Obstetricians and Midwives

modus vivendi for current times

GUEST EDITORIAL

Obstetric services need to be women-centred and based on mutual respect and collaboration

Obstetricians and midwives have complementary roles in the care of pregnant women, and each group would find survival without the other difficult. Nor would women necessarily receive the best care if access to one or other of these professions were restricted. Having complementary roles, though, has not prevented hostility or 'turf' wars between the two groups, with midwives claiming that maternity services are over-medicalised,1 and obstetricians counter-claiming that there is no demand for midwife-led care.2 So what is the current modus vivendi for obstetricians and midwives, and to where feasibly could it evolve by 2020?

Maternity services in Australia in 2005 provide much choice for women, including private or public care by obstetricians, general practitioners and midwives. These services can take place in traditional hospital obstetric units, birthing centres and, now less frequently, at home. Australia has not followed the New Zealand model of care in allowing women to choose a midwife as a 'lead maternity carer' as a mainstream option in the public health system. However, in some Australian states, this may soon change.3 If this were to eventuate, Australia would do well to look at the lessons learned from the experience in New Zealand.

‘By 2020, it can only be hoped that an Australian National Maternity Policy will be in place’

Across the Tasman many positive changes have resulted from maternity services reform, such as significant improvement for many women in continuity of maternity caregiver, and greater availability of non-medically based models of care for those women wanting them. But negative changes have also occurred, such as the effective loss of the option for women to have a GP involved in their maternity care, and an initial exodus of experienced midwives out of the public hospital system. In particular, the sheer pain of major change, for both women and care providers, could have been minimised by thorough and consultative planning.

Given all this choice, why should there be hostility between obstetricians and midwives? The main criticisms from midwives stem from a perception that obstetric care in Australia is too medicalised and that obstetric intervention rates are too high.4 Because better continuity of care from a known midwife may lead to fewer obstetric interventions5 and greater certainty for women, there has been a strong push by midwives and consumer groups, such as the Maternity Coalition, for funded midwife-led care.6 On the other hand, obstetricians point to an established system of care, with low rates of maternal and perinatal morbidity as well as generally high levels of community satisfaction.2

Provision of maternity services in Australia has also been made more difficult by work force issues. The average age of obstetricians in Australia is 51 years7 and of midwives 41 years.8 The work force survey carried out by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) in 2003 revealed that a quarter of Australian Fellows were now aged 60 or more.7

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The committee has made some progress in reviewing international clinical guidelines for possible use in Australia, but has been hampered by lack of funding, obstetricians suspicious of change, and midwives frustrated by lack of change. Difficulties have arisen in reconciling differences between obstetricians, GPs and midwives in how to provide safe evidence-based care that will not diminish current levels of safety.

By 2020, it can only be hoped that an Australian National Maternity Policy will be in place. At present, there is none. If this is to occur, obstetricians, GPs and midwives must work to develop collaborative policies that are women-centred, not provider-centred, and which will ensure individualised care to meet the particular needs of each pregnant woman. The development of adequate continuing professional development programs (CPD) for all maternity care providers should be mandatory, and the development of some joint CPD programs crossing profession groups would be useful. There should be development of systems of care that allow for continuity of care for women during pregnancy, labour and postnatally, but which protect against burnout of care providers.

There are already good examples of effective services in various places across Australia, ranging from large metropolitan units, such as the Adelaide Women’s and Children’s Hospital Community Midwifery Program, to rural services, such as those provided at Wangaratta Hospital in Victoria, that are women-centred and based on mutual respect and collaboration between obstetricians and midwives. The challenge is to make this the norm for the benefit of mothers and babies as well as their care providers.

References

• Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Melbourne, VIC. Edward W Weaver, MB BS, FRACOG, Chairman, Joint Committee for Maternity Services; Kenneth F Clark, MB ChB, FRANZCOG, President.
• Australian College of Midwives, Turner, ACT. Barbara A Vernon, BA(Hons), PhD, Chief Executive Officer.
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The experience of travelling abroad and witnessing the practice of your own specialty in another country is intriguing. I soon learned that the practice of Obstetrics and Gynaecology in Australia has both clear similarities and striking differences to the US.

In general, the management of patients is the same here as it is in the United States, as both countries practice modern western medicine. The general guidelines for Obstetric management of patients, and the decision making for high risk patients are almost equivalent. Also, the Caesarean section rate is almost equal!

A major difference I have noticed in my limited time in Melbourne is the role of the OB/GYN in the community. In the United States, gynaecologists have become, at least in part, primary caregivers for many women. We perform the majority of annual exams and pap smears, as well as routine health care such as checking cholesterol, glucose, thyroid function, and scheduling women for screening colonoscopy. In large cities, family doctors do not tend to provide much gynaecological care. In Australia, at least in the public system, it seems that family doctors provide most of the primary care, including pap smears and annual exams. Gynaecologists act more as specialists, and see patients when they have a specific problem, such as an abnormal pap smear, pelvic pain, or bleeding abnormality.

One aspect that is different pertains to the involvement of midwives. First, that the majority of uncomplicated deliveries in Australia are done by midwives. In the States, nurses care for the labouring patients, and then the doctors perform the deliveries. American patients tend to seek midwives when they want a more ‘natural’ delivery experience.

The midwives mainly deliver the patients whom they have seen in their outpatient offices.

There are a number of differences that likely pertain to the incredibly litigious society the United States, especially the Northeast US, has become. Continuous CTG monitoring is used for almost all labouring patients. It is also used for a number of days when many high risk antepartum patients are admitted to the hospital, until they are ‘stabilised’. Forceps have essentially become a tool that is read about in textbooks, but not taught clinically. A minority of Obstetricians still utilise them as a tool, but the cases are rare. Most graduating trainees do not have the experience necessary to incorporate them into their own Obstetric practice.

‘US gynaecologists have become primary caregivers performing pap smears, checking cholesterol, glucose and thyroid function tests’

In an effort to afford malpractice insurance, most practicing OB/GYN specialists do not own their practice, rather it is owned by a hospital, and they are on salary. Practices also tend to consist of multiple practitioners, who share the on call responsibilities, during the week as well as on weekends.

The most obvious difference from the United States is not unique to OB/GYN, but involves the health insurance system. In Australia, there is public health insurance for all, and some patients choose not to participate, and pay for private insurance. In the United States, public insurance is only for patients who are extremely poor. Therefore, there are many who work, but have very little money and cannot afford health insurance. If uninsured, patients are able to obtain emergency care, but not much else.

In some cities, there is a public hospital system, where the uninsured or public patients are cared for. However, in many areas, all patients are cared for in the same hospital, often with both public and private patients sharing the same room.

There are a few minor differences I have noticed during daily routine patient care. For example, in the US, urine dips are still being performed in routine antenatal care. The GBS swab is sent directly by the obstetrician, not given to the patient. On the labour ward, intravenous pressure catheters are commonly used. Magnesium sulphate is used as a common tocolytic for preterm labour.

One interesting difference is that IVF here is accessible to the general population and as a public patient at least the initial visits are funded by Medicare. Australian patients with a Health Care Card also have a partial subsidy for RBU treatment. In the US, it costs about $15,000 (USD) and is paid for entirely by the patient!

My experience at The Royal Women’s Hospital has been rewarding. It has been good to see that, while there are differences in obstetric practice, colleagues around the world have a universal approach to providing outstanding medical care to women.

Melanie Schatz
OB/GYN, Obstetrics & Gynaecology
Melanie visited the RWH for four weeks as a clinical observer as part of her obstetrics and gynaecology specialist training from the Pennsylvania Hospital Department of OB/GYN
Blood transfusion:
much more than a bag of blood

Transfusion of blood and blood products in hospitals is a complex process. Your Hospital Transfusion Committee aims to facilitate best practice in all aspects of blood and blood product transfusion within The Royal Women's Hospital. Our primary role is to provide an active forum for communication between staff directly involved in clinical and laboratory-based blood transfusion activities, to provide solutions, feedback and education in relation to identified problems and to ensure that transfusion practice accords with best practice.

Who are we?
• Brenda White (Chair/Divisional Director Laboratory Services)
• Helen Savoia (Haematologist, Transfusion Medicine Specialist)
• Jeremy Oats (Women's Services)
• Andrew Buettner (Anaesthetics)
• Sheila Bryan/Jenny Dowd (Emergency)
• Neil Roy (Neonatal Services)
• Sue Jacobs (Neonatal Services)
• Helen Patterson (Neonatal Services)
• Georgiana Chin (HMO representative)
• Fiona Cullinane (Delivery Suites)
• Angela Muir (Midwifery)
• J enny Ryan (Midwifery)
• J anine Furmedge (Transfusion Nurse)
• Eileen Kelly (Senior Blood Bank Scientist)
• Neil Waters (ARCBS).

What are we doing?
• Actively reviewing and updating all policies and procedures related to blood transfusion.
• Developing and updating the RWH blood transfusion website (see www.rwh.org.au/bloodtrans).
• Reviewing the process of anti-D administration.

At RWH the Division of Laboratory Services is responsible for:
• appropriate storage and handling of blood components
• compatibility testing of patient samples
• issuing blood and blood products
• investigating reported transfusion reactions.

Clinical staff are responsible for:
• ensuring samples for compatibility testing are collected and labelled according to hospital policy
• clinical decision making regarding appropriate transfusion
• discussing transfusion with their patient including benefits, risks and alternatives where available
• ensuring the right blood product is given to the right patient in the right way
• caring for patients appropriately while they receive a blood transfusion
• ensuring documentation is complete so that all products are completely traceable from donor to recipient
• detecting, managing and reporting possible transfusion reactions.

A major focus for Transfusion Committee activities over the next 12 months will be an audit of transfusion practice including compliance with the RWH Transfusion Policy and transfusion appropriateness.

For further information contact:
Dr Helen Savoia, email helen.savoia@rwh.org.au or call the transfusion nurse J anine Furmedge x 2187

Dr Helen Savoia
Consultant Haematologist, RWH/RCH

Window on Women

The Department of Community Services Office for Women site:
• Provides a comprehensive menu listing valuable topics related to women.

Multiple links include the Australian Bureau of Statistics, where you may follow-up reports with intriguing titles such as:
• Population Projections: Fertility Futures
• Family Formation: Young adults living in the parental home.

Learn how the Australian Federal Government responded to the significant population achievement below: ABS baby certificate to help celebrate 20,000,000 Australians.

These and other reports are summarised in a comprehensive list of press releases.

Susan Braybrook
Perinatal Audit Coordinator
Quality & Safety Unit

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Susan Braybrook
Perinatal Audit Coordinator
Quality & Safety Unit

We need a cartoonist of exceptional ability, with great artistic skill and most importantly somebody who is funny! The successful applicant will need to manage deadlines monthly and have a good understanding of the comings and goings @ the RWH. The pay may not be great (nil) but you get to work with a great bunch of people (not always funny, sometimes downright grumpy) and you get to see your work in print. If you think you qualify, contact Les Reti at: leslie.reti@rwh.org.au To increase your chances of appointment, attach a riotous original cartoon.
Hospital acquired infections (also called nosocomial or health care associated infections) remain an important cause of illness in hospitals. It is estimated that between 7% and 10% of patients throughout Australia acquire a nosocomial infection during their hospital admission, leading to increased morbidity and mortality, and length of stay in hospital.

Practicing good hand hygiene is an important component in reducing the transmission of organisms, as hands are a common vehicle for the spread of bacteria and viruses between patients and from patients to staff.

To increase hand hygiene awareness and compliance, a three-year multifaceted hand hygiene promotion and intervention program, called ‘Wash-Up’, has been undertaken at The Royal Children’s Hospital and The Royal Women’s Hospital.

The ‘Wash-Up’ project is unique in Australia. It is the first comprehensive hand hygiene program that has endeavoured to monitor medical, nursing, and allied health workers and to measure success rates in relation to infections. Past studies have shown benefit in reducing MRSA (‘golden staph’) and other infections. MRSA and other multi-resistant bacteria are not as much of an issue in the RWH setting, but the project aimed to determine if other infections, such as blood stream infections (called bacteraemia or septicemia) that can occur in our highest risk intensive care patients and premature infants could be further reduced.

A pilot study over the past 18 months in the maternity and neonatal units has been extremely successful with staff finding that the alcohol hand gel in a dispenser at the bedside makes hand hygiene both quicker and more convenient. The gel dries within 15 seconds and is more effective at killing germs than washing with soap and water.

The study found that blood stream infections decreased by 40% from around 80 a year to around 50.

According to Dr Andrew Daley, Head of Infection Control at The Royal Children’s Hospital and The Royal Women’s Hospital, “Whilst infection rates before the trials were comparable with similar hospitals in Australia and overseas, staff wanted to improve them further.”

The study found that blood stream infections decreased by 40% from around 80 a year to around 50

After the success of the trial, ‘Wash-Up’ has now been rolled out to all wards at the RWH, launched on the 17th of May. ‘Wash-Up’ has introduced several strategies to improve and sustain hand hygiene compliance. These include the provision of an antiseptic alcohol hand gel placed at bedside in wards, surveillance of the use of gel in high risk areas, an education program involving staff promoting hand hygiene procedures, and the education of parents and caregivers in the importance of hand hygiene in the hospital and at home.

To educate staff about ‘Wash-Up’ an educational, but light-hearted video entitled ‘Invasion of the Lurgys: spreading the word about hand hygiene’ has been produced by the hospitals’ Educational Resource Centre. Posters and brochures promoting hand hygiene have also been produced. Bottles of alcoholic gel have now been distributed to all wards so that there is ready access for all staff to practice hand hygiene.

‘Wash-Up’ was developed and implemented by the Infection Control Team following successful funding from the Department of Human Services as a Quality Improvement and Best Practice Project.

The Chief investigator Professor Suzanne Garland, Department of Microbiology and Infectious Diseases submitted the successful project (together with Louise Atkinson who subsequently left the RWH) has coordinated the project across the two hospitals. Successful implementation of the project has been the result of the commitment to the project by the Project Manager, Emily McGuigan.

For further information about hand hygiene and the ‘Wash-Up’ project visit the website www.washup.org.au. The video/DVD is available for purchase from the hospital’s Educational Resource Centre, for $44 (incl. GST & postage). Telephone (03) 9345 5482.

Emily McGuigan
Project Officer, Infection Control

Professor Susan Garland
Director of Microbiological Research and Head of Clinical Microbiology and Infectious Diseases, RWH
Senior Consultant Microbiology and Infectious Diseases, RWH/RCH

Andrew Daley
Director of Microbiological Research and Head of Clinical Microbiology and Infectious Diseases, RWH
Senior Consultant Microbiology and Infectious Diseases, RWH/RCH
This DHS initiative draws to a close in July 2005. One of the key concepts for the Patient Flow Collaborative was to use a whole system approach. For Operation Caesar this meant looking at all areas of the patient journey for women needing elective caesarean sections, from booking in at ANC, to postnatal care following surgery. There has been some success in improving access for this patient group. It’s not over yet; the next three months will be used to ensure the process continues to work well.

In brief the achievements to date include:

**Streamlining the booking process**
- C/S Care Plan and C/S Theatre Booking Form (both start in antenatal clinics): Revision of this paperwork has produced a guide and reference for an effective process which can be used also for documentation of care. This serves as a reference for all other care providers. Further to improving communication for everyone involved in the patient journey, theatre alerts can and should be noted on the revised Theatre Booking Form. These alerts are only visible within the theatre; they provide theatre staff with information necessary to physically prepare for cases or be made aware of sensitive information that may affect patients’ needs.
- In the previous two months there has been increased activity in this hospital, and this is expected to continue. This activity is making it difficult to access theatre time for elective caesarean sections. Clinicians are now asked to nominate a preferred week date for C/S rather than a specific day. The theatre business manager Monique Dyer will liaise with Clinical Director Jeremy Oats on occasions when theatre is fully booked to find additional theatre time and staff.

**Pre operative assessment**
- Establishment of Anaesthetic Assessment Clinic (AAC) to accommodate all anaesthetic consultations – surgical pre-op, antenatal pre-op and ‘other’ anaesthetic consultations (e.g. high risk patients BMI >35). AAC is located in OPD and is managed by the Day Surgery Unit (DSU). Helena Burton has been appointed as AUN. The appointment template for AAC needs to provide appointments at short notice when required, as not all caesarean sections are planned early in the pregnancy. AAC also needs to continue accommodating other surgical pre admission functions for other surgical patients. A much larger percentage of patients attending this clinic are surgical patients (gynaec). By improving patient flow through AAC to C/S patients, consideration also needs to be given to surgical patients accessing AAC. Improving the flow for one group of patients must not impact negatively on others.
- Following up attendance at AAC – We are monitoring attendance and non-attendance for the variety of patients attending this clinic. The follow up for C/S patients who fail to attend AAC is a phone call offering another booking. This aims to maximize the opportunity to see an anaesthetist before day of operation wherever possible.

**Timely notification when paediatrician required**
- Further revision to the Theatre Booking Form has nominated criteria for when paediatric attendance is required. Paediatricians will not be attending all routine C/S in the near future because of finite resources and to bring this practice into line with other hospitals and current policy of the Royal Australasian College of Physicians (Sept 2004).
- Theatre staff will play an important role in notifying paediatricians on the day of theatre – provided the booking form is completed. The process for accessing a paediatrician for a Paediatric Code Blue or referrals to paediatricians for high risk pregnancies remains unchanged.

**Postnatal care plan**
- Redesign of the postnatal caesarean section care plan is progressing. The first draft is being designed and will be on trial within the month of May. Katrina Morrison (AUM 44) has been coordinating this project with staff members from medical, midwifery, nursing and Clinical Staff Development. Vickie Kyriakopolous will conclude the implementation.

**Consumers**
- Consumer health information relating to C/S will be revised. The format will be presented as a fact sheet similar to the revised antenatal information (replacing ‘Having a baby at the RWH’) which is near completion. Consumers have been involved in this review and we will continue to get their feedback on the C/S fact sheet. This fact sheet will replace the ‘Patient Version CareMap’.

**Incident reporting**
- Reported incidents are tracked to identify the reason that the correct process could not be followed. There has been a reduction of reported incidents in relation to Caesarean Section patients. Sept 03-Feb 2004 (6 months) 22 incidents.

Sharyn Donovan
Quality Improvement Coordinator
Quality & Safety Unit
The Better Prescribing and Administration of Medications Project (BPAP)

An audit of drug prescribing and administration practices

Medication errors occur when human and system factors interact within the complex process of prescribing, dispensing and administering drugs to produce an unintended and potentially harmful outcome.1

In order to gain a greater understanding of current practice, a retrospective audit of randomly selected medication charts (MR/90124) was undertaken following discharge. The project team (pharmacist, clinical educator and BPAP project co-ordinator) audited 151 charts for 33 individual criteria. The audit showed where we need to improve our practice.

Where do we need to improve our practice?

Medical prescribers

When taking a history for an admission ask women for a list of current medications and then document this fully in the medication chart. i.e drug, dose and frequency.

Document drug reactions and allergy status on the medication chart. If none, write ‘Nil known’.

A previous audit of allergy documentation also focused on the ‘ALERT’ sheet and antenatal record card.2

Write drug orders generically and with no abbreviations. For example if daily, write daily, four hourly, write 4/24 etc.

After each order sign your name and print legibly.

Sign phone orders within 24 hours.

Cease drugs on the medication chart by drawing two parallel lines at the administration section to denote when order is ceased. Sign and date – as in Medication Policy.

Pharmacists are to sign the medication chart indicating it has been checked with a purple pen.

Nurses and midwives

At the beginning of each shift and prior to the administration of drugs check the medication chart.

Adhere to the ‘5 Rights’ of drug administration; right patient, right drug, right time, right dose and right route. The ‘6 Rights’ of drug administration is the right to refuse and question a drug order about which they are uncertain.

Document the drug, dose and route administered. State the dose administered when a dose range is ordered. For example if dose range is 50–100mg, write 50mg given.

Use the symbols shown on the medication chart to record administration. For example R refused, O omitted, U unable to take.

Take time to learn; what drugs nurses and midwives can administer without a written order from the doctor; along with the correct drug checking and drug discarding procedure (see the Medication Policy on the Intranet).

The BPAP project 3, aims to stimulate a cultural change where drug errors are reported in a no blame environment. It focuses on preventing future errors by addressing the process of prescribing and administration of drugs.

Thank you to the following who have been recruited as Clinical Peer Educators attached to the project.

Medical
• Alex Eskander
• Leanne Benson

Nursing
• MFM Sue Veljanovski, Lisa Lionnet
• MCP Heather Lewis and Barbara Sims
• Ward 91 Jeni Scott
• Ward 51 Zahra Arale

References
2. An Audit of Allergy Documentation; Clinical Practice Review Newsletter, March 2005.
3. BPAP; Clinical Practice Review Newsletter, March 2005.

Ruth Bergman
Incident Report Coordinator
Quality & Safety Unit

Elisabeth Moloney
Project Officer
Quality & Safety Unit
Pharmacy news

Drug Information Service
The Pharmacy Department Drug Information Service answer calls from internal and external callers. Our callers are health care professionals and the general public living in Australia.

Here are some of the recurring questions:

**Q:** Does the Ostelin® 1000 gelatin capsule contain pork product? Is there a mixture available?
**A:** Ostelin® 1000 gelatin capsule contains ergocalciferol (vitamin D2) 1000iu, recommended to women who are at high risk of Vitamin D deficiency.

Research has shown that taking folic acid supplements before becoming pregnant may lower the risk of neural tube defects in newborn babies.

**Q:** How much folic acid do pregnant women need?
**A:** Healthy pregnant women require 0.5mg of folic acid daily. A higher dose of 5mg daily is usually required in pregnant women who have complications such as diabetes, epilepsy, family history of neural tube defects or had babies with neural tube defects in the past.

Research has shown that taking folic acid supplements before becoming pregnant may lower the risk of neural tube defects in newborn babies.

**Q:** Is domperidone a safe galactagogue (An agent that promotes the secretion and flow of milk)?
**A:** Since the warning from FDA (Food and Drug Administration) in June 2004 regarding the adverse cardiac events of the injectable form of domperidone, health professionals and breastfeeding women are reluctant to use domperidone tablets to increase milk supply.

During the months of January to March 2005 we received 1011 calls

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<td>Breastfeeding related</td>
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<td>Other issues</td>
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Domperidone injections are not available in Australia. The pharmacokinetic profile of oral domperidone shows it has poor oral bioavailability (13% - 17%), high protein binding property and no active metabolite. This makes it unlikely to reach the same concentration as the IV route of administration, and therefore unlikely to cause adverse cardiac events. Since the plasma level of domperidone taken orally is low and it does not cross blood brain barrier, it is a suitable option for women who require a galactagogue.

When prescribing domperidone, clinicians have a duty of care to inform the patient of the possible side effects and contraindications for the selected medication.

The maximum maintenance domperidone dose as a galactagogue is normally 20mg three times a day. The dose is titrated according to the need and response of the lactating woman. Domperidone tablets are generally prescribed for short term use only, as long-term use has not been studied.


For enquirery regarding drug related issues, drop us a line. The Drug Information Service can be contacted on (03) 9344 2277.

References on request.

Molika In
Senior Pharmacist
Drug Information Pharmacist

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

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