's first bedroom. This provides families with welcoming and comfortable surroundings like a home away from home. The design has also reduced noise levels and improved patient privacy.

The family-centred environment now means pastoral care workers are able to conduct quiet conversations with parents and families by the baby's cotside and to conduct rituals such as baptism or blessing ceremonies without intruding on the space and privacy of other families.

The increased space around the cot also allows for the mother to express her breast milk at the baby's cot side, supporting her physical relationship with her baby. This has benefits for families who are able to

ANNEMARIE'S STORY

Annemarie was diagnosed with ovarian cancer, stage three, in May 2008. Here is a small insight into her journey over the past 12 months:

"I had some vague symptoms – pelvic discomfort and bloating – and went to my GP. An initial ultrasound seemed to suggest an ovarian cyst which was considered not very significant. However it was only a few days later that the results of blood tests, followed by another ultrasound, confirmed that I had ovarian cancer. It seemed unbelievable. All I could think was 'we can't be talking about me. I feel so well'. But we were. My gynaecologist referred me to the Women's, and within a week I had surgery to remove my ovaries, fallopian tubes and uterus. I had been a private patient up till then, but I elected to have the course of chemotherapy recommended after surgery as a public patient at the Women's.

The care at the Women's has been fantastic from the beginning. I really feel that I couldn't have been in a better place. The doctors, nurses and everyone involved have really taken me, and my care, seriously.

While I was in hospital recovering from surgery, before commencing chemotherapy, the oncologist spent a long time with me and my husband discussing my condition and explaining treatment. This first contact was very significant – I needed to feel confident and have trust in those caring for me.

Coming to the Women's for chemotherapy every three weeks could have been unpleasant but it was actually a positive experience. I was happy to come in to see the staff I knew and my 'chemo buddies'. It was like being nurtured inside a safe and secure cocoon; a calm, caring and happy space.

The other important thing for me was that I felt I was a partner in my care. I felt I had some control about my care. At one stage it was suggested that I have a permanent line put into my vein but I really didn't want this. My opinion and my needs were always taken into account, and I didn't have the line put in.

I am part of the Living with Cancer program at the Women's which is run by two oncology nurses, once a week for five weeks. When I first received the invitation in the mail I thought 'I don't need to learn to live with cancer'. It was a bit of a shock at first. There were six women in the group with different kinds of gynaecological cancer and each week there were different issues addressed, such as menopause, body image and sexuality. One week a doctor came and chatted with us and was available to answer a range of questions. We had access to a whole range of health experts including nurses, physiotherapists, dieticians, pharmacists, social workers and counsellors. I found it very useful.

My suggestion for how my care could have been improved is that it might be useful to be given a folder at the start of treatment with all the information, contact numbers and community support groups that you might need at some stage. This information is available in the chemo room for patients to take at any time, however I think it would be good for women to be able to take it home and browse through it in their own time. You never know when you might need it.

I think the Women's has a fabulous team who do a brilliant job. I felt fortunate to be under the care of people who are professional, honest and open, compassionate and caring and who are experts in their field".

build confidence, gain experience in caring for their baby, and establish breastfeeding while still being supported by our hospital staff. In addition, the overnight parent room has enabled families to spend time with their baby in preparation for taking their baby home.

Feedback from families has identified that further improvements are required around better lighting and more accessibility to power points which the hospital is exploring.

Parents morning tea in Newborn Intensive and Special Care (NISC)

Parents' Morning Tea is a weekly, informal, ongoing group, organised and facilitated by the neonatal social workers for parents who have a baby in NISC.

The group enables parents to meet other parents and share their stories. This helps to reduce feelings of isolation and to encourage them to take a break from being by their baby's cotside. Guest speakers, such as the NISC support group 'Life's Little Treasures', attend monthly to provide parents with information and support.

Evaluating the changes in NISC

Previously in NISC, each baby may have been cared for by 70-80 staff over four weeks in hospital, and the baby moved up to 12 times from one place to another within the nursery. This also meant that parents were moved around and were cared for by many different staff members.

FEEDBACK FROM GROUP PARTICIPANTS HAS INCLUDED THE FOLLOWING COMMENTS:

"…group meetings were like a breath of fresh air in the middle of all the chaos. The group offered a let-out, support, understanding and a well needed break every week. It was many times the highlight of the week!"

To improve the parents' experiences and ensure there is continuity and consistency of care, we have changed the neonatal model of care and improved how we admit babies, provide care and organise the unit's workforce. The results show that these changes have worked well as shown in Table 4.

TABLE 4: EVALUATING THE CHANGES IN NISC

What parents were asked	What we found
'It is easy to find my baby when I come to the nursery'	An increase in "always easy" from 77 percent in 2007 to 94 percent in 2008
'I am more involved in the planning of care for my baby'	An increase in "always " from 25 percent in 2007 to 52 percent in 2008
'In the one week I regularly talk to different doctors about my baby'	In 2007, 44 percent of families saw different doctors" frequently". In 2008 this was only 10 percent.
'I enjoy having the same nurse care for my baby for more than one shift at a time'	An increase in "always" from 55 percent in 2007 to 84 percent in 2008.
'It is helpful having the care manager as a constant person during my baby's stay in the nursery'	This refers to having a single contact person who coordinates care. An increase in "always" from 26 percent in 2007 to 63 percent in 2008.
'Talking with a social worker is important for me in caring for my baby'	An increase in those who answered "always, frequently or sometimes" from 19 percent in 2007 to 73 percent in 2008.

Data source: BTTS, L: Neonatal Model of Care Project Final Report 2009

QUALITY OF CARE REPORT

IMPROVING YOUR EXPERIENCE
AT OUR HOSPITAL

Supporting women with unplanned or unwanted pregnancy

At the Women's we advocate for and influence policy and social change that supports women's healthcare needs.

As part of this commitment to women in November 2008, the Women's welcomed the Abortion Law Reform Act 2008 which now provides clarity for women and their healthcare practitioners. Approximately one third of Australian women will have an abortion at some stage in their lives. Therefore it is in the interests of women, and of the health professionals who care for them, that abortion is regulated through health legislation and not criminal law.

At the Women's we provide counselling and social support, clinical, medical and surgical services for women with unplanned or unwanted pregnancy. During the parliamentary debate, we provided expert advice to ensure that the legislation subsequently passed was in line with clinical practice and community standards. Our clinicians provided briefings to parliamentarians and community leaders as well as an opinion piece for the public about the proposed changes.

The new law provides clarity for women and their healthcare practitioners. Removing abortion from the Crimes Act has provided a clear and secure framework for health professionals to respond to women's health care needs in an appropriate and timely way.

CONSUMER SURVEYS – INFORMING OUR SERVICE IMPROVEMENTS

Feedback from women and their families about their experiences of our services is an extremely important way of gathering information so we can make improvements to the care we provide. During 2008-09, a number of surveys were undertaken to learn more about the consumer's experience of services at our hospital as follows:

Women's Social Support

The Women's Social Support Services, the Family and Reproductive Rights Education Program team and the Aboriginal Women's Health Business Unit introduced consumer surveys to inform improvements to these services. These surveys, which provide women with an opportunity to give feedback about their experiences, are continuing and the results from this project will be provided in our 2009-2010 Quality of Care report.

Family Accommodation

The Family Accommodation Service provides temporary accommodation for patients and families from rural or interstate areas experiencing extreme crisis. The accommodation is located in Carlton, a short walk from our hospital.

During the year a client survey of Family Accommodation residents found 'women felt they received good information about Family Accommodation once they were admitted but did not get much information before admission.'

In response to this and other feedback from women and families we are exploring:

- Further training with outpatient clinic and birth centre staff to ensure women know about this service before their first visit or immediately upon arrival;
- Options to update furniture and equipment of the flats, particularly child friendly facilities and play areas; and
- Options to relocate Family Accommodation closer to the hospital.

There was an overwhelming response from residents who said they would use Family Accommodation again or recommend it to others (94 percent). As one resident stated "it's a vital need of country patients (and) we were and still are very thankful for such a service".

OUR FAMILY ACCOMMODATION

"The accommodation was our safe place through the worst and hardest times of our lives. We can never thank you enough for being able to stay there for 18 weeks".

Family accommodation resident

The Well Women's Clinic

The Well Women's Clinic is operated by Nurse Pap Test Providers and offers free cervical screening, which is an important step in preventing cervical cancer. In particular the clinic sees women from culturally diverse backgrounds or women who are under screened or who have never been screened.

In October 2008, the Well Women's Clinic conducted a survey to gather feedback from women about the service which highlighted some significant progress and areas for improvement as follows:

- 57 percent of women who accessed the service were born overseas and came from 19 different countries including Vietnam, Thailand, El Salvador, China, Lebanon, Greece, Italy and Turkey.
- Nearly two thirds of women seen had been under-screened for more than two years prior to coming to the clinic.
- A third of the women surveyed identified the 'reputation of the Women's Hospital' as a reason for coming to the clinic and said they felt safe at the Women's.
- 83.9 percent used the Clinic as they wanted the Pap test done by a woman.
- 21 percent of the women identified that they had difficulties booking an appointment.
- Nearly all women reported a high level of satisfaction.

Future evaluations will aim to capture data on women with disabilities and women with mental health issues to provide further insight into improvements that we can make to benefit patients in our care.

LEARNING FROM WOMEN – THE VICTORIAN PATIENT SATISFACTION SURVEY

The Department of Health funds the Victorian Patient Satisfaction Monitor (VPSM) and reports twice a year on satisfaction with Victorian hospitals. It uses the Index of Care, which includes a range of factors as a way of measuring this.

The period of the survey covers six of the first seven months at our new site here in Parkville when the hospital experienced a very high level of maternity demand. As expected, results for the physical environment improved, but some other results declined. As noted elsewhere, the results for cleanliness were excellent. We are making further improvements now we have settled in our new site and are more familiar with the new design, layout and ways of working.

We achieved very high results against the following questions:

1. The cleanliness of the room where you spent the most of your time
2. The cleanliness of the toilets and shower
3. Being treated with respect
4. How well your cultural or religious needs were respected by the hospital
5. The courtesy of the nurses
6. The opportunity to ask questions about your condition or treatment

Improvements are required against the following questions:

1. The way the hospital routine and procedures (like meal times, visiting hours, doctors' visits, etc.) were explained to you.
2. The quality of food overall
3. The quantity of food overall
4. Facilities for storing belongings - availability, security and ease of use
5. The time given to planning your return home

Following the move to our new hospital, we were concerned with women's feedback about our food quality and worked closely with our provider, the Austin Hospital, to make improvements. Our survey results that we submit monthly to the Department of Health Metropolitan Food Services show that patient satisfaction rose from an average of 75 percent towards the end of 2008 to an average satisfaction rating of 85 percent in the first half of 2009. This is an excellent and satisfying result.

TABLE 5: VICTORIAN PATIENT SATISFACTION MONITOR SHOWS OUR RESULTS

Index Measure (20-100 Scale)	Mar to Aug 2006 Score	Sept 2006 to Feb 2007 Score	Mar to Aug 2007 Score	Sept 2008 to Feb 2009 Score
Overall Care	75	75	74	74
Access and Admission	76	74	72	69
General Patient Information	80	80	79	76
Treatment and Related Information	78	77	76	75
Complaints Management	81	79	79	76
Physical Environment	69	67	67	74
Discharge and Follow-up	74	73	73	72

Data source: VPSM
For a comparison between the Women's and other metropolitan hospitals you can go to www.health.vic.gov.au/patsat/

QUALITY OF CARE REPORT

IMPROVING YOUR EXPERIENCE
AT OUR HOSPITAL

DEVELOPING QUALITY INFORMATION TO ASSIST AND GUIDE CONSUMERS

Our consumers health information plays a vital role in improving health literacy and empowering our consumers to make fully informed decisions about their healthcare. The Women's is committed to understanding and providing for the health literacy needs of women, based on consumer input and good research and improving health education. This includes providing information in the right format and language for women who use the Women's services as follows:

Information for women to assist them make decisions about their care

Multidisciplinary working groups in maternity care and women's health include consumer representatives who develop and improve our health information. The perspective of consumers informs this literature by contributing to the production of high quality health information and participating in focus groups or reviewing the content.

We are working to increase the diversity of consumers who participate in these processes and are looking at providing information in other formats such as audio-visual formats.

Support for families whose baby has died

When a baby dies, parents are faced with many decisions which are difficult and often complicated to deal with. Consistent with the hospital's approach to providing evidence based, high quality consumer health information, the Women's developed a booklet to guide families through the decision making processes in the immediate aftermath of their baby's death.

This booklet was developed for families during 2008-09 with extensive consultation involving families, clinicians and external agencies such as Stillborn and Neonatal Death Support and Sudden Infant Death Syndrome and Kids Victoria.

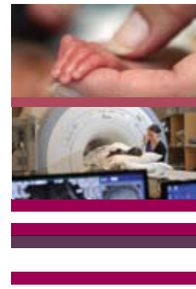
The overwhelming response from families was that while they wanted the information to be presented in a way that was supportive and gentle, they also wanted a clear guide in regard to: what happens in the days that follow; what decisions they need to make; what the legal implications are; and what is expected of them.

Reviewing information given to consumers

This year the Women's evaluated the booklet *Having Your Baby at the Women's*, which is given to staff and women receiving pregnancy care. 71 women at various stages of pregnancy were interviewed. Over half the women interviewed spoke English as their first language with 16 other languages represented in total.

Most women were very positive about the book and found it 'helpful', 'informative', 'easy to understand', 'useful', 'practical' and 'concise'. Most health professionals interviewed felt the booklet was useful in reinforcing discussions and encouraging women to ask questions. All of the women interviewed said that the Women's should provide written information as from the hospital it is deemed to be reliable; women have confidence in the information; it is important having a central source of information and the booklet contains important information especially for first time mothers.

The Women's is improving the *Having Your Baby at the Women's* booklet so that it has information relevant to a wider variety of women.



Working in schools to prevent violence against women

The Women's recognises violence as a significant health issue facing women in our community.
In response the Women's developed the Sexual Assault Prevention Program in Secondary Schools (SAPPSS) to reduce and prevent violence against women.

SAPPSS has been developed by the hospital's Centre Against Sexual Assault House in partnership with schools. This whole of school approach aims to create an environment where young people are taught to practice respectful relationships, recognise abusive behaviours, feel safe to disclose sexual assault and receive information and support.

In April 2009, the Federal Government announced a new ' Respectful Relationships' program, as part of its plan to reduce violence against women and children. Under this program, the Women's has been funded for three years to support the delivery of SAPPSS in three secondary schools in Canberra, in conjunction with the Canberra Rape Crisis Centre. To date, SAPPSS has been introduced into 11 Victorian schools which supports our ongoing commitment to educating the community about the role they can play in reducing violence against women.

The No Means No Show introduces SAPPSS students to the issue of sexual assault and their rights and responsibilities in relationships. This highly engaging theatre uses comedy, songs, scenarios and skits to provide young people with practical 'how to' advice regarding negotiating intimacy and building confidence in their relationships.

THE JOURNEY THROUGH THE HOSPITAL – ENSURING CONTINUITY OF CARE

At the Women's, we value and encourage open and honest communication among our staff, women and their families. As a result, a number of improvements have been made to strengthen communication between the hospital and our community as follows:

Continuity of care into our community

The Women's was one of the first Victorian hospitals to develop an electronic discharge summary that could be autofaxed to a patient's GP.

Some clinical areas rate very highly when communicating with a woman's GP. A recent audit of communication about women being treated for cancer showed that the Women's communicated with GPs 100 percent of the time via a letter from the primary treating clinician. Graph 3 shows that the Women's compares very well with the other Western and Central Melbourne Integrated Cancer Service (WCMICS) hospitals.

Some improvements we are making in this area to ensure continuity of care between our staff, the woman and her GP, is to change the way data is entered; how information should be exchanged between databases; and to ensure GP details are most up to date.

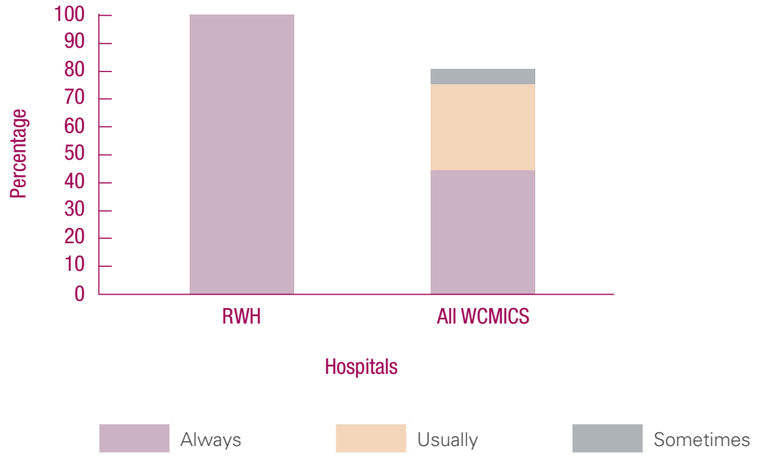
Hospital in the home

The Home Based Services department provides services for hospital discharge planning, Hospital in the Home (HITH) and Post Acute Care referrals.

HITH nurses visit patients at home for a variety of conditions including severe nausea and vomiting in pregnancy, intravenous antibiotics, complex wound dressings and chemotherapy for some oncology patients.

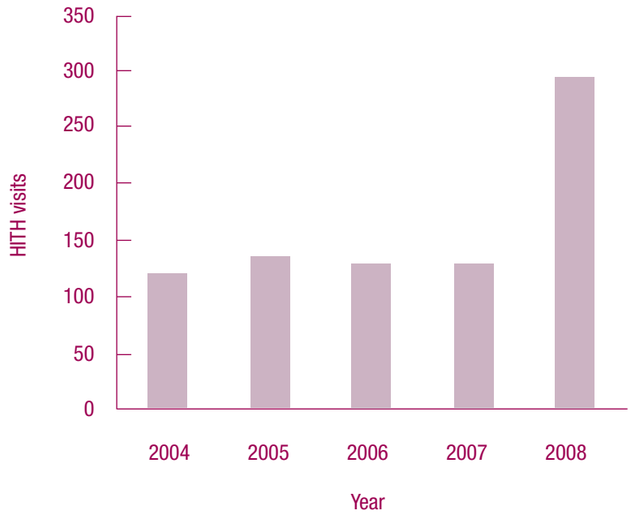
Graph 4 shows that HITH referrals have increased significantly in the past year. This is due to our focused effort on promoting the service and implementing clear guidelines around eligibility for HITH. We have also ensured all our procedures and guidelines are developed or updated to reflect evidence based practice and that patient information brochures are widely available.

GRAPH 3: TREATMENT RECOMMENDATIONS COMMUNICATED TO THE GP

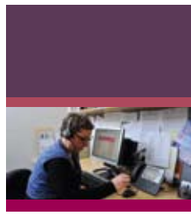


Data source: WCMICS Multidisciplinary Team Meeting Audit 2009

GRAPH 4: HOSPITAL IN THE HOME VISITS (HITH)



Data source: The Women's HITH Database



SAFE CARE AT YOUR HOSPITAL

SAFE CARE AT YOUR HOSPITAL

Safe, high quality healthcare is dependent on a hospital culture where staff can report, discuss and learn from occasions when things go wrong.

HOW DO WE ENSURE OUR HOSPITAL IS SAFE

We proactively work hard to review and improve our hospital systems and processes, listen to consumer feedback and monitor high-risk areas to improve care, enhance consumer experiences and avoid incidents as follows:

- Best clinical practice based on research evidence is promoted throughout our hospital. There are more than 120 Clinical Practice Guidelines on the internet to inform best clinical practice and provide further education to our staff. These guidelines are reviewed and updated regularly and are available to our consumers.
- Clinical reviews of patient care are held regularly to test and assess the care provided through our hospital.
- Incidents are reported to make sure the systems and processes that need improving are addressed. This helps to create a 'culture of safety' where staff look out for things that might go wrong.
- A Patient Safety Policy is in place to promote a 'no blame' culture amongst staff so that people speak up when something goes wrong, and the entire organisation can learn from it.
- Patient complaints are taken seriously to inform the hospital of things that go wrong and so improvements can be made.
- Staff work to identify things that may cause harm to patients (risks) and put measures in place to prevent harm. This includes ensuring any potential clinical risks are identified and managed as part of our annual service planning.
- Clinical directors and managers are responsible for ensuring quality and safety.

Incident reports for 2008-09

It is very important that our staff report all incidents that occur to ensure our hospital is safe. During the year we continued to encourage staff to report incidents more broadly.

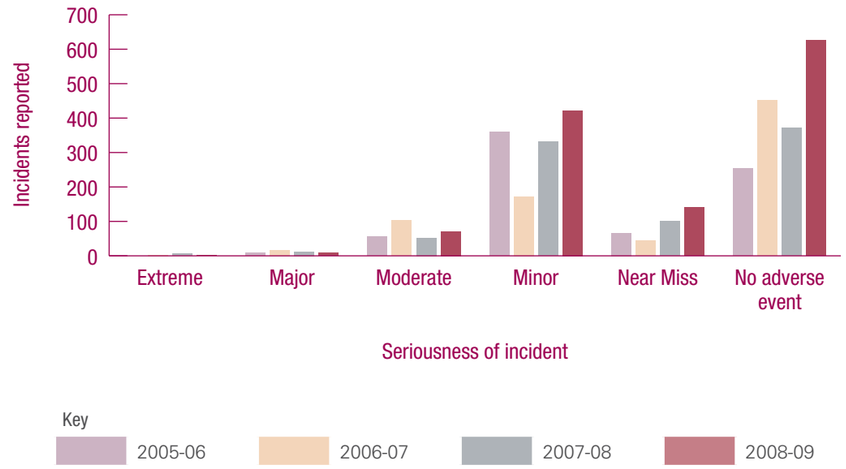
Graph 5 shows an increased number of incidents reported during the 2008-09 year. This doesn't mean that more things went wrong but that a broader range of staff recorded and reported things when they did go wrong compared to previous years. This was due to increased education and training for staff encouraging them to report incidents.

Graph 6 shows that the increase in incidents in 2008-09 was predominately in the category of 'incidents without serious consequences' (minor, near miss, no adverse outcome) which is an excellent result.

GRAPH 5: INCIDENT REPORTS FROM 2003 TO 2009

Data source: The Women's Riskman database

GRAPH 6: CLINICAL INCIDENTS BY SERIOUSNESS FOR THE LAST THREE YEARS



Data source: Riskman database

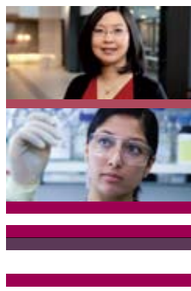


TABLE 6 SIGNIFICANT IMPROVEMENTS TO SAFETY IN 2009

Activity	What we did	The result after the change
Patient Identification	Improvements to policy and practice have resulted in new processes being implemented for the unique identification of a woman and her baby.	An audit of identification bracelets of babies and mothers for all inpatient, and selected outpatient areas found that these were all 100 percent correct.
Outpatient appointments	A Bed Manager has been appointed to work with maternity teams to identify more readily if a woman requires genetic counselling or an interpreter and they take responsibility for organising the woman's appointment. This will assist in reducing the wait time for a woman's first pregnancy appointment.	The system which now identifies urgent referrals required by fax to the hospital ensures those women requiring urgent attention receive an appointment as quickly as possible.
Managing maternity demand	In 2007 the state implemented a range of measures to enable the three tertiary hospitals – the Women's, the Mercy Hospital for Women and the Monash Medical Centre, to prioritise access to women and babies requiring high risk, complex and specialist care. This policy was implemented to encourage women experiencing low risk and straightforward pregnancies to give birth closer to home. The Women's set up a Taskforce to identify what it could do to achieve this for women in our care.	A plan was implemented ensuring women who require complex and specialist care from across Victoria can receive access to tertiary care when they need it. In addition, women who require low risk maternity care are also now able to give birth closer to home.

Activity	What we did	The result after the change
Identifying mental health and psychosocial needs of women	A range of plans have been implemented to increase awareness amongst staff of the Centre for Women's Mental Health and Women's Social Support Services and the support they provide women. This includes: training of staff in the Women's Emergency Centre, by the Centre for Women's Mental Health, to recognise women's psychosocial needs; more information provided to junior medical staff about mental health and referral processes; and Post-Natal Psychiatry Clinics established.	Referrals to the Women's Centre for Mental Health and the Women's Social Support services have steadily increased and the hospital continues to identify and make improvements in this area.

Responding to serious incidents

When a major incident occurs, a Root Cause Analysis (RCA) is conducted as a method of reviewing and understanding what went wrong and to look for improvements and ways to prevent a reoccurrence.

A Root Cause Analysis is also conducted at times when an incident could have had serious results (a near miss) but didn't. Conducting a RCA is a good way to review incidents as it brings the different clinicians, and at times representatives for the woman or families involved, together to look at the problem.

This analysis supported the introduction of the new Maternity Clinical Information System and the hospital has now implemented stage one. The system allows consultants and midwives better access to information about the health of the mother and baby during labour and is generating great support among clinicians. This system enables large amounts of information collected during labour to be stored electronically. Clinicians in the Birth Centre are now able to view the tracing of the baby's heart rate at the main desk, on various computers around the hospital, and from home. This guides staff and ensures improved access to information to enable timely and appropriate decision making.

Stage two is being implemented in October 2009 and will provide further information and improve communication among clinicians for the benefit of women giving birth and the care we can provide.

Improving our response to the deteriorating patient

In past years, Root Cause Analyses conducted on a small number of incidents and near miss reports, identified issues relating to the early identification of gynaecology patients who needed medical assessment after hours. This issue was found to be common in hospitals around the world.

As a result, funding was sought for a project to improve clinical handover processes and the introduction of methods to better identify and communicate the deterioration of a patient. The following significant improvements have since been made:

> the introduction of a formal medical clinical handover for gynaecology patients, which improves communication between carers about the patients in the ward;

> the start of a trial of a new nursing observation chart which incorporates an Early Warning Score aimed at providing clearer visual clues for nurses and doctors about when a patient is becoming sicker; and

> training to identify easier ways of communicating between clinical staff about a patient.

THE ISBAR METHOD IS USED FOR THIS AND REFERS TO:

I (identify yourself, the patient and who you are talking to)

S (situation – why you are calling)

B (background – the patient's story)

A (assessment – what you think is going on)

R (request or recommendation)

HEARING YOUR COMPLAINTS AND CONCERNS

Responding to patient concerns and complaints is about improving safety and a woman's experience at our hospital. Women, friends and family are able to contact the Consumer Advocate to offer feedback, discuss an issue of concern, request assistance or make a formal complaint.

During the past year the Consumer Advocate service received 782 complaints – a 47 percent increase from 2007.

The increased awareness amongst both women and staff of the service and its ability to assist in resolving issues quickly has contributed to the increased use of this service.

As staff get to know and trust the service, they are more likely to refer consumers for assistance in resolving their concerns and for someone to advocate on their behalf. The values of a no-blame but accountable culture, transparency, open communication and finding a resolution that respects and acknowledges the needs of all involved, informs the work of this service.

Not all issues addressed by the Consumer Advocates are complaints. Consumers regularly request assistance to advocate on their behalf, to assist them with directions, to gather more information or to arrange further contact with a doctor or a midwife.

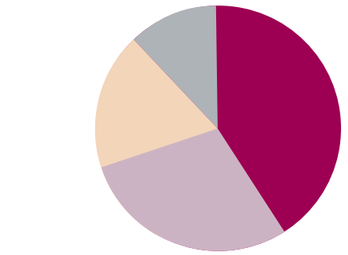
What are the complaints about?

Every complaint received provides the opportunity to look for ways to improve hospital systems in order to reduce the likelihood of the same issue reoccurring.

Often complaints present as opportunities for improving the quality of care and services that we provide to women. A woman who had a history of mental health and had attended Women's Emergency Care reported that staff did not adequately address her issues or offer her appropriate support. The consumer advocate reported this complaint to the Clinical Director and Nurse Unit Manager of Women's Emergency Care and agreed that in-service training and education be provided on a regular basis to staff to enhance their skills and knowledge of women's diverse experiences of mental health. This training was organised in conjunction with the Women's Centre for Mental Health.

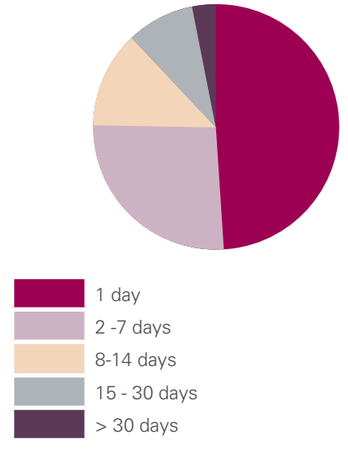
Each year our greatest challenge is effective communication with our patients. Our goals are to provide adequate information, improved customer services, and skills by our staff. To address this, there has been training in communication and customer service in key departments. There are plans to further improve this area over the next 12 months.

GRAPH 7: BREAKDOWN OF COMPLAINT ISSUES



Data source: The Women's HCIP database

GRAPH 8: NUMBER OF DAYS TO CLOSURE



Data source: The Women's HCIP database

Improvements relating to treatment for patients often involves feedback from patients who believe they have received inadequate care. On many occasions, more information and an opportunity to have their questions and concerns addressed face to face has resolved these complaints.

The Consumer Advocate service aims to respond and resolve complaints as soon as possible. During the past year 49 percent of complaints were addressed within one day.

Some complaints take longer to resolve as more complex issues can involve liaison with a range of staff across our hospital. Consumers are kept informed of the process and provided with expected timelines for resolution. Last year, 97 percent of complaints were resolved within 30 days, which is a 17 percent improvement on the resolution of complaints received three years ago.

ENSURING THE SAFE PROVISION OF MEDICATION

During 2008-09, a multidisciplinary team was formed to complete the hospital's Medication Safety Self-Assessment (MSSA) required for all Victorian hospitals. The survey identified that the Women's major strengths are its quality processes, risk management and patient education. When compared with other Australian hospitals, the Women's scored either higher or was equal to the national average across the ten core areas of assessment. This audit also highlighted the following areas for improvement such as: patient information; drug information; drug labelling; packaging; nomenclature (name listing); and staff education. We will report on these improvements in next year's publication.

Making improvements to Medicine safety was a core focus during the last 12 months as follows:

- The times for giving pain relief following a caesarean section have been standardised so women do not experience unnecessary pain;
- posters are in place in preparation rooms on all wards to remind staff of the differences between drugs with names that sound alike such as: oxycontin (long acting) and oxycodone (short acting) powerful pain relief drugs;
- visual alerts have been introduced for women with a medicine allergy. For example in the operating theatre, women with allergies now wear a red theatre hat;
- an educational video, *Get Smart,* was developed to remind staff of medicine safety tips; and
- neonatal medication charts for sucrose, Hepatitis B vaccine and Vitamin K are pre-printed so titles and dosages are clear. A reconciliation process has been introduced to ensure that Vitamin K and Hepatitis B vaccine are only administered once.

Preventing pressure injuries

Pressure ulcers and other skin injuries are not a frequent occurrence at the Women's. However a woman who is very sick with cancer may get skin damage and a sick baby may experience skin damage around the nose due to the tubes and tapes required to assist the baby's breathing. These patients who are most at risk of skin damage due to a pressure injury have their skin assessed frequently during the day and staff caring for them provide them with treatment to prevent the occurrence of skin damage.

Of all skin injuries, there were 18 recorded pressure injuries. 16 were babies in intensive care and two were women with advanced cancer. There are different grades of pressure injuries and the two adults and seven newborn babies (mostly on nasal continuous positive airway pressure to help them breathe) had stage two pressure injuries.

During 2008-09 the Women's participated in the Department of Health's Pressure Injury Clinical Indicator program to ensure staff were receiving education and training around how to prevent pressure injuries on any patient.

TABLE 7: INCIDENTS RELATED TO ALL SKIN DAMAGE

	2005/06	2007/08	2008/09
Major	1	0	0
Moderate	1	2	7
Minor	13	7	13
No adverse event	0	4	0
Total	15	13	20

Data source: The Women's Riskman database

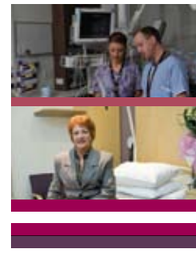
To improve care for newborn babies at risk of pressure injuries, neonatal nurses receive extensive education during their training on how to reduce pressure on the skin. During the past year changes were made so that two clinicians are required to move a baby who has breathing equipment attached. This measure helps reduce the pressure on the baby's nose and subsequently the risk of pressure injuries.

REDUCING THE RISK OF INJURY FROM FALLING IN HOSPITAL

The incidents of patient's falling over at the Women's are very rare and there were no serious injuries from patient falls last year as shown in Graph 9. In previous years, we have found that most often women fall because they faint after the birth of their baby or because they are sick and frail. As we are aware of this, it may explain why the incidences of patients falling at the Women's is so low.

GRAPH 9: INCIDENCE OF FALLS BY SERIOUSNESS

Data source: The Women's Riskman database



PREVENTING AND CONTROLLING INFECTIONS

The Women's is extremely vigilant when it comes to preventing and controlling hospital acquired infection and there are a number of areas we focus on including ensuring:

- The sterilisation of medical equipment used on patients is sterilised appropriately.
- Patients who are vulnerable to infection including taking extra special care of babies in the Newborn Intensive and Special Care unit.
- Prescribing antibiotics before surgery.
- Washing hands to prevent infections being carried from patient to patient.

Some patients are more at risk of infection than others because they are sicker or have other health conditions. For example, they may have diabetes or are overweight. This year, we are reporting on the number of women and babies who had a wound or blood infection. To demonstrate how we compare with other hospitals who contribute to the Victorian Nosocomial Infection Surveillance System (VICNISS), we have used a colour code in Table 8-10 below. A 95 percent confidence interval is taken into account when comparing our data with the state aggregate rate.

While the ideal rate is no infections the Women's is able to report rates which are generally lower than other hospitals and with no grey cells to indicate rates higher than other hospitals, these are excellent results.

TABLE 8: WOMEN WHO HAD A WOUND INFECTION FOLLOWING AN ABDOMINAL HYSTERECTOMY AND HOW WE COMPARE WITH OTHER HOSPITALS

Target	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09 Year to date
Number of women with a wound infection	5	4	2	5	3	0

Data source: VICNISS

TABLE 9: WOMEN WHO HAD A WOUND INFECTION FOLLOWING A VAGINAL HYSTERECTOMY AND HOW WE COMPARE WITH OTHER HOSPITALS

Target	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09 Year to date
Number of women with a wound infection	1	1	3	1	1	0

Data source: VICNISS

TABLE 10: WOMEN WHO HAD A WOUND INFECTION FOLLOWING A CAESAREAN SECTION AND HOW WE COMPARE WITH OTHER HOSPITALS

Target	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
Number of women with a wound infection	7	6	12	8	7	15

Data source: VICNISS

Key

- Rates are similar to other hospitals
- Rates are higher than other hospitals
- Rates are lower than other hospitals

Wound infections in women

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 of time afterwards. Infection rates are monitored and submitted to the Victorian Nosocomial Infection Surveillance (VICNISS) program for comparison.

Tables 8-10 show the number of women who had a wound infection for hysterectomy and caesarean section. Our rates are either similar or better than other hospitals. We focus on caesarean section for six months and then hysterectomy for the next six months, so these figures are based on six months of the year. Infections for vaginal hysterectomy are also lower than for abdominal hysterectomy. This is one of the advantages of vaginal hysterectomy.

Blood stream infection in premature and sick babies

Babies who need to be cared for in our Newborn Intensive and Special Care unit are at risk of infection because they are so small and sick. Central venous lines into blood vessels are used to administer essential medications and nutrition, but also provide an entry point for infection. We monitor bacterial infection rates related to these lines and compare our rates with other hospitals in Victoria (VICNISS) and overseas.

Over the last three years there has been a reduction in infection rates, even in the highest risk babies with very low birth weights. This was maintained in 2008/09. Our rates are either similar to or better than other hospitals. This year, there was one infection in the 1001-1500g babies (rate 0.7/1000 line days) which historically is exceptionally low.

These rates have been achieved through a range of practices including improved aseptic technique and skin antisepsis (the way we insert central lines), hand hygiene, and placing an ongoing emphasis on removing lines early and keeping antibiotic courses short.

TABLE 11: NUMBER OF BABIES WHO HAD A BLOOD STREAM INFECTION

	2008/09 Year to date July 2008 to March 2009
Central line <750 gms	1
Central line 751-100gms	2
Central line 1001-1500gms	1
Central line 1501-2500gms	0

	2008/09 Year to date July 2008 to March 2009
Peripheral line <750 gms	0
Peripheral line 751-100gms	0
Peripheral line 1001-1500gms	2
Peripheral line 1501-2500gms	0

Data source: VICNISS

Key

- Rates are similar to other hospitals
- Rates are higher than other hospitals
- Rates are lower than other hospitals

SAFETY - BEHIND THE SCENES AT THE WOMEN'S

Every day, behind the scenes at the Women's, a number of safety processes are carried out that are vital to patient care.

For every operation performed, strict safety checks have already been conducted by the Sterilising Process Service (SPS) team to ensure all surgical instruments and linen are sterile and safe for use.

Before leaving theatre, all instruments are entered into the BBraun Instrument Tracking system and recorded as being 'checked-out' of theatre. They are then delivered to the SPS where they are scanned into the decontamination area and decontaminated through a batch washer. Once in the clean room they are checked for damage and to ensure they are in working order after the decontamination process. Once this has occurred they are scanned into the tracking system. A checklist and barcode label is then generated for each tray. Single instruments are also issued with a bar code that enables complete tracking to the patient's records. All trays and instruments are wrapped in special steam permeable wrapping or laminated pouches.

The sterilising operator scans the trays into the tracking system and manually cross-checks the barcodes before the trolley is loaded into the steriliser. This is to ensure the label matches what is in the packaging.

The Women's has two large sterilising units. Each unit takes up to 45 minutes to complete the sterilising process, which includes a number of stages – a vacuum stage, steam charge, sterilising, exhaust, drying and an air intake.

Following this process, the sterilising units print out a receipt detailing the exact time each stage was completed and whether all parameters have been met, indicating a pass or a failed load. A visual warning sign will appear on the computer screen if the load fails, but as an added safety check the operator also manually cross-checks the receipt to make sure the times set have been successful. Once passed, the trays are scanned out of the system and are taken to a holding bay for cooling and from there they are delivered back to theatre by an SPS team member. If for any reason the load fails, the equipment is then reprocessed again from the beginning.

The tray is then unwrapped in the sterile theatre and each tray and instrument are scanned into the system against the patient's name. In the event an instrument has not been scanned out of the SPS system a visual sign will alert theatre staff that this piece of equipment cannot be used on the patient.

The BBraun Instrument tracking system is new to the Women's at Parkville and is just one of the ways advances in technology, combined with staff diligence, create a safe hospital for our patients.

TABLE 12: HAND HYGIENE AUDIT

Ward	November 2007	March 2008	August 2008	November 2008	March 2009	August 2009
Neonatal Intensive Special Care	23%	51%	77%	77%	79%	80%
Special Care Nursery	29%	46%	81%	80%	73%	83%
24 /Birth Centre	12%	39%	61%	74%	67%	63%
51 / 5 North / Oncology	14%	40%	74%	-	-	-
Women's Emergency Care	-	-	-	76%	71%	76%
Overall	20%	44%	73%	77%	73%	75%

Data source: Infection Control Audit 2009

Hand Hygiene

The Hand Hygiene audit measures whether staff wash their hands in accordance with the hand hygiene guidelines set by Hand Hygiene Australia and the World Health Organisation (WHO) as the "five moments of patient care".

In the past year the Women's exceeded the target of 55 percent set by the WHO and adopted by the Victorian Department of Health. One-on-one education of staff has contributed to the improvements made throughout our hospital.

Staff vaccinations and reducing patient exposure to infection

As 'seasonal' influenza in pregnancy carries an increased risk of complications for mothers, annual influenza vaccination is recommended in the second or third trimester. During the flu season, staff were also actively encouraged to have an annual flu shot to protect vulnerable patients, including newborns. Over 1100 staff were vaccinated before the 2009 winter flu season.

H1N1

With the arrival of H1N1 (swine flu) pregnant women were quickly identified as a risk group for complications. As a specialist maternity centre, the Women's formed an H1N1 Response Group to implement the hospital's Pandemic Management Plan and ensure the requirements according to the various phases of the pandemic were followed. During this time, the Infection Control team was responsible for:

- staff education;
- monitoring any exposure to patients and staff; and
- implementing web based information for staff and the community on the internet.

The Women's was successful in managing the care of a small number of pregnant women who had H1N1 and who were able to return home safely to their families.

Whooping cough

Although whooping cough (pertussis) has become a fairly rare disease, Australia does have outbreaks every few years. Whooping cough is an acute, highly contagious respiratory infection, spread person-to-person by airborne droplets. It is most dangerous for young babies because they have little, if any, immunity to the disease. This year Victoria and some other states have seen a significant increase in the number of babies infected and hospitalised with whooping cough.

To protect our newborns and pregnant mothers the Women's funded pertussis vaccination for staff. In 2009, more than 350 direct-care staff were vaccinated as part of a Staff Immunisation Program which commences when staff are employed to ensure they are immune to vaccine preventable diseases.

TABLE 13: HOSPITAL CLEANING STANDARDS

	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
Our score out of 100	90	89	94.7	92.8	91.9	94.4	97.3
DHS cleaning standard	80	80	85	85	85	85	85

Data source: The Women's auditing records/Cogent auditors

A clean hospital

The cleanliness of the Women's is audited against the Victorian hospitals cleaning standards. Table 13 shows our cleanliness rates are constantly improving and we are demonstrating we are exceeding the Victorian standard of 85 percent.

External cleaning auditors commented that 'the Women's presented extremely well with an overall score for compliance with the Victorian Cleaning Standards of 97.3 percent. Seven of the eight departments examined scored over 95 percent, which is commendable. The perfect score for the hospital (100 percent) was in the Women's Emergency Care Centre. Patient equipment and kitchen fixtures were also found to be cleaned to an excellent standard.

Through the Victorian Patient Satisfaction Monitor, women are asked how satisfied they are with the cleanliness of their rooms and bathrooms. The feedback for the Women's has been very good since the move to Parkville in this area. We have demonstrated improvements in the cleanliness of rooms from 89 percent in 2007 to 95 percent in 2008. In addition the cleanliness of toilets and showers improved from 87 percent in 2007 to 94 percent in 2008.

ACHIEVING HIGH STANDARDS IN HOSPITAL ACCREDITATION

One of the ways of ensuring the Women's has the right systems and processes in place to provide safe care is through the hospital's accreditation with the Australian Council of Health Care Standards (ACHS). As part of this accreditation process, the hospital is assessed against national standards for clinical, support and corporate services.

As part of accreditation, surveyors visit the hospital to interview staff and consumers and to review systems and evidence of hospital practices.

Each aspect of the hospital is rated against five levels, including:

> Moderate Achievement (MA) – the hospital has all the appropriate processes in place to measure and improve what they do

> Extensive Achievement (EA) – the hospital went above and beyond and was able to compare itself with other hospitals as a way of improving care

> Outstanding (OA) – the hospital can demonstrate that is a leader in this area

Out of the 45 criteria hospitals have to meet, there are 14 areas where the hospitals must receive a rating of at least an MA.

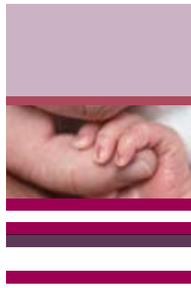
Overall the Women's has received 22 Extensive Achievement ratings, as well as two Outstanding Achievements for research and health promotion. This places the Women's amongst the highest achieving hospitals in Australia for accreditation.

Table 14 shows the mandatory accreditation criteria and the Women's improvements over the past three accreditation surveys and two areas where we can improve further.

TABLE 14: ACHS MANDATORY CRITERIA

Hospital area (stream)	Criteria	2005 rating	2008 rating	2009 rating
Clinical	1.1.1 Care assessment system	EA	EA	EA
	1.1.2 Care planning and delivery	EA	EA	EA
	1.1.3 Consent	MA	MA	MA
	1.1.4 Care evaluation	EA	EA	EA
	1.1.5 Discharge / transfer	MA	MA	EA
	1.1.8 Health Record	MA	EA	EA
	1.5.2 Infection Control	EA	EA	EA
Support	2.1.1 Quality Improvement	MA	EA	EA
	2.1.2 Risk Management	MA	MA	EA
	2.1.3 Incident and complaint management	MA	EA	EA
Corporate	3.1.3 Credentialing	MA	MA	MA
	3.1.5 Corporate and clinical policies	EA	EA	EA
	3.2.1 Safety Management	MA	EA	EA
	3.2.4 Emergency and disaster management	MA	MA	EA

Data source: ACHS Accreditation Reports



SOME TERMS WE USE:

Sentinel events: a rare unusual incident that causes significant harm to a patient and mostly arises from system problems, such as, 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.

Accreditation: public recognition of achievement by a healthcare organisation, of requirements of national healthcare standards.

OUR QUALITY CLINICAL CARE

OUR QUALITY CLINICAL CARE

The Women's continuously improves clinical care for our patients by undertaking research, evaluating performance, implementing evidence-based clinical practice, managing risk, promoting a learning culture and employing the latest technology.

PROMOTING A LEARNING CULTURE

Women want the hospital to have good access to technology, expertise and research. The range of research performed at the Women's is multi-disciplinary and extends to all levels of the hospital and our community. Research undertaken at the Women's is shared internationally with our peers, and the Women's applies international research and expertise to inform our clinical practice as follows:

Centre for Clinical Research Excellence in Newborn Medicine

The Women's, in partnership with The Royal Children's Hospital, the University of Melbourne and the Murdoch Children's Research Institute, has been awarded a prestigious National Health and Medical Research Council grant to conduct research into brain and lung problems for newborns and premature babies.

The $2.5 million grant will establish the new Centre for Clinical Research Excellence in Newborn Medicine, which will be directed by Professor Lex Doyle from the Royal Women's Hospital.

This Centre will:

- look at how frequently brain and lung problems occur in both premature babies and babies born on time;
- investigate the different causes of brain and lung problems in babies;
- understand the long-term consequences of brain and lung problems; and
- develop ways of treating babies suffering these adverse outcomes.

OUR STAFF, PROFESSOR LEX DOYLE

Professor Lex Doyle heads the clinical research development team at the Women's and is Professor of Neonatal Paediatrics at the University of Melbourne.

"All those involved in clinical care, whether directly or indirectly, are devoted to obtaining the best outcome for their patients.

Clinical research involves many things but broadly speaking it is the process of establishing the extent of various problems; finding solutions to those problems; synthesising or creating the evidence required to solve the problems; developing appropriate treatments; and continually re-evaluating whether the original problems have been solved and identifying new problems.

Researchers must think about what they are doing and then begin asking questions as the starting point for clinical research.

All clinical staff are researchers – it is just that many do not see themselves in that role. We need to encourage staff to think as researchers, to recognise that they all have a role in clinical research, and help them improve the health of their patients through research, particularly by asking the right questions. Research underpins all clinical decisions and is fundamental to quality care – it is not an optional extra."

MICHELE'S STORY

In an Australian first, Michele Kramer was one of the first patients to benefit from the new MRgFUS treatment which is now available at the Women's.

MY JOURNEY BEING PART OF MRGFUS MICHELE KRAMER

"The worsening symptoms of increased heavy monthly bleeding, anaemia, the inability to exercise for half the month as well as pain when bending over, had been creeping up on me over three years. My GP had put me on blood clotting medication designed for haemophiliacs. I researched the long-term side effects and found them to include clotting (which could lead to stroke or heart attack) and destroyed eye sight and liver function. I wanted a better solution and after an initial ultrasound I requested a referral to a gynaecologist. I was quickly referred to the Women's – this was the biggest blessing.

I had my initial MRI and the results were so different to what was shown on the ultrasound that making the right decision was easy. I became part of the pilot program for the Magnetic Resonance guided Focused Ultrasound (MRgFUS) treatment. My reasoning was that I could always have surgery later if MRgFUS didn't work. I researched extensively and found that the technology was already proven and only the application was new, which meant there were minimal risks with high maximum gain.

The experience with the Women's and the MRgFUS team was stress-free and the team made themselves available to answer any queries. I had two lots of treatment to treat two large fibroids. Two months post treatment, I stopped the clotting medication to track the improvements in real time. I noticed that within two months, the pain when bending over had disappeared; I was no longer feeling totally incapacitated and I could continue exercising which was a wonderful experience. I also found that I could successfully be off the medication; my eyesight and liver function have improved and the heavy bleeding has now reduced dramatically. The best part was being able to return to work the day after the treatment and continuing with my daily life and routine".

ADVANCED TECHNOLOGY IN WOMEN'S HEALTH

Women value access to innovative and advanced technology to improve their care. The Women's provides up-to-date, world-class technology to improve care for women as demonstrated by these advances in gynaecological surgery over the past twelve months in particular:

Adopting Australia's first MRI guided focused ultrasound (MRgFUS) technology

The new Magnetic Resonance Imaging (MRI) service, which is dedicated to women and newborn babies, is now available at the Pauline Gandel Women's Imaging Centre.

The hospital's MRI service has been established to address the gap in the provision of women's pelvic, abdominal and breast MRI imaging and to improve care for premature babies.

In an Australian first, uterine fibroids can be treated without making a single incision. The most common non-cancerous tumours to grow within the wall of the uterus, uterine fibroids can be extremely painful and can cause excessive bleeding, affecting 1 in 3 women.

Specialists who were initially trained overseas were accredited for solo practice at the Women's under the supervision of mentors. They use the MRI scanner to pinpoint the fibroids and then ultrasound waves are used to heat and destroy the fibroid without causing damage to the surrounding tissue. Real-time MRI images enable the doctor to watch the progress and accuracy of the treatment.

Normally recovery from surgery takes weeks but this new technology means that a woman can have a same-day procedure and resume normal activities within a few days.

Harmonic Scalpel

During 2008-09, the Women's introduced the regular use of the harmonic scalpel for total laparoscopic hysterectomy. This device uses vibration energy to seal blood vessels and cut tissues (previously requiring two instruments). This has reduced the time taken to perform total laparoscopic hysterectomies, improved training of junior staff in this operation and reduced the operation time for women.

A WORLD FIRST STUDY

Julianne Negri took part in the world-first study

In the past year the Women's has been involved in a world-first study, which harnesses iPhone and Nintendo Wii technology to monitor the movements of babies at risk of being born too early.

The Pregnancy Research Centre is recruiting 350 women for the two year trial which uses a monitor the size of a 50 cent coin to record babies' movements, while letting the pregnant woman continue with normal activities. The monitor uses accelerometers, like an advanced pedometer or the movement-sensing component of an iPhone or Nintendo Wii.

The monitor looks at the number of times the baby moves, with the expectation that healthy babies will move more than those who are not so healthy. Once this information is collected, it is hoped that it may be used in the future to improve outcomes in babies who are not moving enough.

QUALITY OF CARE REPORT

OUR QUALITY
CLINICAL CARE

Second Generation Endometrial Ablation Device

The second-generation endometrial ablation devices represent a major advance in gynaecology and offers a relatively simple alternative to hysterectomy.

This second generation endometrial ablation device allows a woman to undergo a 90 second treatment rather than hysterectomy which requires a period of four to six weeks recovery. The result is significant improvement in her quality of life. A major advantage is that more patients can potentially be offered this treatment in comparison to other major surgery.

Pelvic Organ Prolapse

A new pelvic floor repair system, developed by a specialist from the Women's, is a novel approach to surgically treating prolapse in women. Prolapse occurs where the ligaments supporting the vagina and uterus have weakened and are stretched due to childbirth and age.

The mesh implants are held in position for 3 to 4 weeks by a vaginal support device. A balloon is attached to the device and inflated with air then is deflated and removed 24 hours after surgery.

The clinical results have confirmed this to be a safe and effective operation for the management of prolapse. In a clinical study involving women from Europe, the United States and Australia, one year following the procedure, the success rate was 88.3 percent with all measures of quality of life and sexual function improving significantly for women.

USING RESEARCH EVIDENCE TO IMPROVE CLINICAL PRACTICE

Women value a balance of services requiring critical and complex care in general and specialist services, obstetrics and gynaecology. In all of our services we use clinical research evidence to provide the best care for women as demonstrated by the following projects:

Projects to improve maternity care

COSMOS (Comparing Standard Maternity care with 'One to one' Midwifery Support)

In the past year, the Women's continued to support the COSMOS (Comparing Standard Maternity care with 'One to one' Midwifery Support) clinical trial.

This research is evaluating a one-to-one midwifery model of care (caseload) for women at low risk of pregnancy complications as a randomised controlled trial. Although there is evidence that one-to-one midwifery care is favoured by many women, and many midwives prefer to work this way, there is little rigorous evaluation of this type of care and how it compares with the usual options for women. This is why we are supporting this trial to look for ways to tailor and improve individualised care plans for women in the lead up to, during and post pregnancy.

Our research, run in partnership with Latrobe University, has recruited more than 1,500 of the 2,008 women we needed for the trial. Half of these women receive one-to-one care and half of these women choose from all other pregnancy care models available at the Women's.

Postnatal pilot study into offering early discharge

During the past year a postnatal pilot study exploring the feasibility of offering women early discharge in conjunction with extra home visits was completed.

Of the 108 women who participated, most were positive about the model, and 83 percent indicated they would opt for the program in a future pregnancy. The hospital is now planning to offer this option to more women and will continue to monitor staff and women's experiences.

As part of improving postnatal care a review of all processes is underway to ensure women get the most out of their postnatal care in hospital and at home.

Infant Feeding

In collaboration with La Trobe University, Frances Perry House and the Mercy Hospital for Women, the Women's is recruiting 1000 women with newborn babies to follow their infant feeding patterns over six months. This research will explore whether the care we give women in hospital affects babies feeding over the next few months.

Exercise for pregnancy: Healthy mother, healthy babe

Through evidence based research, women are starting to better understand the need to be physically and psychologically prepared for pregnancy and recovery after birth. The Physiotherapy Department at the Women's now offers pregnant women a variety of exercise classes to match the different health needs of pregnant women. These range from gentle Pilates exercise to fitness classes and the aim is to offer the most suitable exercise to meet the health needs of every pregnant woman at the Women's.

Despite the demands of pregnancy, exercise benefits most women and has minimal risks. Exercising helps women adjust to the physical changes that occur during pregnancy and promotes a sense of psychological wellbeing. Moderately vigorous exercise may also help to prevent conditions such as pre-existing and gestational diabetes (diabetes that develops during pregnancy) and high blood pressure. Exercise can also be used to manage weight gain during pregnancy and helps lower the risk of postnatal depression.

Understanding women's experiences of unplanned pregnancy and abortion

The Women's Pregnancy Advisory Service (PAS) in collaboration with the Key Centre for Women's Health in Society at the University of Melbourne and VicHealth, undertook research to better understand women's experiences of unplanned pregnancy and abortion.

The data from the one year audit of records from the PAS show that women who sought pregnancy advice came from a range of backgrounds and circumstances. Women needed improved access to coordinated services which: reduce inequalities, are sensitive and responsive to women's needs, and reduce stigma and shame. The audit and the interviews reinforced knowledge of unplanned pregnancy and abortion as common reproductive events experienced by women in diverse circumstances.

Recommendations from the project include more research; establishing a coordinated system of pregnancy support services throughout Victoria for women who are dealing with an unplanned or unwanted pregnancy; and recruiting and training more health professionals across the sector in this important area of women's health.

Providing pain relief to newborns in the Newborn Intensive and Special Care unit (NISC)

The Women's NISC has developed a pain management strategy to minimise any negative effects on a baby which may result from pain caused by tests and procedures. Evidence has shown us that this has an impact on a newborn's quality of life and future development.

Administering sucrose, a sweet solution shown to reduce and alleviate the pain experienced by the baby for a very short duration, has now become standard practice for all potentially painful interventions. This is in addition to sucking, containment, and supportive positioning to enable a baby to feel calmer and increase their ability to cope with procedures. When necessary, analgesia can be used with these methods.

Recently, NISC developed pain scoring tools to objectively measure a baby's pain level. As the majority of babies cared for in NISC are born prematurely, the Premature Infant Pain Profile (PIPP) was specifically designed to interpret their cues about pain which will better assist the care of the baby and provide additional support for the family in being able to better identify pain in their critically ill baby.

WORKING COLLABORATIVELY TO IMPROVE CARE (MULTIDISCIPLINARY CARE)

Research has shown a multidisciplinary approach to women's health can improve the outcome for women. Therefore the Women's has implemented the following clinics and programs:

Chronic Pelvic Pain Clinic

Chronic pelvic pain is common and is believed to affect one in six women. It is a health problem with many possible causes however for many women a cause cannot be determined.

The Chronic Pelvic Pain Clinic (CPPC) at the Women's was set up to improve a woman's quality of life. The multidisciplinary team of psychologists, physiotherapists, pain specialists and social workers offer a range of tools and options for women being able to better manage their pain.

The clinic offers group work, training women in relaxation, body awareness, general exercise and behavioural strategies to manage pain.

Maternal Weight Management Program

In response to the growing incidence of obesity within the maternity population and the significant implications for mother and baby, the Nutrition and Physiotherapy departments have initiated a joint program.

The aim of the program is to minimise weight gain and improve physical fitness during pregnancy for women with a high pre-pregnancy Body Mass Index (eg over 35). The program places equal emphasis on diet and exercise. Women are assessed by a dietician and a physiotherapist and given personal guidelines for diet and exercise throughout their pregnancy. Follow up is provided by a mix of face to face visits, telephone or email contact and printed newsletters. These women will be followed up postnatally and linked into community services.

Diabetes Pre-Pregnancy Groups

The Diabetes Unit has developed a very successful group education program for women with type 1 diabetes planning a pregnancy. Research has shown that blood glucose control is critical for these women at the time of conception to reduce the risk of birth defects and miscarriage. The program helps women to manage the changes that occur to blood glucose control throughout pregnancy.

The program is run by a multidisciplinary team of diabetes physicians, a dietician, a diabetes educator, an obstetrician and physiotherapist and covers 'hands on' activities such as insulin dose adjustment using simulated scenarios, weighing and calculating the carbohydrate content of common foods and practical exercise. The success of the group program for women with type 1 diabetes has led to the development of an adapted version for women with type 2 diabetes.

The unit has observed that women who have attended the program are much better prepared for their pregnancies and can manage the challenges of diabetes in pregnancy more effectively than women who have not attended.

Continence Assessment Clinic and the Continence Management Clinic

The evidence for pelvic floor muscle training for women with incontinence is so strong that in 2005, the International Consultation on Incontinence stated that 'pelvic floor muscle training should be offered as first line therapy, to all women with urinary incontinence'.

The Women's reorganised its Urogynaecology Clinics to allow suitable women to be supported through twelve weeks of pelvic floor muscle training as their first line therapy.

The aim of the Continence Assessment and Management Clinics is to reduce urinary and prolapse symptoms and improve quality of life using conservative management such as pelvic floor muscle training to minimise surgical and medical intervention. The clinics combine the specialty skills of the continence physiotherapist, continence nurse and urogynaecologist.

EVALUATING CLINICAL PERFORMANCE

The Women's makes improvements to our maternity services through evaluating our clinical performance as follows:

TABLE 15: THE WOMEN'S MATERNITY SERVICE PERFORMANCE INDICATORS

	2003/04	2004/05	2005/06	2006/07	2007/08	2007/08
	RWH	RWH	RWH	RWH	RWH	VIC average
For women aged between 20 and 34 years with no health complication or who had their first baby at term						
percent of women who will have their baby induced	21.5	8.8	6.8	9	5.6	**4.8**
percent of women who will have a caesarean birth	23.7	18.8	14.7	17.9	13.6	**14.8**
percent of 3rd or 4th degree tears for women having her baby vaginally	3.1	2.9	4.3	6	8.7	**5.2**
For women with one previous caesarean section having their next birth						
percent of Vaginal Birth After Caesarean Section (VBAC) among women who planned for VBAC	41.5	50	51.2	42	47.3	**56.6**
For all women						
percent of women referred to postnatal domiciliary care or Hospital-In-The-Home	88	93	94.4	91	88.7	**89.8**
Number of WHO Ten steps to successful breastfeeding achieved by the hospital	10/10	10/10	8/10	9/10	8/10	**9/10**
percent of women who wait more than 30 minutes for hospital antenatal clinics	34	36.4	31.4	29.4	34.9	**10.9**
For women assessed as needing an interpreter (see chapter 2 about interpreter services)						
percent of women who have an interpreter	60	73.7	79.4	71.1	80.3	**84.3**

Data source: Department of Health Maternity Service Indicator Report

Third degree and fourth degree tear audit

When we looked at the maternity service indicators we were concerned that we had one of the higher rates of 3rd and 4th degree tears for women having their first baby compared with other maternity hospitals in Victoria.

We conducted a clinical audit of all women with 3rd and 4th degree tears to identify risk factors and inform clinical practice and education of our staff including better recognition of the occurrence of these kinds of tears in patients from particular backgrounds. The audit found that 3A tears (the less severe kind of third degree tear) made up a third of all reported tears. We also found that because such a high proportion of women we care for are from culturally diverse backgrounds they are more likely to receive a 3rd and 4th degree tear, and therefore this was affecting our results.

For example, women from Asian and Indian sub-continent backgrounds made up 50 percent of the women and seem to be at increased risk of third and fourth degree tears for reasons we don't yet understand.

The Women's continues to monitor these rates and focus on good clinical practices that reduce the likelihood of tears and skilled birthing techniques, repair and appropriate referral and follow-up.

The 2008 figures show a decrease in the incidents of 3rd degree tears and are consistent results for 4th degree tears when compared to 2007 as shown in Table 16.

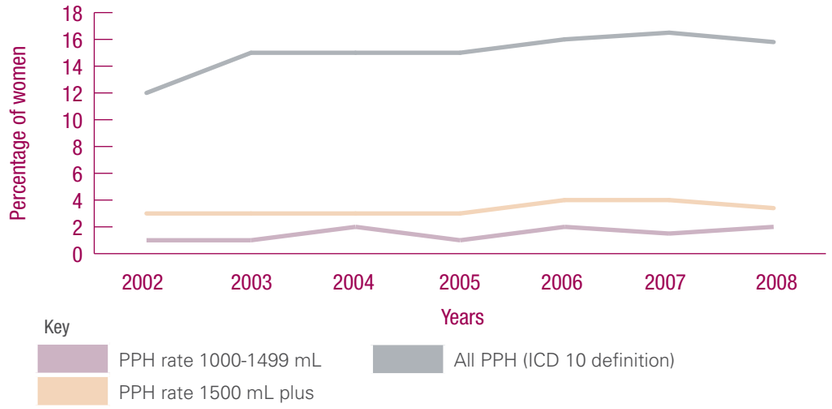
POST PARTUM HAEMORRHAGE

A post partum haemorrhage (PPH) is excessive blood loss after giving birth. Quick and effective management is essential as a very large PPH can be life threatening. At the Women's we have done a lot of work to improve early recognition and more accurate measurement of the volume of blood lost so that it can be treated. We monitor these rates monthly and particularly review blood loss over 1500ml. By comparison with other Australian Maternity hospitals, our rate for blood loss over 1500ml was at the lower end in 2006/07 and at the higher end for 2007/08 (Women's Hospitals Australasia benchmarking) as shown in Table 17.

TABLE 16: RATE OF THIRD AND FOURTH DEGREE TEARS (PERCENTAGE OF WOMEN)

	2001	2002	2003	2004	2005	2006	2007	2008
Third degree tears	1.7	2.7	1.9	1.8	2.4	3.3	3.1	2.6
Fourth degree tears	0	0.2	0.2	0.2	0	0.3	0.1	0.1

Data source: The Women's Robyn Database



Data source: The Women's Robyn Database

TABLE 17: POST PARTUM HAEMORRHAGE RATES 2002 TO 2008 (PERCENTAGE OF WOMEN)

	2002	2003	2004	2005	2006	2007	2008
PPH rate 1000-1499 mL	3	3	3	3	4	4	3.4
PPH rate 1500 mL plus	1	1	2	1	2	1.5	2
All PPH (ICD 10 definition)	12	15	15	15	16	16.5	15.8

Data source: The Women's Robyn Database

Caesarean birth rate

Table 18 shows the caesarean birth rate has had a slight increase in line with the trend experienced by other hospitals within Australia and overseas. We have a high volume of women whose pregnancies are high risk and complex which may explain part of this increase. Other reasons for this increase are varied and are in part due to factors such as increasing maternal age and obesity. Changing expectations of women and their partners may also contribute to this increase. The ideal caesarean section rate is uncertain. The decision to perform a caesarean section is taken in the best interest of the baby and mother.

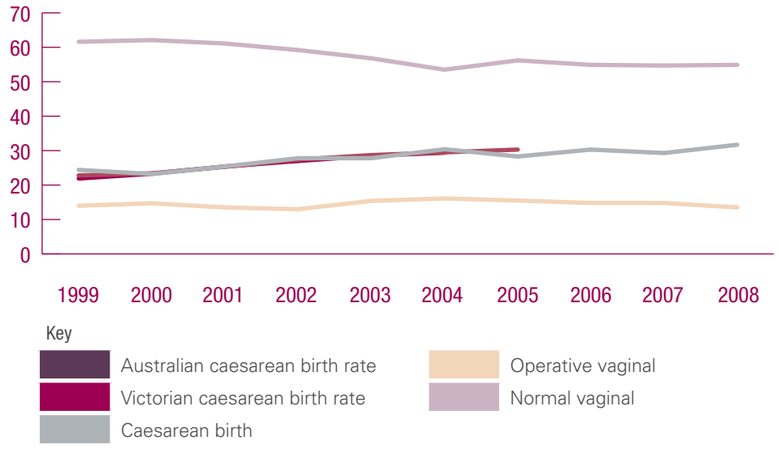
Neonatal Unit Occupancy

With the rise in births in Victoria over the past three years, as well as changing practices related to respiratory management in infants, there has been increasing demand on neonatal cots across Victoria. The Women's monitors this demand closely and during 2008-09, the Newborn Intensive and Special Care unit was provided with additional funding to increase from 18 respiratory support intensive care cots to 20 cots. The usual occupancy of 18 cots was reached or exceeded on 39 percent of days of the year, and our extended capacity of 20 cots was reached or exceeded on 18 percent of days during the year. An additional respiratory support cot was provided from July 1, 2009.

TABLE 18: WOMEN GIVING BIRTH VAGINALLY AND BY CAESAREAN (DATA PERCENT)

	2000	2001	2002	2003	2004	2005	2006	2007	2008
Normal vaginal	62.1	61.1	59.2	56.8	53.5	56.2	54.9	54.7	54.9
Operative vaginal	14.7	13.5	13.0	15.4	16.1	15.5	14.8	16.0	13.5
Caesarean birth	23.2	25.4	27.8	27.8	30.4	28.3	30.3	29.3	31.7
Victorian caesarean birth rate	23.4	25.3	27.4	28.7	29.5	30.4	30.6	*	*
Australian caesarean birth rate	23.3	25.4	27.0	28.5	29.4	30.3	30.8	*	*

Data source: The Women's Robyn database
** Data not yet available*



Data source: Victorian National Perinatal Statistics Unit and the National Perinatal Statistics Unit and the Women's Robyn database.

Babies who are improving and who graduate from intensive care require a special care cot. On 45 percent of days, the NISC had all 52 cots occupied, however returning appropriately well infants to a special care nursery closer to their home is important to see continued improvements in their care. The Women's talks to families and other level two hospitals who have special care units and are able to accommodate families closer to home. This is aligned with the Victorian Government's commitment to ensure the State's tertiary level hospital's are able to prioritise access for high risk, complex and specialist women and new born babies from across Victoria.

Care for premature babies

Approximately 8 percent of babies born in Australia are born preterm (before 37 weeks' gestation) and less than two percent are born before 32 weeks. These babies make up the majority of babies admitted to the Women's Newborn Intensive and Special Care unit.

Changes over the past 30 years have led to a dramatic increase in the 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. Table 19 shows data from the Women's for these babies. While the survival of babies has improved, research conducted by the Women's looks at ways to improve their long term outcomes as discussed earlier in this chapter.

When premature babies die

Of course some babies are born too premature and are therefore too small to survive. These babies make up the perinatal deaths reported each year to the Consultative Counsel on Obstetric and Paedriatic Mortality and Morbidity. This information also assists us in determining where more research and analysis into the causes of premature death in babies is needed.

All perinatal deaths are reviewed weekly by a multidisciplinary team of senior obstetricians, the quality and safety registrar, paediatricians, pathologists who undertake autopsy and tests, midwives, the Director of Clinical Governance, Women's Social Support Workers and bereavement counsellors. This review classifies the cause of death, aims to understand more about the causes of premature births and reviews our care to see if we could improve any of our systems and processes. It is obviously a very important area of focus for the Women's.

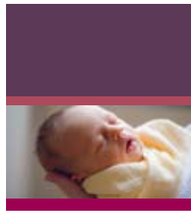
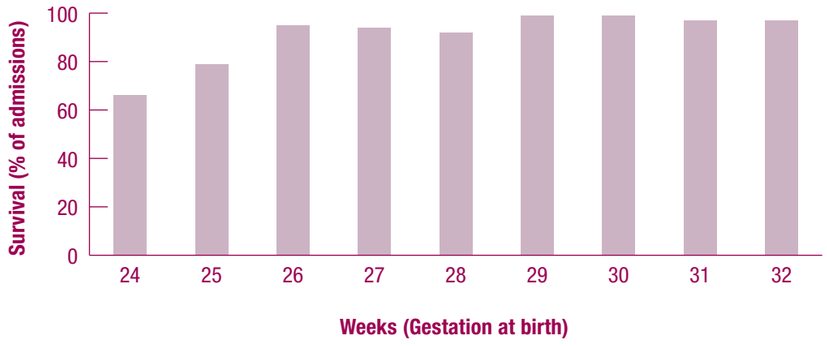


TABLE 19 SURVIVAL RATES OF BABIES ADMITTED TO THE NEONATAL UNIT



Data source: The Women's Cartwright database

TABLE 20: PERINATAL DEATHS BY CAUSE AND GESTATIONAL AGE

	Gestational age									
	20-27 weeks		28-31 weeks		32-36 weeks		37+ weeks		Total	
Cause of death (PSANZ PDC)	n	%	n	%	n	%	n	%	n	%
Congenital abnormality	56	50.9	5	29.4	3	37.5	8	34.8	72	45.6
Infection	2	1.8	2	11.8	0	0	5	21.7	9	5.7
Hypertension	0	0	0	0	1	12.5	0	0	1	0.6
Ante partum haemorrhage	6	5.5	2	11.8	1	12.5	2	8.7	11	7.0
Maternal conditions	0	0	0	0	0	0	1	4.3	1	0.6
Specific perinatal conditions	16	14.5	1	5.9	0	0	0	0	17	10.8
Hypoxic peripartum death	0	0	1	5.9	0	0	2	8.7	3	1.9
Fetal growth restriction	2	1.8	2	11.8	0	0	0	0	4	2.5
Spontaneous preterm	26	23.6	3	17.6	1	12.5	0	0	30	19.0
Unexplained antepartum death	2	1.8	1	5.9	2	25.0	5	21.7	10	6.3
No obstetric antecedent	0	0	0	0	0	0	0	0	0	0
Total	**110**	**100**	**17**	**100**	**8**	**100**	**23**	**100**	**158**	**100**

Data source: Perinatal mortality database January 2007 – January 2008

As one of the State's three tertiary hospitals with the Newborn Intensive and Special Care unit, 85 percent of the perinatal deaths that occurred during 2008 were babies less than 37 weeks of pregnancy and 77 percent were less than 28 weeks.

Women are referred to the Women's because of pregnancy complications or their newly born babies transferred because they are critically ill. As premature babies have a better chance of survival if they are born in a tertiary hospital women are often transferred, in utero, from anywhere in the State, before they give birth to their baby.

During 2008, there were 158 perinatal deaths at the Women's which is consistent with previous years and which also includes terminations because of congenital abnormalities. There were two cases of hypoxic peripartum death which is when a baby dies from a lack of oxygen during labour but are full term.

We pay particular attention to these cases to see if anything could have been done differently. A Root Cause Analysis is undertaken as a way of reviewing these. (See terms used in chapter 4 for an explanation on page 59).

Table 21 shows the number of these types of deaths over the last five years.

TABLE 21 HYPOXIC PERIPARTUM DEATH 2004 TO 2008

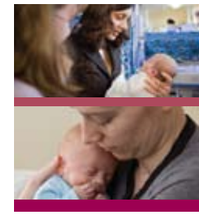
YEAR	HYPOXIC PERIPARTUM DEATH
2004	3
2005	0
2006	0
2007	2
2008	2

Data Source: Perinatal Mortality database January 2004-2008

Providing grieving families with support

When a baby dies, whatever the stage of the pregnancy or the circumstance, it is a very difficult and emotional time for any woman and her family. We ensure our staff including our obstetricians, midwives, neonatologists, neonatal nurses, geneticists, anaesthetists, physicians, pathologists, bereavement counsellors and other allied health professionals are all available to support them. The Bereavement Support Services team provides specialist bereavement counselling, information, and assistance to families with referrals to support services in their local community. Families are also offered spiritual support according to their belief and faith traditions, such as blessings and prayer. Every year, a ceremony is held in our multifaith Sacred Space to remember those babies who died.

During the year we received letters and cards from families thanking our staff for the care and support they received. Some of these families have gone on to provide fundraising support for the Neonatal Intensive and Special Care unit by hosting events, in memory of their baby, within their own communities.



TERMS WE USE:

Stillbirth: the birth of an infant of at least 20 weeks gestation, or if this is unknown, of at least 400g birth weight, who shows no sign of life after birth.

Neonatal death: the death of a liveborn infant, within 28 days of birth, of at least 20 weeks pregnancy or if this is unknown, of at least 400g birth weight.

Perinatal death: A stillbirth or a neonatal death.

Congenital abnormality: an abnormality present at birth.

Hypertension: high blood pressure.

Antepartum haemorrhage: when a woman has vaginal bleeding before or during birth.

Antepartum: before birth.

Post partum: after birth.

Hypoxic peripartum death: a stillbirth or neonatal death as a consequence of a lack of oxygen during labour .

Fetal growth restriction: the baby is significantly smaller than normal.

Morbidity: Illness or disability as a consequence of an event such as pregnancy or childbirth.

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

YOUR FEEDBACK

Thank you for reading the Women's 2008-2009 Quality of Care Report – Safe care, your right, our responsibility.

We welcome your feedback about this report which enables us to improve the care we provide women, newborns and their families.

Every year the Women's consults with our Consumer Advisory Committee (CAC) to seek feedback on how we can improve the structure, readability, relevance and accessibility of our Quality of Care Report, in particular to consumers from diverse communities. As a result we are considering how we can translate a summary version of this report in future years.

Distribution Strategy

This year's Quality of Care Report is freely available to the Women's community and actively distributed to patients, staff, community health organisations and State and Federal government.

We monitor distribution by auditing the number of copies we provide to our consumers and evaluating any feedback.

The Report is available:

- as a 'take-home' printed version throughout staff and patient areas in the hospital;
- as a reference guide in the Women's Information Health Centre (as well as take-home copies);
- on our website;
- through our staff who work with community health groups; and
- by mail upon request.

Comments or feedback may be included on the below section of this page and forwarded to:

Mail: Quality of Care Report,
Communications Department,
The Royal Women's Hospital,
Locked Bag 300,
Parkville VIC 3051

Alternatively comments or feedback may be forwarded electronically via:

Email: communications@thewomens.org.au

Web: www.thewomens.org.au

Our home page features a link to the Quality of Care Report and an email address for your feedback. Feedback of your experience at the Women's may also be directed to our consumer advocate:

Email: consumer.advocate@thewomens.org.au

Phone: 8435 2290

Is there other information you would like to see included in next year's Quality of Care Report?

Did you find the Quality of Care Report easy to read and understand?

Do you have any suggestions for next year's Quality of Care Report
(for example on presentation, length, stories etc)

GLOSSARY

ACHS:	Australian Council of Healthcare Standards
AWHBU:	Aboriginal Women's Health Business Unit
CAC:	Community Advisory Committee
CASA:	Centre Against Sexual Assault
COSMOS:	Comparing Standard Maternity Care with One to one Midwifery Support
CPAP:	Continuous Positive Airway Pressure
CPPC:	Chronic Pelvic Pain Clinic
DoH:	Department of Health
FARREP:	Female and Reproductive Rights Education Program
FGM:	Female Genital Mutilation
HITH:	Hospital In The Home
ICAP:	Improving Care for Aboriginal People
KRA:	Key Result Area
MRgFUS:	Magnetic Resonance Guided Focused Ultrasound
MSSA:	Medical Safety Self Assessment
NHMRC:	National Health and Medical Research Council
NISC:	Neonatal Intensive and Special Care
PAS:	Pregnancy Advisory Service
PCP:	Postnatal Care Program
PIPP:	Premature Infant Pain Profile
PPH:	Post Partum Haemorrhage
RBU:	Reproductive Biology Unit
RCA:	Root Cause Analysis
SANDS:	Stillbirth and Neonatal Death Support
SAPPSS:	Sexual Assault Prevention Program in Secondary Schools
SCN:	Special Care Nursery
SIDS:	Sudden Infant Death Syndrome
SPS:	Sterilising Process Service
VICNISS:	Victorian Nosocomial Infection Surveillance System
VPSM:	Victorian Patient Satisfaction Monitor
WCMICS:	Western and Central Melbourne Integrated Cancer Service
WEC:	Women's Emergency Care
WHO:	World Health Organisation

Design: Blueboat

Photography: Gil Meydan
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