

JOURNEY

Annual Quality of Care Report

ROYAL CHILDREN'S HOSPITAL

2004



ROYAL
CHILDREN'S
HOSPITAL



FREE

SUMMARY OF CONTENTS

How do we welcome patients and families?	4
How do we help you find your way around the hospital?	7
How do we provide the information you need?	8
Focus on access and waiting	10
How are we improving the care we offer?	14
Focus on safety	18
What do we do to improve things?	24
How are different religions and cultural beliefs respected?	26
How do we know what you think of us?	28
What about community partnerships?	29
How are we planning for the future?	31

Contact

The Royal Children's Hospital
Flemington Road, Parkville
Victoria, Australia, 3052
Telephone (03) 9345 5522
www.rch.org.au



WE LISTEN

WE CARE

WE CHANGE

AND WE GROW

The Royal Children's Hospital in Melbourne is at the forefront of paediatric medicine, research and education and provides tertiary referral services for sick infants, children and adolescents.

As the major paediatric hospital in Victoria, the Royal Children's Hospital also provides clinical, academic and advocacy services for children and young people. It is internationally recognised as a leading centre for research and education.

This is our journey.

Message from the Royal Children's Hospital

Everybody who works at the Royal Children's Hospital (RCH) is accountable for the quality of the care we provide.

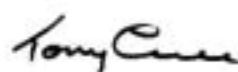
Quality care means that it should be safe, appropriate, effective, given at the time it is needed and that consumers have input into how it is provided. Quality also means that we strive to make the best use of the resources we have, so that we provide the greatest benefit to our patients, their families and the wider community.

The Women's & Children's Health Board adopted a formal Clinical Governance Framework, to ensure that we keep looking at all these issues in collaboration with our funding bodies, our consumers and our staff. We are committed to recruiting the best staff

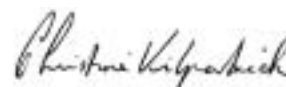
available; to keeping up to date with the most recent research; to consulting and comparing ourselves with our colleagues in other hospitals in Australia and overseas; and to training our staff to provide safe, effective and sensitive health care.

The Victorian Government requires all health services to achieve and maintain accreditation with an approved accrediting body. In Victoria, acute hospitals are accredited through the Australian Council on Health Care Standards (ACHS) and the Evaluating Quality and Improvement Program (EQUIP). Accreditation is awarded when it has been demonstrated that the quality of hospital performance meets the ACHS standards, in the areas of customer focus, leadership, culture of continuous improvement, evidence of outcome and striving for best practice.

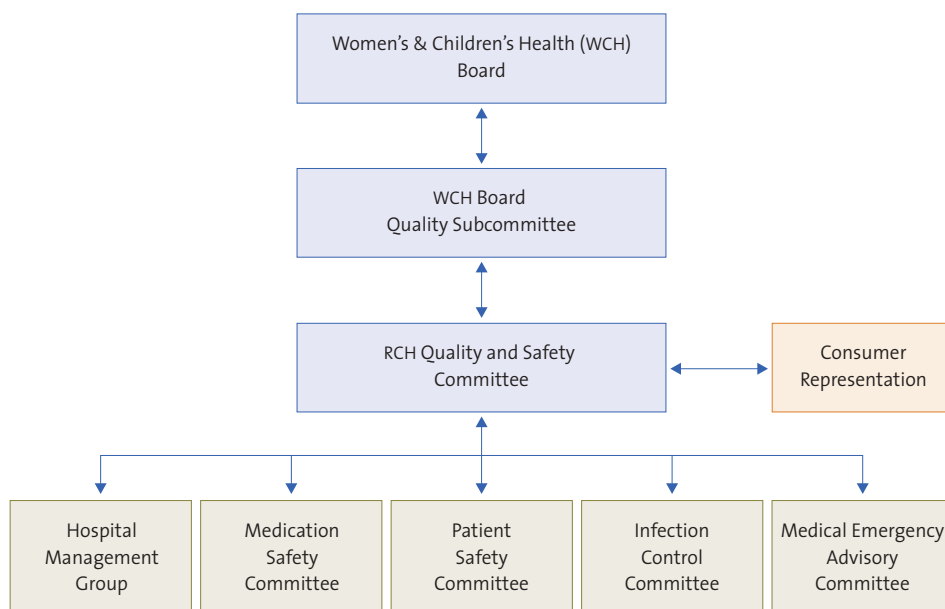
The RCH underwent re-accreditation late in 2002 as part of Women's & Children's Health, and was fully accredited, with no high priority recommendations for improvement, and a number of commendations. The RCH will again be reviewed in March 2005.



Dr Tony Cull
Executive Director
Royal Children's Hospital



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



Introduction



Welcome to the Royal Children's Hospital Annual Quality of Care Report, 2004. We have designed this report once again around a series of questions suggested by hospital consumers and we hope that this makes it interesting and easy to read. Although we have not reported on all activities in the hospital, we have provided a range of information relating to these questions, including what we are doing to improve our services. This year, we have also provided more detail in two areas – access and waiting times, and safety.

Members of the RCH Community Advisory Committee, including representatives from the Association for Children with a Disability and the Chronic Illness Alliance, together with individual consumers and staff from a range of community health centres have contributed to the content of this report.

We know that there is always room for improvement in the way we do things and the way we communicate. We welcome feedback at any time and look forward to your comments on this report, so that we can continue to improve how we report in the future.

THE ROYAL CHILDREN'S HOSPITAL 2003/2004 IN SUMMARY

- 32,769 inpatients were treated (2.3% increase)
- Average length of a multi day stay was 5.2 days
- 54,893 Emergency Department visits – overall less (by 2.4%) than last year, but an increase (by almost 50%) in category 1 and 2 – urgent and semi-urgent cases.

How do we welcome patients and families?

The Royal Children's Hospital is a big place, which can be confusing for families. We aim to make the hospital as welcoming and comfortable as possible in many ways, from fun activities for children to relaxing spaces for adults.

If you have any questions or need help at any time while you are at the hospital, please ask any of our staff. Information is also available at the Family Resource Centre located on the first floor behind the Chemist and at the Child Health Information Centre located near the main Flemington Road entrance on the ground floor.

FAMILY RESOURCE CENTRE

Since opening in May 2003, the Family Resource Centre has become firmly established as a haven of peace and quiet amidst the busy hustle and bustle of hospital life. Almost 19,000 visitors have used the range of facilities available in the past year. These include the business centre, comprising four computers connected to the internet, a fax machine, photocopier and printer; a kitchen and meals area; two privacy cubicles; and the relaxing lounge area.

Recent additions to the services and facilities provided include a weekly visit from Centrelink staff for appointments with families, a lending library with books for both children and adults and continuing upgrades to computers and

equipment in the business centre. The adjacent Personal Care Suite is now open every day and provides accessible showers, toilets, change facilities and height adjustable beds with hoists.

Most exciting has been the recent extension to the opening hours of the centre. The Family Resource Centre is now open until 8:00pm from Tuesday to Friday, and from 9:00am until 12:00 noon on Saturdays. The need for extended opening times was overwhelmingly expressed in feedback from families using the Centre, and the efforts of the staff and volunteers involved with this much needed change is greatly appreciated.

A recent donation to the hospital of over 50 pagers means that families can spend time in the Family Resource Centre while waiting for tests or appointments and yet still be easily contacted.



MATTHEW



Helping families stay in touch

Two year-old Matthew and his mother were in hospital at the same time, each recovering from surgery and unable to visit each other. By using video-link technology Matthew and his mother were able to see and talk to each other. Mum's first words to Matthew, "I love you baby" brought an instant smile to his face.

Videophones have been used for some time on the 'in house' hospital TV show 'Going Nuts With Macadamia' to connect children on the wards with the live TV show, but this is the first time they've been used in this way.

'Hutchison 3G' donated 12 video phones so that children can keep in touch with their families if they cannot easily visit the hospital. In addition 'Orange Pagers and Messagers' provided us with 50 pagers for families to use. This means parents are able to leave their child's bedside for short periods, confident we can contact them if they are needed.

Family Resource Centre

The hospital's Family Resource Centre is a refuge for many families, especially those who spend long periods away from home or work with a sick child in hospital.

The Logans are such a family. Twenty weeks into their second pregnancy Bev and Nic were told their unborn baby had a lethal heart condition, and would need life-saving surgery at the Royal Children's Hospital in Melbourne. So in March Bev, Nic and 18 month old Jack packed up and moved to Melbourne from their home in South Australia.

Bev and Nic were soon directed to the facilities in the Family Resource Centre. They found the computers useful for keeping family and friends back home up to date with the progress of new baby Jesse James. Jack was able to play more freely in the centre and Nic often took time out there to read the paper.

"You really need to have time out from the wards," said Bev, "and going into the centre, and talking to the staff or other families, draws your focus away from your problems. It's a great place for families."

After five months in the RCH the Logans took new baby Jesse home to meet family and friends in South Australia.



GOING NUTS WITH MACADAMIA

'Going Nuts with Macadamia' is a one hour daily interactive television program for children who are patients in the hospital. It is the only program of its kind in Australia, is hosted by Shari Stewart and a cheeky puppet called Macadamia – and stars the children!

There are segments such as Ward Visits, Ward Talk, Jokes of the Week, Musical Sessions, Handwasher of the Week, and talkback with patients via telephones in wards. Educational pieces cover topics like: what to expect when you have an X-ray; how to cope with finger pricks; and having a plaster cast put on and taken off.

If your child is a patient in the hospital, you may see the team filming on your ward on a Wednesday morning, or your child might be asked if she or he would like to come down to the studio to star on the show.

The staff of Safeway fund the show which is produced by the Educational Resource Centre and Educational Play Therapy.

Macadamia

Twelve year old Leanna Babet has been in and out of the Royal Children's Hospital since she was three years old, and she can't imagine what hospital would be like without Macadamia.

Leanna has cystic fibrosis so she spends a lot of time in the hospital and often gets to make an appearance on the show. "It gets you out of the ward, and you stop thinking about hospital," she said. Leanna loves everything about being involved in the Macadamia experience like meeting new people and seeing what goes on behind the scenes, and she especially loves chatting with Macadamia – "I love the expressions on his face," she said, laughing at the idea of a puppet having an expressive face.

Leanna often needs to be isolated to ensure she doesn't pick up any bugs, so she also loves watching the program on TV in the ward. Sometimes she'll see a friend on the show who she didn't know was in hospital. "And then even though I can't visit their ward I can see them on TV," Leanna said. "Hospital would be boring without Macadamia."

LEANNA

How do we help you find your way around the hospital?

We provide written information when children are booked to come into hospital. However, we have discovered that not all families receive this information. We have therefore prepared a new booklet (with feedback from consumers) and are working on ways of making sure that all families receive it. It is called 'A really helpful guide to the Royal Children's Hospital for families' and we hope that you do indeed find it helpful.

The role of the RCH Signage Committee is to advise on accurate, useful and consistent signs around the hospital. One of the important changes they have recommended is to colour code all the lifts to make it easier when giving directions. The front building on Flemington Road has silver lifts, the main building clinics have orange lifts, the wards blue lifts, the north west building pink lifts and the south east building on Gatehouse Street green lifts.

One of the other ways of helping families find their way around the hospital is for staff to offer to help anyone who looks a little bit lost. While some staff members do this as a matter of course, we want all staff to know how important this is to families. We are therefore incorporating reminders of this into staff training.



How do we provide the information you need?

Information on some illnesses and conditions can be very complicated. However, we do our best to make it as clear as we can.

We provide a large amount of information to patients and their families in written form as well as on our website. We provide general information about facilities, services and patients' rights and responsibilities, as well as information about specific issues of interest to patients and families.

KIDS HEALTH INFORMATION FOR PARENTS <http://www.rch.org.au/kidsinfo>

During the last year we developed Kids Health Information for Parents. This is an on-line resource, developed by our medical, nursing and allied health staff, with consumer involvement. It provides easy to understand information about illnesses and procedures that can be printed as fact sheets and used by general practitioners, maternal and child health nurses, school nurses and others involved in caring for children.

St Kilda Football Club coach, and father of eight, Grant Thomas, recently joined us to launch the website. He predicted that this on-line site would be a great resource for parents.

Because the hospital is so large, with many different departments contributing to the site, we recognize that the information could be better coordinated. We're pleased to report that we have created a new position, the Kids' Health Information Coordinator. The coordinator will encourage and assist our staff to prepare clear information, in a range of languages, for patients and their families.

THE KIDS COMPANION ON KIDNEYS

Greg Shipperd, coach of the Victorian Bushrangers cricket team, recently launched a new booklet *'The Kids Companion on Kidneys'*, written by staff in the Department of Nephrology.

BILLY'S ROCKET SHIP

Peter Schwab, coach of Hawthorn Football Club, recently launched an interactive book for primary school aged children about brain tumours *'Billy's Rocket Ship... travelling through the galaxy with a brain tumour'*. The book provides basic information about brain tumours and is designed to be used in classrooms where a child has been diagnosed with a brain tumour.

PAIN, PAIN, GO AWAY

The Children's Pain Management Service has recently launched a new booklet for children and parents called *'Pain, Pain, Go Away: Helping Children with Pain'*. The booklet provides information which helps parents to understand and manage their children's pain and explains medical terms and common medicines. It is available from the Child Health Information Centre.

PLASTIC AND MAXILLOFACIAL SURGERY BOOKLETS

The Plastic and Maxillofacial Surgery Department, in partnership with the Mark and Chapter Freemasons of Victoria (the 'We Care' program), have produced three booklets for parents and healthcare professionals: *'Understanding Brachial Plexus Palsy'*, *'Cleft Lip & Palate – Questions and Answers'* and *'Craniofacial Surgery Information'*. We have sent copies of these to 1,700 paediatricians, paediatric neurologists, paediatric neurosurgeons, obstetricians, general practitioners and maternal child health nurses throughout Victoria and Tasmania and have had very positive feedback.

During the next year, again with the help of the 'We Care' program, we hope to produce further publications about Vascular Anomalies and Salivary Control. Our specialist surgeons are working on putting these booklets together at the moment with a similar mail out planned for later this year.



Pain

Moustafa Mark Haidar has been to the hospital many times as an outpatient, but recently he was admitted for the first time. Moustafa is a troublesome feeder and because of this is not the weight he should be at five years old.

Doctors from the Gastroenterology Department inserted an endoscopic gastrostomy tube, or 'peg' as it's commonly called into his stomach to assist with feeding. Moustafa is always a happy little boy, so when he became irritable and grizzly after surgery, his mother Rina thought he might be in pain. Sue Penrose, a clinical nurse consultant with the Children's Pain Management Service, came to check on Moustafa to assess his pain and adjust his medication. "I was relieved when Sue gave him something for the pain," said Rina. "It wasn't long before he was happy again, and we were both able to get some sleep during the night." Sue was able to reduce Moustafa's medication next morning.

MOUSTAFA

Focus on access and waiting

We understand that coming into hospital with children is stressful even when things go well. Access to all areas of the hospital needs to be easy and we need to minimise waiting times as far as possible. We are working on this in a number of ways – through new staff positions, new programs and new units.

RCH continues to perform well to meet children's needs for surgery. The only area where we experienced an increase in waiting times was in the total waiting list, which is a measure of the demand for RCH services. However, while the overall waiting times may have increased, we were still able to meet all urgent requirements for surgery.

Hospital Initiated Postponements (HIPS) occur when patients coming into hospital for an operation are cancelled due to hospital factors like bed unavailability, overbooked theatre lists or staffing levels. Some things are beyond our control, such as emergency demand for both beds and theatre time. This year, the main issue has been the availability of Paediatric Intensive Care Unit (PICU) beds for our increasing cardiac patient lists.

Our target is to keep HIPS at 6% (i.e. six patients out of every 100 booked) and we closely monitor this to reduce preventable occurrences of HIPS. This year, we were very close to this target, as 6.8% were postponed.

We have managed to achieve this through the introduction of theatre booking guidelines that reduce overbooked lists, as well as a staff recruitment drive to increase the number of beds available.

HOW WELL DOES RCH PERFORM ON WAITING TIMES?

		2002	2003	2004
% Emergency Department patients admitted within 12 hours	Target	100	100	100
	Actual	100	100	95
		2002	2003	2004
% Emergency Department Triage Category 1 (urgent) patients seen immediately	Target	100	100	100
	Actual	100	100	100

RCH elective surgery performance 2001-2004	2002	2003	2004
Category 1 (urgent cases) proportion of patients admitted within 30 days (%)	100	100	100
Category 2 (semi-urgent cases) proportion of patients admitted within 30 days (%)	100	100	100
Average waiting times (days) for category 2 patients on the waiting list as at June 30th (Acceptable time frame for this category is 90 days)	24.5	26.8	36

		2003	2004
Hospital Initiated Postponements (HIPS)	Target	6%	6%
	Actual	6.1%	6.8%

SHORT STAY UNIT

The Emergency Department is usually very busy and we have been concerned that recently children and their families can spend over 12 hours there, waiting for a bed in the hospital. In May 2004, we opened a purpose-built Short Stay Unit, which can accommodate 12 children and their parents, next door to the Emergency Department. The aim of the unit is to provide a streamlined process for children who are expected to need less than 36 hours of hospital care. We want to make sure that their treatment is not delayed and that they can return home as soon as they are well. Parents and children took part in designing the Short Stay Unit, which is welcoming and comfortable.

Short Stay Unit

When eight month-old Sophie Vine began vomiting her mother took her to her local GP. Fearing she may become dehydrated, he advised her mother to bring her into RCH, where doctors in the emergency department diagnosed gastroenteritis, and inserted a naso-gastric tube to administer fluids.

Doctors wanted to monitor her progress but she wasn't so sick that she needed to be admitted to a ward. Instead she was admitted to the new Short Stay Unit (SSU) where nurses and doctors could keep an eye on her overnight and her mother could get some sleep on a sleeper-chair next to Sophie's cot.

After 12 hours in SSU Sophie was back to her old self and ready to go home. "The Short Stay Unit has been terrific," said Sophie's mother Marsha. "It's quiet and relaxed, and the attention from the staff was great. And the bed was very comfortable!"

SOPHIE



RHIANNON



Scoliosis Surgery

Rhiannon Rodstead knew she needed spinal surgery when she was 13. She was afraid of what was ahead but she knew it was necessary because the small curve in her back would get worse.

It's been a tough road for Rhiannon. In March 2003 she had surgery to lengthen one of her legs before surgeon Michael Johnson could perform the two-stage surgery to correct the curve in her spine.

In the first operation Mr Johnson removed a rib and discs in her thoracic spine. Rhiannon remained completely immobilised in halo traction for two weeks, then returned to surgery where steel rods were inserted into her spine. Rhiannon remembers being in a fair bit of pain, particularly while lying in the halo traction. "But I've started to walk by myself," said Rhiannon, "and I'm looking forward to showing off my new height – I've gained two centimetres since the surgery."

PATIENT RESOURCE MANAGER

This new position was filled in April 2004. The Patient Resource Manager works closely with the Emergency Department and the wards and is responsible for making sure that children are admitted to the most appropriate area of the hospital and that there are the right number of staff to look after them. They are also responsible for reviewing elective waiting lists and ensuring that children with the most urgent medical needs are admitted as soon as possible. We will be able to provide further information on this new role in next year's Quality Report.

THE FAMILY RESOURCE CENTRE OFFERS TRANSIT LOUNGE FACILITIES

When children are ready to be discharged from hospital, there may be delays while they wait for transport or medication. At these times, we are encouraging families to make use of the Family Resource Centre where they can wait in comfort and still be easily contactable.

GENERAL PRACTITIONER CLINIC

Our Emergency Department tends to be particularly busy during the evenings and weekends resulting in longer waiting times. Many families attend the hospital because they are unable to see their regular general practitioner (GP) after hours. A proposal has been developed to set up a GP Clinic adjacent to the Emergency Department and this is awaiting approval from the Commonwealth Government. The GPs working in the clinic would receive additional training in the care of children and would be available after normal business hours. The GP Clinic would provide more timely assessment and treatment for those children with illnesses that do not necessarily require the more specialist skills of the Emergency Department staff.

PATIENT FLOW COLLABORATIVE

The Patient Flow Collaborative (PFC) has been jointly planned by the Clinical Innovation Agency and the Department of Human Services to target delays. Over the next 18 months, we will be analysing the patient 'flow' throughout the hospital in these ways:

- Mapping patients' journey through the hospital – which parts of the hospital they go to and how long it takes
- Checking ward records to identify how delays occur
- Asking patients and their families about their experience of the hospital.

Following this mapping exercise, we will identify three areas in which patient flow can be improved. Small teams will then work on changing the way we do things in these areas, so that families spend less time waiting.

SCOLIOSIS PROJECT

In January 2004, the Department of Human Services funded RCH to become the statewide provider of scoliosis (curvature of the spine) surgery for all Victorian and Tasmanian children.

Spinal surgery to correct scoliosis can be a very complex procedure and up to three stages of surgery may be required for correction of the spine. The new Scoliosis Coordinator role coordinates all the specialists who are needed for surgery (from the Departments of Respiratory Medicine, Anaesthesia, Cardiology, Radiology, Pathology, Haematology, Neurology, Physiotherapy, Dietetics, Child Development and Rehabilitation and Medical Photography) and makes sure that there is a smooth transition from hospital to home, working with the RCH Education Institute, Occupational Therapy, Social Work, Home and Community Care and community based services.

We have also established Complex Spinal Clinics where each patient has a 45 minute appointment (instead of multiple short visits), during which all options of treatment and outcomes are discussed and decisions made by the family and scoliosis team.

We are pleased to report that the number of patients undergoing spinal surgery for scoliosis has nearly doubled since this time last year; that waiting lists are decreasing, despite the increased number of children seeking treatment; and that children with the most severe conditions wait the least time for surgery.

How are we improving the care we offer?

We take pride in continuing to improve the way we do things. Here are some examples of what we have done over the past year.

PAEDIATRIC INTENSIVE CARE

The Paediatric Intensive Care Liaison Nurse is a new role in the Paediatric Intensive Care Unit (PICU). S/he will review patients on a daily basis who have been discharged from PICU to another area, with the aim that all patients will be reviewed within the first 24 hours after leaving PICU. S/he will also liaise with, educate and support other care managers and ward staff. There is research evidence in adult Intensive Care Units that this type of role decreases readmission rates. We will report in next year's Quality Report as to whether this has occurred.

HOME AND COMMUNITY CARE

Home and Community Care is a program, which provides home nursing care for children with acute and chronic conditions that can safely be treated at home. With the new appointment of an Intake Liaison Nurse who facilitates transition to the program, there has been a significant increase in referrals to the program.

PAEDIATRIC TRAUMA MANAGEMENT MANUAL AND CD ROM

The Minister for Health, the Hon. Bronwyn Pike, recently launched the Paediatric Trauma Management Manual and CD ROM, produced by RCH Trauma Service and funded by the Victorian Trauma Foundation. This package provides doctors and nurses with a comprehensive guide to all trauma management from dental injuries to burns. It concentrates on the important first few hours of resuscitation and gives step-by-step instructions on life saving procedures. Video clips on the CD allow staff to actually see the procedures being performed.

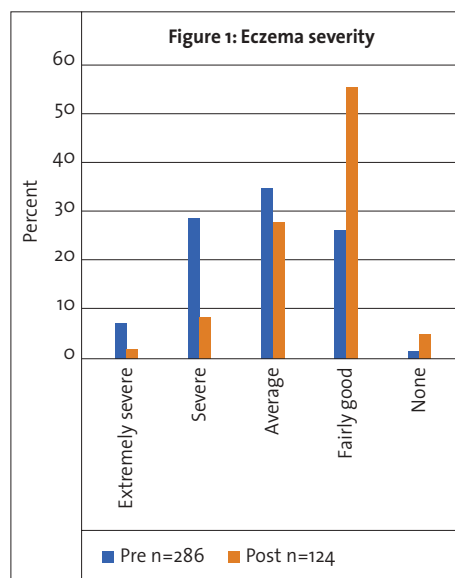
EPILEPSY

The Children's Neuroscience Centre has been successful in using a new kind of surgery to reduce epileptic seizures in children with Tuberous Sclerosis. This condition causes tubers to grow in the brain and other parts of the body – as a result children can have developmental delays, behavioural problems and skin abnormalities. Five children have had this surgery so far and all have shown marked improvements in their seizures and behaviour, with two children having no seizures at all since the operation.

ECZEMA

In last year's Quality Report, we mentioned the Eczema Workshops developed by the Dermatology Department. At each workshop, six children and their parents spend four hours learning to apply different treatments and receiving support from nursing staff and each other. We have now completed an evaluation of these workshops for the children who attended them between October 2002 and October 2003. We are pleased that the results

have shown that the children's eczema has decreased in severity (Figure 1) and that the children are happier and sleeping better. Parents also have more confidence in following the eczema management plan at home and have given very positive feedback, some saying that the workshops have been 'life changing'.



DIABETES

We have increasing numbers of children (including babies) who have been diagnosed with diabetes. Since the Department of Endocrinology and Diabetes has increased its contact with the community through the diabetes educators, the number of recurrent admissions with diabetic ketoacidosis has significantly reduced.

Betterdiabetes.com has been set up for young people to communicate with the department. Of the over 1,200 children and adolescents in our diabetes clinic, about 25% have registered with this website and we receive 15 phone messages every day as a result of it.

Eczema

Six year-old Stephanie Maino suffered with the itchy, dry skin of severe eczema since she was two years old. Stephanie visited her GP many times but the treatments offered provided only short-term relief.

Her GP referred her to the Dermatology Department at the Royal Children's Hospital and she was admitted to Ward 5 West where doctors could monitor her treatment. During her four nights in the hospital Stephanie was prescribed antibiotics and she also had wet dressings applied to her skin. Stephanie's mother Mary was also shown how to apply the wet dressings at home.

"The staff at the hospital were wonderful," said Mary. "Stephanie's condition has improved 100%, and she's now a much happier little girl at home and at school."



STEPHANIE



MEDICAL IMAGING

Over the past year, the Medical Imaging Department has undertaken a major equipment replacement plan, together with renovation of key patient areas. This has meant that patients and their families can be offered a faster, safer, more reliable service.

We have been able to replace a range of equipment through the generous support of donors to the Good Friday Appeal. This includes two new ultrasound units and a CT scanner. The CT scanner has reduced the time children need to spend in the machine from approximately 25 minutes to a couple of minutes, which has also meant that waiting times for the machine have been greatly reduced. We are also pleased to report that a new magnetic resonance imager (MRI) will be purchased.

As part of the equipment installation, renovations to the fluoroscopy area have enabled the creation of a disabled toilet that is needed for many of our patients in wheelchairs, as well as mothers with prams and young children. The waiting areas have also been expanded and we have commissioned the interior design committee to decorate these areas.

Medical and nursing staff can now look at images on computers in the wards, clinics and operating theatres without needing to locate the films, which in turn means that children are able to return home sooner. Consultant radiologists have access to the hospital computer system from their homes and this has assisted in accurate and fast advice when children become critically ill after hours.

Medical Imaging and the Educational Play Therapy Department have combined to make the MRI process easier for children. Children are shown the machine and given a pretend MRI before they have their real scan. This greatly reduces their fear and has meant that 90% of children are now able to have a normal MRI without the need for a general anaesthetic.

COUNSELLING SERVICES

Many staff offer emotional support to children and their families as an intrinsic part of their work at the hospital. However, we have a range of more formal services which offer counselling and psychotherapy.

- **Social Work Department** – provides counselling and support for patients, parents and siblings at times of crisis and for grief and loss.
- **Mental Health Service** – provides general child and adolescent psychiatry, as well as specialist counselling through the Infant Mental Health Team, and for conditions such as autism.
- **Genetic Counselling** – provides support and counselling for families where there are health issues which may be genetic in origin.
- **Aboriginal Family Support Unit** – provides support, advocacy and advice for families of Aboriginal background.
- **Gatehouse Centre** – provides specialist counselling for children who have been the victims of abuse.
- **Centre for Adolescent Health** – provides a range of counselling services to adolescents.
- **Community Child Health** – provides support through a range of clinics e.g. for ADHD.
- **Psychology** – provides some general counselling, as well as specialist counselling relating to neuropsychology.
- **Psychotherapy**
- **Chaplaincy** – provides support and counselling in a spiritual context for a range of religions.



Mock MRI

Ryan Paterson has had 45 general anaesthetics since he was diagnosed with a brain tumour four years ago at the age of two. Thirty of these were given when he was having radiotherapy. The other 15 were to sedate him during MRI examinations.

Ryan's hysteria usually began as soon as he entered the MRI room. He said he could smell gas and he associated this with the smothering feeling he felt when the mask was placed on his face. It was necessary for Ryan to have MRI examinations to ensure there were no cancerous cells left behind. They were very scary experiences for Ryan. Even the chocolate essence the radiologists put on his nose to conceal the unpleasant smells couldn't reduce his fears.

But thanks to an idea developed at the hospital, Ryan faced his last MRI wide-awake. The day before the real MRI Ryan practised in the hospital's Mock MRI, which was developed to get children used to the noise and the confined space of the machine.

Ryan still felt fearful and uneasy when he approached the real MRI the next day, but with some coaxing from Shawna, the technologist and Leanne from Educational Play Therapy, he took control and did it, without a general anaesthetic!

"He was just beaming afterwards," said his mother Stephanie. "It was a very positive experience."

Ryan will have another MRI in January and if that is all clear he won't need another for a year – that's great news!

Focus on safety

KIDS AND BUGS!

Infection control is all about minimising the risk of 'shared bugs', as well as preventing children from being exposed to new bugs when they come to hospital.

In any children's hospital, around a third of the children are admitted to hospital because of an infection. Most of these admissions are for infections like gastroenteritis or respiratory infections. Through our understanding of how infections are spread, we can put into place precautions to reduce the risk of the infection spreading to other children. For example, some infections are spread by direct contact and may be controlled by careful hand washing, while others spread through the air, which means that the child with the infection should be placed in a single room.

Behind the scenes, there are many hospital policies and procedures that guide staff in preventing infections. However, despite this, children may still occasionally pick up an infection during their hospital stay. This can be because they have no immunity to a particular infection, or because they have not yet completed all their immunisations.

If a child develops chicken pox spots unexpectedly, Infection Control will investigate all patients, staff and visitors who had contact with that child when the child was infectious. Anyone with no immunity is offered vaccination and some people may need additional

medication if they have an illness which puts them at increased risk of severe infection. As you can imagine, if the child who develops chicken pox has run around a 28 bed ward, we have lots to do!

Premature babies have underdeveloped immune systems, so they cannot easily fight infections. Newborn babies will not have had previous exposure to many infections, even though they may have protection for some illnesses from their mother's antibodies. This group of patients is therefore at a high risk of acquiring an infection and are therefore nursed in a special unit with higher staff ratios and stringent infection controls.

SALMONELLA, SERRATIA AND OTHER BUGS

In May 2003, the Neonatal Unit reported that several babies had developed diarrhoea, caused by a rare form of salmonella. We immediately isolated these babies and tested a range of surfaces – such as hand basins, bottle warmers and breast pumps – as well as the Infant Formula Room. Although we could not identify where the infection had originally come from, careful hand washing and strict adherence to infection control practices meant that the infection did not spread.

In November and December 2003, eight children in the general medical ward developed gastroenteritis, caused by Norovirus, which is very infectious. Grouping these children together, and with strict infection control precautions, meant that no other children were infected and we did not have to close the ward.

In late 2003, there was an increase in the number of babies found to be carrying the bacteria, *Serratia marcescens* in our neonatal unit. *Serratia* is a common bacterium that many of us are exposed to, and does not cause any problems in healthy people. Those patients at risk of infection are premature babies and sick newborns.

In response to this we looked for the source of this bug and ensured that all appropriate infection control practices were followed.

Weekly tests were undertaken using samples from the babies' respiratory tracts and bowels and this helped us to identify any new cases. Careful handwashing was reinforced and additional infection control precautions were implemented, such as the wearing of gloves and gowns. In addition, babies who were found to have an infection or who were carrying the bacteria in the bowel or respiratory tract (without making them sick) were grouped together in one room.

For this reporting period (July 1 2003 – June 30 2004) there were a total of 44 babies found to be carrying *Serratia*, with 11 of these having an actual infection. There were no deaths attributed to *Serratia* during this period. Other Melbourne neonatal units experienced similar problems with this bacteria as well.

We found in fact that several different strains of the bacteria were present in the Neonatal Unit. This has shown us that not all infections have resulted from 'cross infection' and that the infection control efforts of the staff have prevented further spread in this very high risk group of patients.

PICU

Mikaela Williams is a little fighter.

When she was six days old her parents Anita and Simon felt there was something wrong when Mikaela wasn't feeding well and her temperature was low. She was brought to RCH where tests revealed she had myocarditis and encephalitis – an inflammation of the heart and brain, caused by a virus.

Doctors placed her on ECMO (Extra Corporeal Membrane Oxygenation) to allow her heart and lungs to rest and recover. ECMO is similar to a heart-lung bypass machine used during open heart surgery. During three weeks on ECMO Mikaela's chest was open to accommodate the large bore catheter that circulates the blood, so the risk of her contracting an infection was high.

Nursing and medical staff continuously endeavour to prevent hospital acquired infections. Despite these efforts Mikaela contracted a number of infections but fortunately she responded to antibiotics.

Now five weeks old Mikaela still has several lines in to administer drugs and fluids, measure her heart pressure, and remove unwanted fluids. This means she remains extremely susceptible to infection, as her immune system is under stress.

Anita and Simon feel as though they've been riding a roller-coaster during the past five weeks. "But Mikaela has been fighting hard all the way," said Simon.

MIKAELA





	RCH 2002	RCH 2003	CDC
Comparison of infection rates/1000 line days – Neonatal Unit	6.9	6.4	6.5
Comparison of infection rates/1000 line days – Intensive Care Unit	13.5	9.2	7.6

INFECTION RATES

All medical procedures and operations on a baby or child potentially increase the opportunities for bacteria to enter the body. Staff are well educated in the techniques they use to prevent infection and we work to Australian Standards for the sterilisation of our equipment. One way we measure how well we are doing is to look at blood stream infection rates. Intravenous lines commonly put into patients for injecting drugs or giving fluids do not have high complication rates. However, lines that are placed into major blood vessels near the heart are more likely to have complications. These are known as ‘central lines’.

The table above shows the infection rates in the Intensive Care and Neonatal Units for children who have ‘central lines’. We compare each year’s rates (the number of infections against the total number of days in which these lines were present) with the previous year’s and also with similar units in the United States (Centers for Disease Control – CDC is used as there is no comparative Australian data published available). We are of course pleased that our infection rates have dropped in the last year and also that, for the Neonatal Unit, our rates are less than the United States comparison figures.

Victorian Nosocomial Infection Surveillance System (VICNISS) is a Department of Human Services funded coordinating body established in 2003, which is responsible for the collection, analysis and aggregation of infection rate data from metropolitan public hospitals. This project will allow for comparison with rates from other Victorian hospitals and will give a more reliable comparison, as there are many differences between our hospitals and patients and those in the United States, and will be reported on in next year’s report.

Although our overall rate for 2003 in the Intensive Care Unit is more than the United States figures, we are proud that the rate for the last six months of 2003 dropped to 4.3 per 1000 line days after the Wash Up project began in the Intensive Care Unit (see above).

In July 2003, we counted the number of children who developed an infection in the 10 days after they had been a patient in the general medical ward. Of the 286 patients in the ward that month, seven children developed a total of eight hospital acquired infections – gastroenteritis (six), flu (one) and bronchiolitis (one). This means that these children had a 2.4% chance of getting an infection while they were in hospital.

In order to continue to reduce these infection rates, our procedures, staff education and supervision are continuously reviewed.

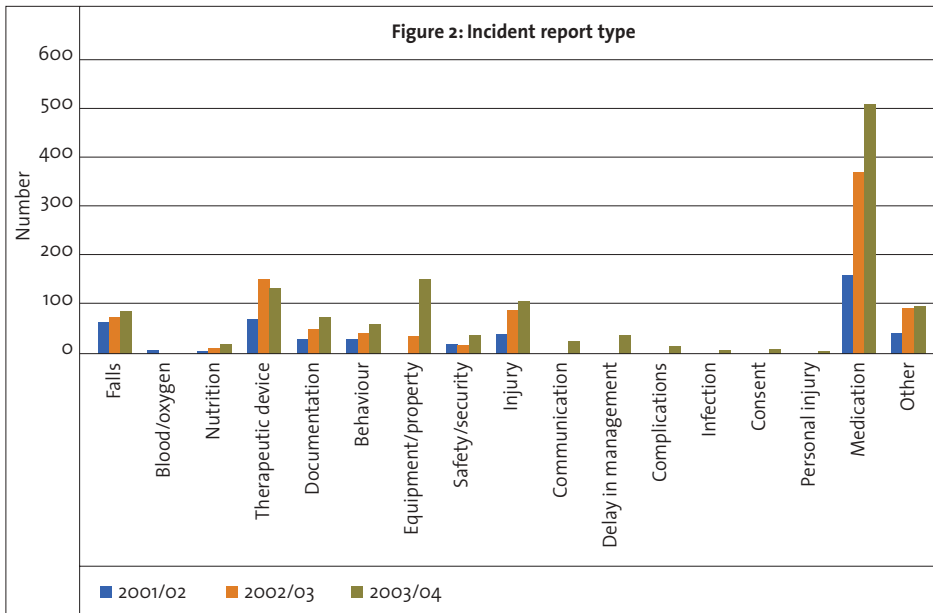
WASH UP

Hand washing is considered to be the simplest and most cost effective way of preventing infections. In last year’s Quality Report, we mentioned that ‘Wash Up’, a project sponsored by the Department of Human Services, was underway.

For our ‘Wash Up’ project, we have implemented hand washing guidelines in the Intensive Care and Neonatal Units and have educated staff and parents/caregivers about the importance of these. We improved hand washing in both units by 26% from July to November 2003. We will monitor hand washing once again in November 2004 to see if we have been able to improve these rates. At this time, we will also analyse the amount of soap, alcohol solution, moisturiser, gloves and antibiotics used.

The ‘Wash Up’ project will also be launched in a general paediatric ward in June/July 2004. We will monitor respiratory and gastrointestinal infections in this ward to measure the effectiveness of the project.

The Infection Control Department consults widely within the hospital and is available to assist other community organisations (such as child care centres) and parents.



MEDICINES – A COMPLEX PROCESS

There were 32,769 inpatients at RCH in 2003/04 and each had an average of 4.2 medications prescribed. This means about 138,000 medications were prescribed during the year.

The Spectrum Medication Error project, conducted at RCH, developed tools to measure medication error and these are now routine practice. These tools measure each aspect of the medication process (prescribing, dispensing and administration). The project was undertaken with funding from the Australian Safety and Quality Council as part of the Medication Safety Innovation Awards Program.

WHAT TYPES OF MISTAKES HAPPEN WITH MEDICATIONS AND WHAT ARE WE DOING ABOUT IT?

Paracetamol, antibiotics, intravenous (IV) fluids and morphine are the most common medications involved in error. These and other medications considered to be high risk are highlighted in rotating 'Drug of the Month' posters to alert and educate staff.

Our audits assessed IV errors and found that there have been significant improvements in care and documentation of IV infusions. To build on these improvements a Peripheral IV Management Clinical Practice Guideline and new IV fluid charts were introduced to help staff better manage and document IV care. Ongoing audits will measure effectiveness and be reported in 2005.

INCIDENT REPORTING

The two main ways RCH monitors the safety of the care we provide are through adverse event monitoring and incident reporting. Clinical staff increasingly report adverse events at the time they happen, rather than being identified later through medical record review. This trend is seen in the number of incident reports – there has been a 165-180% increase in reports received. This does not mean more errors are occurring, but that they are noticed and reported more often. Staff see the value in reporting incidents and know that this is an essential way to learn and make improvements.

In 2003-04, 166 patient records were reviewed for adverse events. This process detected 65 adverse events, 24 of which were considered to be preventable. The Patient Safety Committee monitors the issues that arise through adverse events and is very proactive in ensuring improvements are put in place in response to the adverse events identified. This year, a range of improvements have occurred – new clinical guidelines, development of working groups, education and training. Some examples of these improvements are:

- Clinical guidelines and protocols have been updated for conditions including renal biopsy, eye trauma management, intussusception, and the baclofen pump procedure
- A committee overseeing the Medical Emergency Team (MET), Equipment Safety and Trauma Services has been developed and a MET Coordinator position has been created
- Improved staff and patient identification methods
- Training of doctors and nurses using a national standard paediatric life support course
- Education of staff via a monthly forum, presentations and a bi-monthly on-line Patient Safety Newsletter.

Figure 2 shows incident reports for 2001-2004. It should be noted the increase in numbers related to medication incidents has been as a result of an intensive education project for staff to report both actual incidents and near misses.

Figure 2 illustrates improved reporting since 2001. The data now includes near misses and is not an indication of actual events.

RESPONDING TO NATIONAL ISSUES

The Australian Council for Safety and Quality in Health Care highlighted potassium as a high risk medication. RCH has a standardised method for prescribing potassium to reduce error. In addition, we have implemented safety measures such as minimising the availability of potassium in clinical areas and using custom made IV fluid bags that already include potassium.

NURSES AS A SAFETY NET FOR MEDICATION ERROR

In order to increase the safety of prescribing and administration of medication, the Better Prescribing and Administration Project (BPAP) was undertaken, thanks to the Australian Council for Safety and Quality in Health Care, Safety and Innovations in Practice II funding. The focus of the project was to review safety practices relating to prescribing and administration of medications, education regarding the 'five rights of medication administration' and the introduction of the new RCH sixth right – the 'right to refuse'. The 'right to refuse' refers to doctors' and nurses' right to clarify a medication prescription until they are satisfied it is totally clear and appropriate. Incident reports since BPAP indicate that nurses are questioning prescriptions more often and are insisting on a higher standard of prescription for the safety of children and young people in hospital.

HOW MUCH HAVE WE IMPROVED?

A prescribing audit conducted in May 2004 indicates a significant improvement in the standard of prescriptions since mid-2003. Preliminary data analysis of an audit of 1261 prescriptions indicates:

- Legibility has improved by 30%
- Dose errors have reduced from 14% to 4%
- Frequency errors have reduced from 20% to 7%.

OTHER TYPES OF INCIDENTS

Falls, patient consent, injury and therapeutic device (medical equipment) errors are the other most common types of mistakes that are reported.

FALLS

There were 97 falls in the last year (July 2003 to May 2004) compared to 76 falls in 2002-2003. These were mostly falls from a bed or cot and occurred despite safety rails being in position. In response to this, a Falls Risk, Prevention and Management Guideline has been developed and was launched in June 2004. All ward areas have undergone and achieved satisfactory results in Wet Area and Equipment Assessments, and the tool developed for these assessments will be part of routine Occupational Health and Safety assessment in the future.

PRESSURE AREA CARE

There were 18 reports of pressure areas (2% of all non-medication incidents), most of which occurred in our sickest patients who are in bed for an extended time. The number of pressure areas reported is the same as in 2002-03. A new assessment tool for pressure areas is being used to assess children in Intensive Care, however it is too early to determine the impact of this tool.

CONSENT

A project to refine the process of consent to ensure the right patient has the right operation and the consent is completed appropriately has been a significant undertaking with involvement of consumers, surgeons, anaesthetists, nursing staff, the Surgical Consultative Council and the Department of Human Services. The new process is based on the best available evidence and will be introduced by August 2004.

MAKING SURE WE ARE PROVIDING THE BEST CARE

Tools such as Clinical Practice Guidelines (CPGs) and Clinical Pathways (CPs) provide accessible easy-to-use information that guide clinicians as they make decisions about patients' care. At the same time, these tools educate clinical staff about the best ('evidence based') care.

There are currently 85 paths in use for a range of patients. In 2004 the focus has been on reviewing current documentation and implementing best evidence based practice.

Examples where evidence has led to a change in practice are:

- reduced invasive techniques such as suction where evidence supports this
- ceased use of unnecessary antibiotic ointment for patients who have had craniofacial surgery.

Clinical Pathways are now available on the RCH Intranet site which has improved access and allows clinical staff to be sure they have the latest version regardless of where the child is in the hospital.

www.rch.org.au/rch_clinpath

User friendly CPGs, based on the best available evidence, are readily available on computers in all clinical areas via the RCH website. There are currently 172 CPGs on the RCH website for a range of paediatric conditions and procedures. These are accessed by people from inside RCH and in the community, both within Australia and overseas. The site has an average of 100 visits per day and 3,500 pages within the site are visited each day. CPGs can also be downloaded onto hand-held electronic organisers providing immediate access at all times for those staff who own these devices. A group of staff in the hospital has been established to support the writing and publication of CPGs for other disciplines and specialties in RCH where CPGs are currently not available.

CARE COORDINATORS

Patients with complex needs require more specialised coordination of their care. Care Coordinators identify special needs early, and utilise all the resources available in the hospital for their patient. They also make sure that information is consistent amongst the treating team and the family, and that patients and their families are kept involved in the treatment of their child. The coordinator role often extends into the community, ensuring that patients have the right supports when they return home, and that the transition from hospital to their community is a smooth one.

Eight wards have a Care Manager for this purpose and there are 29 staff around the hospital who provide various types of specialised care coordination. These include the ward based Care Managers, diagnosis related Care Coordinators, and Nurse Practitioners.

MEDICATION

The Australian Paediatric Pharmacology Research Unit (APPRU) has been established by the RCH Department of Clinical Pharmacology and the Murdoch Childrens Research Institute to focus on the safety of all medications for children, including over the counter and alternative medicines. We do this in conjunction with other hospitals, both interstate and overseas.

Within the hospital, we have evaluated a range of medicines, in terms of appropriate prescribing, as well as monitoring children's reactions to them. Overdoses are reviewed at a regular toxicology meeting which involves discussion between staff from Clinical Pharmacology, the Emergency Department and the Poisons Information Centre.

MOTHERSAFE

This is a new service for pregnant women and community-based health care providers who may be concerned about the effect of various medicines on unborn children and babies who are being breast fed. The service offers consultation and follow up of babies who have been exposed to medication, and contributes to national and international research.

What do we do to improve things?

WHAT DO WE DO TO IMPROVE THINGS THAT AREN'T WORKING WELL?

Suggestions and complaints by families are often important in changing things that are not working well.

One example of this is the Accelerated Care through Emergency (ACE) Project, which was set up because families whose children had complex and chronic illnesses and/or disabilities and who visited the Emergency Department frequently, were having to repeat all the information about their child at each visit, and often had long waits. The hospital received funding from the Department of Human Services for the ACE Project, which now serves 180 children and their families. Parents and carers can ring a mobile phone number any time, for advice about their child's condition, and if the child needs to come into hospital, everyone is prepared for their arrival. Families are understandably very satisfied with this service.

The key parts of this successful project are:

- Partnership in care planning. Staff and families work together to create a prospective care plan which covers all aspects of the child's care – medical, social and psychological.
- Care coordination. The Care Coordinators know each child and family and carry with them the children's care plans on Palm Pilot databases.
- Access to the hospital. Families can ring the ACE mobile phone number 24 hours a day, seven days a week for advice. If the child needs to come in to the hospital, the file is ready for them and the child is seen by senior medical staff as soon as possible.

ADVERSE DRUG REACTION COMMITTEE ACTIVITIES IN 2003

An Adverse Drug Reaction (ADR) is any reaction to a drug which occurs at the normal dose and which is unusual and unsafe. Australia has a very good record in reporting these reactions. As you can see from figure 3, our staff are also very positive about reporting ADRs due to staff training, awareness of patient safety and the 'no blame' culture at the hospital.

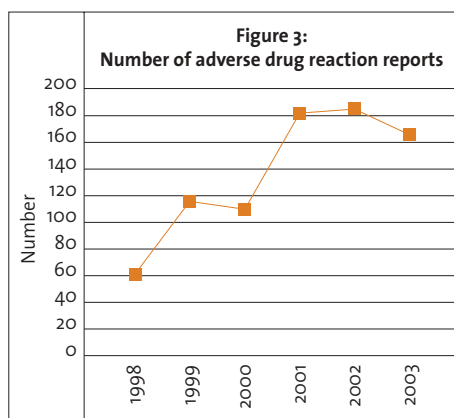
NUMBER OF REPORTS RECEIVED PER YEAR

Adverse Drug Reactions (ADR) are identified by our doctors, nurses, pharmacists and medical records coders. The RCH ADR Committee meets every month to review all ADR reports and to work on ways of preventing these situations occurring again. One of the ways we do this is to give an alert card to patients and carers with information about the ADR. This card can then be given to doctors, pharmacists and other health care professionals at RCH or in the community. Patients may also be referred to the Allergy Clinic for allergy testing.

In addition, in situations where children need to be given drugs which have a higher than normal risk, guidelines have been developed and given to staff, patients, parents and carers, so that negative reactions can be avoided.

The hospital also plays an important part in preventing adverse drug reactions across Australia. For example, in January, three RCH reports on Travacalm were sent to the Australian Drug Reactions Advisory Committee. These contributed to the investigation, and withdrawal, of Pan Pharmaceuticals products.

The RCH ADR Committee gives lectures within the hospital and has frequent contact with other hospitals within Victoria and interstate. The Committee also has regular reports in the RCH pharmacy newsletter, Keeping Tabs. Our agenda for the next year includes reviewing serious reactions to non-steroidal anti-inflammatory drugs and paracetamol.





JAMIE

Accelerated Care through Emergency – ACE Program

Jamie Murphy is 14 years old and has had 20 hospital admissions with cyclical vomiting syndrome. Whenever Jamie picks up a bug or virus, constant and uncontrolled vomiting usually follows, resulting in a trip to the Emergency Department for treatment.

Each time Jamie returned to the Emergency Department, it was necessary for him to go through the usual procedure of triage, and there were sometimes delays in getting the medication to treat him, as it is not routinely kept in the Emergency Department. Jamie's doctor, gastroenterologist Dr Don Cameron decided to put Jamie onto the ACE program to help speed up the process of administering treatment.

Now when Jamie needs to come to hospital, his mother calls the ACE mobile number to let them know he's on his way. "Now that Jamie is on the ACE program everything is ready for him when we arrive at the hospital", said his mother Jenny. "This means he gets the medication he needs without delay and he recovers quicker."

The good news for Jamie is that he should grow out of this condition.

How are different religions and cultural beliefs respected?

The RCH community of patients and staff is made up of many different ethnic groups. For example, in the year 1 June 2003 – 31 May 2004, 5,473 of the children who were patients at the hospital came from families where both parents were born in a non-English speaking country and 15,170 children came from families where one parent was born in a non-English speaking country.

It is important that we continue to learn about religious and cultural beliefs in the lives of all families, as well as how these may affect understanding of illness and treatments.

The Community Division continues to consult regularly with an established group of representatives from 12 ethnic communities. This group has undertaken a range of projects with the hospital's Safety Centre and has recently given valuable input into the RCH Mental Health Service's Policy on cultural diversity.

We are considering setting up a Cultural Diversity Resource Group, perhaps as a sub-committee of the Community Advisory Committee.

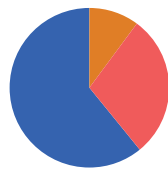


Figure 4

- Parents from an English speaking background
- Both parents born in a non-English speaking country
- One parent born in a non-English speaking country

ABORIGINAL FAMILY SUPPORT UNIT

RCH recently participated in the Aboriginal and Torres Strait Islander Accreditation project, which has been set up to make sure that there are culturally appropriate services for Aboriginal and Torres Strait Islander people in Victorian hospitals. The Aboriginal Family Support Unit and RCH Human Resources are working together to ensure that the hospital meets the recommended standards.

The Aboriginal Family Support Unit is also currently negotiating a partnership with Aboriginal Hostels Limited to develop an Aboriginal Medical Transient Hostel. RCH is committed to providing a property, situated directly opposite the hospital, for this purpose. This will enable Aboriginal families from country Victoria or interstate to stay in a safe and friendly environment.

On 26 May each year, the anniversary of Sorry Day, the Journey of Healing is commemorated in events throughout the country. It is a day when Aboriginal and non-Aboriginal Australians come together, remember the harm done to Aboriginal families in the past and commit themselves to healing the wounds. This year the Physiotherapy Department organised a stall with information, posters and ribbons and provided a bush tucker morning tea.



The Safety Centre's Peer Educator Group, from left: Sonia Orzeszko, Nicky Miseski, Helen Markelis, Tiffany Lau and Lina Hassan.

HALAL FOOD

There is at present no separate space in the kitchen which is suitable for halal food preparation. Our staff have consulted with suppliers of halal food, but there is unfortunately no current commercial supplier of halal food who is able to offer a service to the hospital. In the short term, we will continue to search for suitable suppliers, while our longer term plans for a new hospital include dedicated kitchen space for preparing halal meals.

MUSLIM PRAYER ROOM AND WASHING FACILITY

Space (and lack of it) is always an issue in the hospital. At the moment, one corner of the chapel has been set aside as a Muslim prayer space. However, we know that this is not ideal. We have had several discussions with the Islamic Council of Victoria and would like to provide separate prayer rooms for men and women. These rooms need to be close to washing facilities. We hope to be able to report more progress on this in next year's report.

DO WE PROVIDE FEMALE DOCTORS FOR TEENAGE FEMALE PATIENTS?

Not all specialist areas in the hospital have female doctors available at all times. However, a female support person is always available and can be requested.



Cultural Diversity

During the past year the hospital's Interpreter and Non-English Speaking Background Service assisted 2,152 families whose children were in hospital, and 14,283 families who visited the Outpatients Department. This is where eight year old Ebru Unal and her parents were assisted by Silvio Proy who manages the service.

Ebru's parents, Nermin and Hayati understand a little English, but appreciated having Silvio there to explain in detail what Dr Scott Ferris was telling them when he checked Ebru's progress.

Ebru was only concerned with presenting her best smile for the camera.

The seven staff who work in the Interpreter Service speak 14 languages, and another 246 interpreters are on call to assist with another 107 languages.

EBRU

How do we know what you think of us?

There are many ways in which you can tell us what you think of us.

Patients and their families often make suggestions or raise concerns with clinical staff or with the Consumer Liaison Officer. Staff are encouraged to bring these issues to their managers, so that we can improve our service. For example, over the past year, we have made the following improvements as a result of these suggestions:

- Improved shower and toilet facilities for families
- Decreased delays to parking
- Introduction of more secure filing in Outpatients
- Improved notice boards
- Introduction of Patient Resource Manager position.

We actively seek your feedback through forums or individual interviews on particular issues. For example, we have recently conducted telephone interviews on how we can improve our new Short Stay Unit. One of the outcomes of this process is that we are now providing a light breakfast for parents in the Unit.

The RCH Community Advisory Committee provides valuable feedback on our service – in fact, they continually challenge us to improve the ways in which we interact with patients and their families.

We also undertake Patient Satisfaction Surveys, which are analysed by an international organisation (Press Ganey) and compared to other hospitals. We have been undertaking these surveys in the Emergency Department (ED) since 2001 and our ED 'scores' better than most other EDs. In 2003, we introduced the Press Ganey surveys to other areas of the hospital – inpatients, outpatients and day

surgery. We have identified that we have room to improve in these areas as we haven't scored as well as we would like. The main issues for families in these areas were: waiting times, plus the need to have information about delays; the need for better coordination of appointments; and not knowing how to voice concerns about the hospital.

CONSUMER FEEDBACK

Consumer feedback, in terms of issues, as well as the number of contacts, has not changed very much over the past few years. Most feedback is received via a visit or phone call, with a smaller number coming in writing. It is summarised in figures 5 and 6.

There are three areas, which have been the main focus of consumer feedback over the past few years:

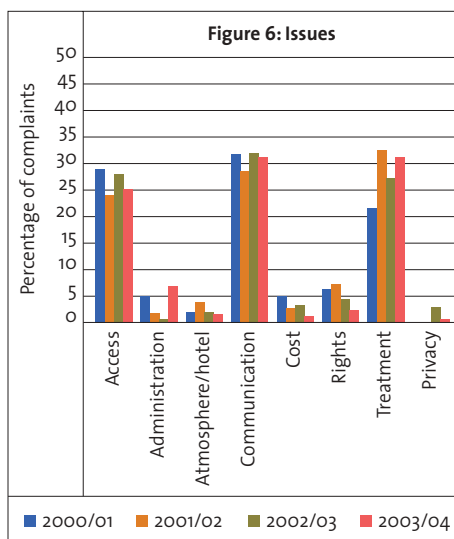
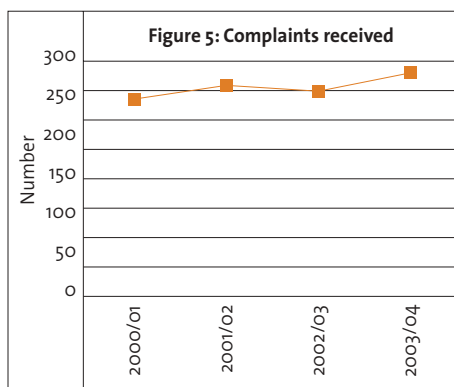
- Communication, particularly in terms of families receiving inadequate or conflicting advice
- Access, especially waiting
- Treatment, particularly postponement of surgery and perception of inadequate diagnosis. Communication is also a key factor in this area.

We use information from direct consumer feedback, as well as from surveys, as a basis for improving our service. You will have seen examples of these improvements throughout this report.

FOOD SURVEY

In October 2003, the Department of Nutrition & Food Services undertook a food satisfaction survey at the same time as another major children's hospital interstate. Both hospitals used the same survey on the same day and about 70% of all the children in both hospitals took part. The survey will be repeated regularly in conjunction with interstate hospitals.

Although the interstate hospital has a new kitchen, the satisfaction ratings were very similar for both hospitals. At RCH, 54% of the children rated the food as 'good-fantastic' and 34% as 'OK'.



What about community partnerships?

RCH has many partnerships with other Victorian community organisations, including parent support groups, as well as with health care bodies interstate and overseas.

RCH COMMUNITY ADVISORY COMMITTEE <http://www.rch.org.au/cac>

Hospitals are not only responsible under the Health Services Act for the quality of clinical care, but also for community participation. In fact, we know that effective consumer participation leads to improvements in the quality, safety and accessibility of health care.

Earlier this year, we advertised for people to join the RCH Community Advisory Committee (CAC) and were delighted to receive 31 applications. The Committee is made up of community-based people who have a wide range of experiences and knowledge. The CAC advises the hospital Board, managers and staff on ways of making sure that the needs of patients and their families are at the centre of health service planning and delivery.

COMMUNITY ASTHMA PROJECT

We have many joint programs with other community organisations and we are always looking for new ways of building on these relationships. One such program is the Community Asthma Project (CAP), which is funded by the Department of Human Services. The CAP service, which is run by Dianella and Dousta Galla Community Health Centres in conjunction with RCH (and other community organisations), provides free asthma education and support to children with asthma and their families who live in the northern and western regions of Melbourne (postcodes 3000-3099). The Community Asthma Liaison Nurse, refers patients with asthma who present to the Emergency Department on to the program.

Asthma educators visit children and their families at home and also provide support to schools, child care centres and sporting clubs. The educators, who work closely with GPs and paediatricians, help families to learn more about medications, trigger factors and the warning signs of asthma.



Four year old Caitlyn Gashi is pictured with Community Asthma Liaison Nurse Emma Conrad.



BENJAMIN

Care Assistance and Support Project in Emergency Department

Fifty-six thousand children came to the Royal Children's Hospital Emergency Department last year. At the busiest times, families sometimes wait many hours to be seen by a doctor. This can be stressful for families and frustrating for staff who don't like to see children waiting.

The CAS project in the Emergency Department (Care Assistance and Support) helps to ease some of these stresses. CAS volunteers offer practical support to families while the staff are busy providing clinical care.

Ten year old patient Benjamin Steenholdt and his mum recently drove from Casterton, near the border of South Australia to see a doctor at the Royal Children's Hospital. While they were waiting in emergency, CAS volunteer Jenifer Williamson helped by getting them something to drink, organised forms so they could claim transport costs and chatted to Ben and his mum to help pass the time until they saw a doctor.

RED CROSS VOLUNTEERS IN EMERGENCY DEPARTMENT

Fifty volunteers from The Australian Red Cross are supporting families in the Emergency Department in a range of practical ways – caring for the siblings of sick children, assisting with directions and helping parents to make phone calls.

THE WELLCONNECTED PROJECT

The RCH Education Institute and Multimedia Victoria have combined to provide VCE students at the hospital (or recuperating at home) with laptop computers and broadband internet, so that they can stay connected with their teachers and friends.

TRANSITION TO ADULT SERVICES

Transition to adult services for children with long term health care needs is an important part of our service. We have transition programs in place for young people with a range of conditions such as cystic fibrosis, haemophilia and developmental delays.

An example of this kind of service is the partnership between the Department of Plastic and Maxillofacial Surgery at RCH and the Department of Plastic Surgery at the Royal Melbourne Hospital (RMH). Young people with a cleft and/or craniofacial abnormality are supported in the transition from RCH to RMH by the Cleft and Craniofacial Coordinator at RCH.

FESTIVAL FOR HEALTHY LIVING

Our Mental Health Service was recently given a Public Health Award for the Festival of Healthy Living, which promotes the emotional health and wellbeing of students in primary and secondary schools in Victoria.

How are we planning for the future?

We plan for the future all the time, in terms of looking at ways of improving how we do things. However, we have also done a large amount of planning over the past year on how we want RCH to develop over the next five to ten years.

EVERYDAY PLANNING FOR IMPROVEMENT

The Department of Plastic and Maxillofacial Surgery recently appointed a new Director, Mr John Meara, who has introduced a 'Balanced Scorecard' approach to improving practices within the department. The Balanced Scorecard, developed in the USA, is a management tool which shows whether improvement in one area may have been achieved at the expense of another. It looks at:

- How patients/families experience our service
- How we can continue to improve
- How we can do our work in a financially responsible way.

We look forward to reporting on the Balanced Scorecard next year.

MEDICAL IMAGING

The next year will be an exciting one for the Medical Imaging Department, with a range of initiatives which will improve patient care. A new international paediatric clinical and research MRI unit is to be created jointly by RCH and the Murdoch Childrens Research Institute. A smaller initiative, which will nevertheless be important for families, is the creation of a new nuclear medicine patient waiting room (which will replace waiting in the corridor!)

INTERNATIONAL ALLIANCE

RCH has just become part of an alliance with the Murdoch Childrens Research Institute and Quintiles, the largest clinical trial organisation in the world. This means that international studies of new medicines will be referred to us, making sure that we stay in the forefront of research and patient care.

CANCER AND NEUROSCIENCE CENTRES

Plans are progressing for the redevelopment of the facilities for cancer patients and neuroscience services, in collaboration with the Children's Cancer Centre Foundation and Brainwave.

LONGER TERM PLANNING

The RCH Service Plan has been developed during the last year, focusing on what works well at present and how the hospital might need to change in the next five to 10 years. The process has involved extensive consultations with consumers, staff and other organisations.

Some of the issues which have led to this process are:

- The growth in illnesses such as asthma and other chronic conditions, including mental illness, learning and behavioural problems and eating disorders
- The increase in demand for intensive care, especially for low birth weight and premature babies
- The trend to more children being treated on a same-day basis, with a smaller (but growing) number of children with complex conditions needing longer lengths of stay
- The trend for other hospitals to refer children to RCH, especially for surgery
- The need for facilities which are more family friendly.

In addition, the separation of the Royal Children's Hospital and The Royal Women's Hospital means that we will need more staff and facilities, especially in the areas of administration and support.

Please tell us what you think

Acknowledgements

The RCH Quality of Care Report 2004 was made possible by the invaluable contribution and support of many staff members and consumers of the RCH, including:

Cas O'Neill, Project Coordinator

Quality of Care Report Reference Group

Consumer Advisory Committee on Children's Health

Public Affairs

Quality and Safety Committee

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

Dr Annie Moulden,
Director of Clinical Support Service

Photography and design:
Educational Resource Centre, Royal Children's Hospital

We would also like to thank our patients for allowing us to use their photographs in this report.

If you would like to register your interest in becoming involved in the hospital, we would be pleased to hear from you. You are most welcome to contact us:

Phill Goulding, Consumer Engagement Consultant
Telephone (03) 9345 7058
Email phill.goulding@rch.org.au

Judith Smith, Consumer Liaison Officer
Telephone (03) 9345 5676
Email judith.smith@rch.org.au

We invite you to let us know what you think of this report.

In general, what information do you want to see in this report?

Is there anything that you particularly like or find useful?

Is there anything that you particularly dislike or that you think shouldn't be in the report?

What do you think about the design of the report?

Are there other things that you would like to see in the report?

Once completed, please return this form to:

Judith Smith, Consumer Liaison Officer
The Royal Children's Hospital
Flemington Road, Parkville
Victoria, Australia, 3052

Telephone (03) 9345 5676
Facsimile (03) 9345 5050
Email judith.smith@rch.org.au

www.rch.org.au/qualityreport_rch



