IN THE MATTER OF THE ROYAL COMMISSION INTO FAMILY VIOLENCE

ATTACHMENT FD-23 TO STATEMENT OF FRANCES MARIE DIVER

Date of document: 3 August 2015
Filed on behalf of: the Applicant
Prepared by:
Victorian Government Solicitor's Office
Level 33
80 Collins Street
Melbourne VIC 3000

[redacted]

This is the attachment marked '**FD-23**' produced and shown to **FRANCES MARIE DIVER** at the time of signing her Statement on 3 August 2015.

[redacted]

Before me:

Attachment FD-23

Continuity of Care

Service guidance for Victorian Public Health Services and Maternal and Child Health Services

This document is currently under consultation by the sector and has not yet had professional edit, copy edit, design or layout.

May 2015

Continuity of Care – Practice guidance for Victorian Public Health Services and Maternal and Child Health Services is a joint initiative between the Department of Health and Human Services, the Department of Education and Training and the Municipal Association of Victoria. It replaces *Continuity of care: A communication protocol for Victorian public maternity services and the Maternal Child Health Services, 2004.*

Published by the Department of Education and Training
Melbourne

[insert month] 2015

Authorised by the Department of Education and Training
2 Treasury Place, East Melbourne, Victoria, 3002.
ISBN [to be inserted if required]
This document is also available on the internet at [insert URL].

Contents

Foreword

The quality of care and the health and wellbeing of families and communities is strongly linked to collaboration and partnerships between service sectors. Victorian public health services and maternal and child health services are an integral part of the service continuum providing antenatal, birth and postnatal care for families and their babies.

Continuity of Care is a joint effort between the Department of Health and Human Services on behalf of Victoria's public health services, the Department of Education and Training on behalf of maternal and child health (MCH) services, and the Municipal Association of Victoria (MAV) on behalf of local government. This document aims to support better continuity of care for recent parents and their babies, particularly the most vulnerable in our society, during what is a significant period in their lives.

To achieve this aim, *Continuity of Care* seeks to strengthen partnerships between public health services and MCH services by improving coordination, collaboration and communication, and providing clarification on each service's roles and responsibilities. We also acknowledge, however, that individual communities are often best placed to develop local solutions tailored to their needs.

Designed as an overarching framework, *Continuity of Care* will guide public health services and MCH service providers to establish collaborative relationships at a local level, promote good practice, and help ensure Victorian families consistently receive the support they need throughout their child's first years of life.

We thank the working group that developed this document and the maternity services and MCH staff who provided advice and contributed to its development.

Dr Pradeep Philip
Secretary
Department of Health
& Human Services

Rob Spence
Chief Executive Officer
Municipal Association of Victoria

Gill Callister
Secretary
Department of Education
& Training

3 Continuity of Care

1. Introduction

The Victorian Context

The state's health services[1] aim to provide safe, high quality care and support to members of the Victorian community as they need it. The Victorian Government, through the Department of Health and Human Services and the Department of Education and Training fund a wide range of primary, secondary and tertiary health and community services to promote and maintain the health and wellbeing of individuals, children, families and communities across the state.

For young children and their families in particular, it is Victorian health services (both public and private) and MCH services that work together across a service continuum to provide antenatal, birth and postnatal care.

The health and wellbeing of families and the quality of care they receive is strongly linked to collaboration and partnership between health services and MCH services. It is essential that effective communication and coordination processes and care planning are established and followed to help ensure families have a positive experience of childbirth, early childhood and parenting.

For the majority of families, this process is generally straightforward. However, a smaller group of families presenting with a number of significant clinical and psycho-social risk factors will require additional assistance. The *State of Victoria's Children Report 2012: Early Childhood* found that by and large, Victorian children and families are doing well, with good quality services available. However, there are a minority who are vulnerable and the Victorian Government and the community sector are working together to improve their lives and address the challenges they face.

In May 2013, the *Victoria's Vulnerable Children – Our Shared Responsibility Strategy 2013–2022* was released. This strategy will drive change over the next decade to deliver on the government's objective that vulnerable children are kept safe from harm and have every opportunity to succeed in life.

As part of this strategy, a commitment was made to revise the 2004 document, *Continuity of Care: A communication protocol for Victorian public maternity services and the Maternal and Child Health Service* to ensure that vulnerable new mothers and families are more strongly linked into postnatal support in the community.

[1] For the purpose of this document, the term **'health service'** is taken to mean all public hospitals or health services providing maternity and birth services.

Why Continuity of Care?

Continuity of care is described as a coherent and connected journey through the service system[i]. In the context of this document, it refers to consistency in the care and advice provided to families by public health (maternity) services and the Maternal and Child Health service during pregnancy, childbirth and in the postnatal (early parenting) period. It is supported through policies, processes, a shared understanding of roles and responsibilities and good communication.

Ensuring continuity of care and service integration can contribute to improved outcomes in the postnatal period, improving individuals' health and wellbeing, leading to greater levels of satisfaction with the care received, and enhanced feelings of control, safety and support[ii]. Collaboration between health professionals providing care to women and their families during this period facilitates timely access to care, tailored to individual needs and expectations[iii].

Fragmentation across different parts of the health system can result in a lack of continuity of care and this can adversely affect the outcomes for women and their families[iv]. Continuity of care and collaboration between health professionals are particularly important for women and babies who are vulnerable or at risk of becoming vulnerable and/or whose care requires linkages to specialist and other support services[v].

Continuity of Care: Service guidance for Victorian Public Health Services and Maternal and Child Health Services (*Continuity of Care*) aims to strengthen service integration between health services and MCH services to support the provision of continuous and collaborative care in the antenatal and postnatal periods and beyond.

5 Continuity of Care

2. Aims and shared principles

Aims

Continuity of Care is designed to support effective continuity of care for women, families and their babies, particularly the most vulnerable in our society through improved coordination, collaboration and communication between health services and MCH services across the state. The key objectives of the document are to:

- promote safe, evidence-based and high quality care and support for families from pregnancy through early parenthood, as provided by health services and MCH services
- promote improved communication and strengthen partnerships between families, health services and MCH services
- clarify processes to identify and actively engage families with emphasis on those who are vulnerable or at risk
- promote mutual understanding of the respective roles and responsibilities of health services and MCH services
- promote consistent and complementary approaches to the transfer of information between health services and MCH services
- provide scope, direction and authority for the development of local policy and protocols between services that meet the needs of families in the postnatal period
- support the operation of Part 7 of the Child Wellbeing and Safety Act 2005 in relation to birth notification.

On a community level, the document provides an overarching framework to complement local initiatives and protocols and support further work to resolve local issues.

Shared principles

The principles underpinning *Continuity of Care* focus on the interface between health services and MCH services. These are:

- **Collaborative and co-ordinated care –** families are supported by a responsive, integrated and co-ordinated system of care between health and MCH services.
- **Planning in partnership with families** – effective antenatal and postnatal care is based on collaborative and respectful partnerships and communication between service providers and families.
- **Family sensitive and inclusive practice** – services support family choice and participation and are responsive to the strengths, needs and priorities of individual women and families.
- **Continuous quality improvement** – opportunities are sought to jointly monitor, evaluate and review service provision at a local level.
- **Cultural responsiveness** – every person has the right to receive high-quality health care regardless of their cultural, ethnic, linguistic and religious background or beliefs.
- **Information sharing and privacy –** information about women and families is documented and shared according to privacy principles to support continuity of care

Guidance overview

Continuity of Care is arranged in sections based on the shared principles outlined above.

The document outlines the broad roles and responsibilities of health services and MCH services in the:

- antenatal care period – care during pregnancy, and
- postnatal care period – care provided after the birth, in hospital and following discharge from hospital. This includes when there is a need for a premature or unwell baby to be admitted to a special care nursery or neonatal intensive care unit.

Care in these periods is provided by a range of health care professionals (both public and private) such as general practitioners, obstetricians, midwives, maternal and child health nurses as well as neonatologists, paediatricians and social workers when required. *Continuity of Care* highlights ways in which health services and MCH services can collaborate for effective continuity of care but notes that local needs are often best met by local solutions. Planning in partnership with parents and families is also an essential part of this process.

In each section, guidance is provided on how staff in health services and MCH services can support women and their babies through enhanced communication and collaboration. Where possible, additional guidance is provided on supporting vulnerable families experiencing or at risk of experiencing medical and/or psycho-social issues. Examples of good practice are provided in blue breakout boxes throughout the document. *Continuity of Care* has been developed in line with:

- the *Postnatal Care Program Guidelines for Victorian Health Services* (Department of Health and Human Services, 2012); and
- the *Maternal and Child Health Service Guidelines* and the *Maternal and Child Health Service Program Standards* (Department of Education and Training, 2009).

7 Continuity of Care

3. Collaborative and Co-ordinated Care

The health service where a woman has her baby is accountable for the care of the mother and baby in the postnatal care period. This period of time is usually considered to be the first six weeks after birth (Commonwealth of Australia, 2011), however, in accordance with the *Postnatal Care Program Guidelines for Victorian Health Services* (DHHS, 2012), the period of time is dependent on the individual needs of the woman, the woman's geographical location and the health service configuration.

The time that women spend in hospital following childbirth has steadily declined. In Victoria in 2009-10, the average length of stay for a public hospital birth episode was two days for an uncomplicated vaginal birth and four days for a caesarean section without major complications (Department of Health, 2012). This reflects improvements in acute care and the development of alternative and appropriate care settings, including the woman's home.

As the average length of hospital stay following childbirth may continue to decrease, service integration is critical to ensuring women are well supported at home as they transition from care provided by the health service to care provided by the MCH service. The length and service intensity of this transition period is dependent on the needs of the mother and baby and necessitates good communication between health services and MCH services to ensure continuity of care.

Upon discharge from hospital, women are referred to their local MCH service which takes on the responsibility to provide a primary care service for the baby until the child reaches school age. The MCH service also assumes responsibility for making referrals to any additional services that are needed, including the enhanced MCH service.

Following receipt of the birth notification, the MCH service attempts to contact the family to arrange a home-based visit. The home visit enables the MCH nurse to view the home environment and undertake an assessment of the newborn's sleeping and living arrangements.

Discussion forums and idea sharing are important for the provision of high quality care to meet individual needs and expectations[vi]. Maternity and MCH services should promote opportunities for integrated care planning and decision making such as regularly scheduled meetings and case conferences[vii] with families, to strengthen communication and shared processes.

Providing an effective, coordinated service to families is dependent upon health and MCH services working collaboratively and with a clear understanding of roles and responsibilities.

Both health services and MCH services have an important role to play in the continuity of care:

- **Health services** provide care associated with birth. This includes services provided in public hospitals during pregnancy and following birth including care provided in the home in the postnatal period. Care is provided by a range of health care professionals including obstetricians and midwives.

- **Maternal and child health services** provide support to families with children from birth to school age. This includes referrals to other services as needed. Services are provided by specially qualified nurses and midwives in partnership with local government.

While the services provided by general practitioners and other community-based providers, such as Koori Maternity Services, are not included in the scope of this document, it is recognised that the linkages between these services and health and MCH services are important for continuity of care.

Continuity of care should also be achieved for women who give birth in Victorian private hospitals and transition home to an MCH service. These services are encouraged to review and apply the principles and practice guidance outlined in this document when working with community-based support services.

In order to achieve the most effective and efficient service for families, the specific roles and responsibilities, processes and relationships between health services and MCH services are best developed at the local level[viii], noting that there are also a broad range of evidence-based actions that services are encouraged to undertake.

Examples of good practice to promote continuity of care

In the antenatal period, health services link families with the MCH service and provide them with information about the service and the Child Health Record.
Upon receipt of the birth notice from maternity services, an MCH nurse will typically initiate contact with the family to commence their care planning.
A local memorandum of understanding assists health services and MCH services to together identify overlapping strengths or any gaps in their service provision with the aim of providing families with optimal continuity of care[1].
Health services and the MCH service jointly develop and review policies and procedures at a local level, working together to ensure care is consistent with current evidence, legislation, government policy and quality and safety frameworks.
Liaison between health services and MCH services occurs through: • case coordination and care planning with families • network meetings held on a regular basis for discussion of specific or general issues that have been identified • inter-disciplinary training or professional development opportunities.

Supporting vulnerable families

Many families will be vulnerable at some stage. Sometimes the safety and wellbeing of families and children may be threatened by individual, parental, family or social circumstances. In some cases these circumstances or vulnerabilities will pass, at other times they can be significant and long lasting and can affect children into adulthood.

Vulnerability is a multi-faceted problem stretching beyond traditional economic measures of disadvantage. There are usually a host of factors, including personal circumstances and social environments that cumulatively impact on vulnerability. Isolation, as a result of geography, culture or language, social or other factors can be a contributing factor to a family's vulnerability.

Children from all cultural and socioeconomic backgrounds may be vulnerable to adversity which in turn may lead to possible child abuse and neglect. However, evidence suggests that some groups are at higher risk of vulnerability and that this vulnerability can be exacerbated if there is not early intervention and adequate supports in place[ix].

Health services and MCH services should be aware of specific population groups in their local area that may experience vulnerability. For example, children who may be at increased risk of vulnerability include:

- Aboriginal children, who are underrepresented in universal services which promote health development, learning and wellbeing.

"Children and young people are vulnerable if the capacity of parents and family to effectively care, protect and provide for their long term development and wellbeing is limited"

Victoria's Vulnerable Children Strategy 2013-2022

9 Continuity of Care

- Children of parents with a disability or mental illness where the parent or carer is not adequately supported through services or informal support networks.
- Children of families who have recently arrived in Australia, particularly refugee families who have experienced trauma and hardship.

Some families may need additional support from health and MCH services. Connecting with these families prior to birth is essential when women request contact, when there are identified medical or other health issues or when the family attends a service antenatally for a specific issue such as drug and alcohol use.

Health care that counts: A framework for vulnerable children sets out what all Victorian health services need to do to identify, protect and support vulnerable children and families. It acknowledges the health professional's role in *recognising* factors that contribute to vulnerability in children and families and *intervening early* in their response to reduce or prevent further harm.

Examples of good practice to promote continuity of care

- If clinical and/or psycho-social issues are identified in a family, health services, in consultation with the woman, contact the relevant MCH service with information relevant to care planning.
    - The MCH service may then contact or visit the woman and her family prior to birth to engage with them about the MCH service and offer support.
    - If available, and with the consent of the woman, health services can provide the MCH service with relevant and appropriate historical information about the family, including risk factors or support services required after previous births such as mental health services.
    - If there is an immediate risk to the safety and wellbeing of a child, a report to Child Protection should be made. In situations where there is a concern for a baby's safety, then consent from the mother or primary carer is not required.

4. Planning in partnership with families

Ideally, effective antenatal and postnatal care will be based on collaborative and respectful partnerships and timely communication between service providers and families. This not only enables families to make informed decisions regarding their care and the care of their baby, but it also empowers them to engage in a way that enables expression of needs and can increase confidence and satisfaction with their antenatal and postnatal care.

Generally, this requires families to be provided with evidence-based, consistent written and verbal information and education that is tailored to their individual needs[x].

It is beneficial that the transition plan for moving from hospital to community-based services and beyond be undertaken in partnership with families as early as possible. As some families may be unaware of the MCH service, it is important to raise awareness early of the support that is available to them in the community.

Examples of good practice to promote continuity of care

Health professionals find suitable ways of explaining options to families regarding the care they receive, both in and out of hospital, being aware of the family's cultural background and level of health literacy.

Health professionals consult with families on their personal preferences and expectations about their care, and who they would like to be involved in planning for and delivering care throughout the ante and postnatal periods.

Maternal and Child Health services involve families in the decision making process regarding their child's health, development and wellbeing, as the family transitions with their newborn from hospital to home.

Supporting vulnerable families

Collaboration between services is critical for vulnerable families. Planning in the antenatal period should involve an assessment of any risk of harm to the woman or baby or any parenting difficulties that may impact on the health and wellbeing of the baby. Where a significant medical or psycho-social risk to a family is identified in the antenatal or postnatal period, health services and the MCH service are encouraged to work together to engage the family early and formulate a care plan that meets individual needs and provides the best possible care and safety for the child.

The Enhanced MCH Service supports families with additional needs. It provides an average of 15 to 17 hours of home-based MCH services to families with children aged from birth to 12 months. It is provided in addition to the universal Key Ages and Stages MCH consultations.

Early referrals should be made to other services in the care and welfare network, where appropriate, to meet the individual physical, emotional and psychosocial needs of women and to ensure safety where there is a risk of family violence, child abuse or neglect.

The *MCH Service Guidelines* and *Health professionals working together to keep children safe*[1] provide advice on processes and tools that services can utilise to assist them in the care and protection of vulnerable families.

Examples of good practice to promote continuity of care

Health services and MCH services undertake a comprehensive assessment of vulnerable families to support the early identification and ongoing monitoring of physical, emotional, psychological and social risk factors for the family.

11 Continuity of Care

There is:

- an overlapping period of care between the health service and MCH service to ensure there is no period without care for a family
- joint care planning in the antenatal period and/or prior to discharge with the family
- engagement of the MCH service with a family prior to the birth of the baby
- engagement of community or hospital-based service professionals where they have case coordination or case management responsibilities for the family
- inclusion of ACCHOs in communications between health service and MCH staff, where appropriate for vulnerable Aboriginal families.
- sharing of more detailed information between services to support the transition of care from hospital to community-based services including:
  - details of the birth and the baby's health status
  - carer's details and other information as found on the birth notice
  - discharge strengths and concerns
  - requirement of an interpreter
  - anticipated discharge date if in a specialist care unit
  - postnatal care planning undertaken
  - domiciliary midwife visiting schedule
  - details of other services involved with the family
  - referrals made to other health professionals or organisations
  - involvement of Child Protection and contact details of the relevant Child Protection service[2]
  - information relevant to worker safety issues.

[2] Child Protection is the Victorian Government agency that protects children at risk of significant harm. Child Protection has statutory powers and can use these to protect a child.

5. Family sensitive and inclusive practice

Families experiencing extended post-birth engagement with health services
For a range of reasons, some families may remain engaged with a health service for an extended period of time after the birth of their baby. This may include extended hospital stays for either the mother or baby, engagement with specialist units to address specific post-birth issues or other forms of additional support. For these families, more intensive, sustained and coordinated care by health services and MCH services than usual is often required.

Effective coordination between health services and MCH services will:

- ensure the needs of the family unit can be most effectively addressed
- minimise additional pressures on the family
- avoid service duplication
- support positive relationships between the family and the professionals supporting them at this critical time
- supports seamless transitions between care providers

Examples of good practice to promote continuity of care

Health services provide the relevant MCH service with details of a family's extended engagement arrangements with services. This includes communication of expected discharge dates, planned service engagements and any relevant information regarding the health and wellbeing of the family and the child.

Babies requiring care in a special care nursery or neonatal intensive care unit
Following birth, most newborns do not require medical care. However, some will require additional care that is not appropriate or possible to be provided at their mother's bedside. A premature or unwell baby may spend varying lengths of time in a special care nursery or neonatal intensive care unit (NICU). Should only a short stay be required, the baby may return to the general maternity ward prior to discharge to support the principle of keeping mother and baby together.

Other babies may remain in the special care nursery or NICU after the mother has been discharged. Depending on the baby's needs, at times it may also be necessary to transfer a baby to another hospital to ensure the appropriate level of care.

Babies experiencing stays in a special care nursery or NICU require comprehensive discharge and care planning which may include Hospital in the Home (HITH) or domiciliary services over an extended period of time. Good communication between all staff is encouraged to ensure adequate care and support for these babies and their families.

Examples of good practice to promote continuity of care

For babies who have experienced a longer stay in a special care nursery or NICU health services provide the MCH service with information: • the baby's health care needs • details of any planned transfer including contacts at the receiving hospital • details of the doctors who have looked after the family at hospital • any specific needs of the family, for example access to an interpreting service, alcohol counsellor or other specialist or support services. • schedules for home visits by HITH or domiciliary services.

For babies with significant ongoing health needs, staff in the SCN or NICU complete the Health and Development Record in detail and include essential documents such as the neonatal health record, discharge plan and discharge summary letter.

13 Continuity of Care

The MCH nurse may choose to visit the family prior to discharge to support them in planning for the baby's home arrival and to attend to any immediate health needs or appointments.

Families experiencing a stillbirth/neonatal death

In the event of a family experiencing a stillbirth/neonatal death, it is important that maternity and MCH services collaborate to help ensure appropriate care and support can be offered.

Examples of good practice to promote continuity of care

If the family has experienced a stillbirth or neonatal death, as early as possible, health services notify the MCH service in the area in which the family resides.

For example, health services telephone the local government MCH coordinator and directly inform them of the circumstances of the stillbirth or neonatal death before sending the birth notice or as soon as practicable. This will ensure appropriate and sensitive communication with the family occurs.

Supporting vulnerable families

Families may lose engagement with or withdraw from services offered to them as a result of finding the transfer process from hospital to home problematic. This risk may be heightened if the family is also experiencing additional stresses.

Families may choose, for a range of reasons, to decline postnatal home-based care following discharge from hospital. Health services and the MCH service should exercise discretion to avoid disadvantaging women and families in the case of individual choice, misunderstanding and other extenuating circumstances.

Examples of good practice to promote continuity of care

The health service telephones the MCH nurse highlighting the health service's concerns about the family. It may also include an initial joint home visit from health service staff with the MCH nurse to assist in a smooth transition.

Where home-based postnatal care is declined during a family's time in hospital, health services document this in the hospital-based patient record. Where health services have identified a potential risk to the family or baby and they decline the offer of a home visit, the relevant MCH service is notified.

Reasonable attempts are made by the MCH nurse to contact a family who may not be present on the day of an agreed postnatal home-based visit, or their nominated GP, to arrange another visit at a time that is convenient. These attempts are recorded on the MCH-centre based record.

Failure to gain entry into a home after concerted effort may indicate the presence of factors relevant to the safety of the baby.

Nurses and midwives are legally obligated under the *Children Youth and Families Act 2005* to make a *mandatory report* to the Department of Health and Human Services (**DHHS**) Child Protection where, in the course of practising their profession, they form a reasonable belief that a child has suffered or is likely to

suffer significant harm as a result of physical injury and/or sexual abuse, and the child's parents have not protected or are unlikely to protect the child from that harm.

A report to DHHS Child Protection may also be made by any person, even if it is not mandatory to do so, where there are *other protective concerns* for a child including, concerns of harm to the child's emotional/psychological development, or their physical development / health,

Where a person forms a *significant concern for the wellbeing of a child or an unborn child* this concern may be reported to DHHS Child Protection or referred to community based child and family services - ChildFIRST.

15 Continuity of Care

6. Cultural responsiveness

Cultural awareness is an appreciation of cultural difference and cultural diversity. For health professionals, this refers to awareness that cultural differences may necessitate an altered approach to care[xi].

Cultural safety builds on the concept of cultural awareness and is based on the basic human rights of respect, dignity and empowerment, safety and autonomy. Providing services that are culturally safe and inviting is essential to optimising health outcomes for Victorian families[xii].

A culturally responsive healthcare system is one where there is acceptance and respect for cultural diversity[xiii]. Such a system has processes in place to support clinicians to provide care that ensures the cultural perspective of the woman and her family is at the centre of all interactions and care. The system supports efforts to design, implement and evaluate service delivery to meet the needs of different population groups and address health disparities[xiv].

The first step to providing culturally safe care for Aboriginal and Torres Strait Islander families is for health services and MCH services to ask all women during their first visit:

1. Are you of Aboriginal or Torres Strait Islander origin?
2. Is your baby of Aboriginal or Torres Strait Islander origin?

Aboriginal women and families can be referred to culturally sensitive services such as the Aboriginal Hospital Liaison Officer, Aboriginal Health Worker (within the health service) or a Koori Maternity Service located in an Aboriginal Community Controlled Health Organisation (see Aboriginal agencies section below). A woman's choice to accept or refuse referral to these services should be respected[xv].

Examples of good practice to promote continuity of care

Health services and MCH services work to strengthen cultural responsiveness to support continuity of care by:

- embedding culturally safe practices within a service's quality improvement framework at an organisational level.
    - Good communication, building sound relationships with culturally diverse families, engaging bi-cultural workers where available and appropriate and acknowledging cultural preferences is recommended[1]. For example information relating to a family's cultural needs and preferences relevant to their care should be documented and communicated between services so that appropriate care can be provided from the outset.
- providing regular, relevant and ongoing cultural responsiveness training to all staff.
    - It is important that care is delivered by culturally aware staff with experience in comprehensive assessment as well as knowledge of health issues impacting upon people from different cultures and the support services available to them.

For more information on how health services and MCH services can make their service culturally responsive, they may like to refer to the Victorian Governments Aboriginal Inclusion Matrix[xvi] and the DHHS *Cultural responsiveness framework: Guidelines for Victorian health services.* (http://www.health.vic.gov.au/diversity/cald.htm)

Aboriginal agencies

Working in partnership with Aboriginal agencies can improve services' capacity to engage with families and be responsive to their needs. Some agencies provide direct care services while others provide advocacy services only.

The Koori Maternity Service program aims to improve access to culturally appropriate maternity care for women. There are currently 14 Koori Maternity Services across Victoria providing assistance to women and their families. Of these, 11 Koori Maternity Services are located in Aboriginal Community Controlled Health Organisations (ACCHOs) and three Koori Maternity Service program-based models have been established in public health services.

Victorian ACCHOs are community controlled, multifunctional service delivery centres offering services in aged care and disability, housing, drug and alcohol management, legal and justice support and the prevention of family violence. ACCHOs also offer cultural, social and emotional wellbeing programs. Each ACCHO is governed by its own board of management. The ACCHO board is responsible for ensuring the Koori Maternity Service is responsive to the community's needs and is transparent, accountable, sustainable and effective.

ACCHOs facilitate relationships with other service providers as required, including MCH services, to meet individual needs of women and their families by broadening the range of services available to women in the postnatal period and beyond.

Translations and interpreting services

Interpreting services should be provided where required to enable women and their families to ask questions and seek additional advice. It is not acceptable for family, friends or children to interpret complex or sensitive information or to interpret in situations involving critical information and decision making. [xvii]

The Victorian Government provides a practical guide to using interpreting services to ensure effective communication between service providers and clients. This guide can be found at: http://www.multicultural.vic.gov.au/projects-and-initiatives/improving-language-services/standards-and-guidelines

Examples of good practice to promote continuity of care

To ensure equitable access, health and MCH services should:

- provide families who require an interpreter with access to accredited interpreting services including for postnatal care appointments, including home visits.
- provide accessible, culturally appropriate and translated written health information. include details of interpreting services on birth notifications to enable the MCH service to engage interpreting services prior to their first contact with the family.

17 Continuity of Care

7. Information sharing and privacy

Health records

The recording of accurate, complete and timely information about a family and baby is important to the provision of safe and appropriate care (*Australian Commission on Safety and Quality in Healthcare, 2010*).

To enable a seamless transition for the family and help ensure continuity of care, important personal medical information may be passed from one service to another. Sharing and effective transfer of information from health services to MCH services as well as other care providers is important to ensure safety and quality of care[xviii]. For example, providing information about the baby's breastfeeding status and plan could be crucial to providing ongoing support to enable the family to continue breastfeeding and reduce the risk of breastfeeding cessation.

Health services may disclose information only in accordance with the *Privacy and Data Protection Act 2014* (Cth) and *Health Records Act 2001* (Vic) **Victorian privacy law**. Health services may disclose information to another health service with the client's **consent,** or otherwise only as permissible by Victorian privacy law.

Importantly, health services may also disclose information to **DHHS**, without consent, pursuant to the *Children Youth and Families Act 2005* (Vic) as follows:

- **mandatory report of physical or sexual abuse:** nurses and midwives are 'mandatory reporters', and accordingly must report child physical or sexual abuse to DHHS
- **concern about wellbeing of a child** (not mandatory): any person that has significant concerns for the wellbeing of a child or unborn child may reports these concerns to DHHS Child Protection or ChildFIRST
- **upon DHHS request:** when an authorised DHHS officer asks any person for information that the DHHS officer reasonably believes is relevant to the protection or development of the child.

This does not constitute a breach of Victorian privacy law.

Guidance on the collection and storage of patient information is available from the Public Records Office of Victoria at http://www.prov.vic.gov.au

Examples of good practice to promote continuity of care

All collected information is managed in accordance with legislative requirements including Victorian privacy law. Health services respect the family's privacy and operate within the parameters of the *Privacy and Data Protection Act 2014*and the *Health Records Act 2001* in the management, release and sharing of a patient's health information between service providers.

Documentation includes details of all referrals, consultations and decisions relevant to the ongoing care and support of the family including the consent for care, any clinical and psycho-social issues, risk and protective factors and community supports.

A written record of the care and planning provided is kept by both the family (for example in the form of the Victorian Maternity Record and in relation to the baby in, the My Health and Development Record as discussed below) and by health providers (in the form of the woman's health record or MCH centre record).

Health professionals are conscious of, and use, current and evolving communication mechanisms including paper-based and electronic records, and transfer documentation. Health services and the MCH service agree on a suitable method of information transfer to support continuity of care [insert possible case study here].

Birth notification and registration

The *Child Wellbeing and Safety Act 2005* articulates that health services should provide notice of a birth to the woman's local council within 48 hours for the purpose of notifying the relevant MCH service. The *Births, Deaths and Marriages Registration Act 1996* requires health services to provide notice of a birth to the Victorian Registry of Births, Deaths and Marriages (the Registry) within 21 days of a birth.

Health services typically provide families with a birth registration statement. Families are required to lodge the statement with the Registry within 60 days of the child's birth.

Examples of good practice to promote continuity of care

Birth notices posted, emailed or faxed to the appropriate LGA for distribution to the appropriate MCH nurse in the family's locality, as designated by the LGA. It is essential that health service staff obtain the correct address and telephone numbers for where the baby's family will be living before sending this information to the LGA.

Where appropriate, health service staff and MCH nurses providing care in the postnatal remind families to lodge their birth registration statement and if appropriate, reiterate the importance of registering the birth of their child. The **My Health and Development Record** includes reminders for MCH nurses to ask families if they have registered their child's birth at their two-, four- and eight-week consultations.

My Health and Development Record

The *My Health and Development Record* (the Record) provides families with sufficiently detailed information regarding the baby to take to the first and subsequent MCH appointments and to other hospital or community-based services if required. The Record is important communication tool and source of information about the baby.

Examples of good practice to promote continuity of care

Health service staff complete the relevant sections of the Record including any additional hospital discharge information and any treating doctor's summary. Staff ensure the Record contains MCH service contact information for the family, postnatal midwife visits and other scheduled appointments. Health service contact details are provided in the record for the MCH nurse to contact hospital staff to ensure continuity of care.

Supporting vulnerable families

Whilst timely registration occurs for the majority of babies born in the Victorian community, disadvantaged background is a common theme for late registration or non-registration of a birth (*Victorian Law Reform Commission, 2013*). It is current practice for the Registry to send a reminder letter to the parent/s of the child when the Registry has not received a birth registration statement within the prescribed 60 days (*Victorian Law Reform Commission, 2013*).

19 Continuity of Care

Appendices - placeholder

- Useful resources
- Legislation
- Child Protection information:
- It is important to note that the *Children Youth and Families Act 2005,* provides protection from legal liability for persons who make reports to DHHS Child Protection or referrals to ChildFIRST. Under the Act a report made in good faith:
    - does not for any purpose constitute unprofessional conduct or a breach of professional ethics on the part of the person by whom it is made; and
    - does not make the person by whom it is made subject to any liability in respect of it.
- In practice, reporters should not disclose to third parties (such as the child's parents) that they have made a report. The *Children Youth and Families Act 2005* provides that the identity of a reporter to DHHS Child Protection or ChildFIRST should remain confidential. If there are court proceedings in relation to the child, the identity of the reporter should not be disclosed unless the Court specifically permits it to be disclosed, or the reporter consents in writing.

References

[i] *Haggerty, Reid, Freeman, Starfield, Adair and McKendry, 2003*
[ii] *Improving maternity services in Australia; A discussion paper from the Australian Government, 2008*
[iii] *Homer, Henry, Schmied, Kemp, Leap and Briggs, 2009*
[iv] *National Maternity Services Plan, 2011, pp. 14*
[v] *National Maternity Services Plan, 2011, pp. 14*
[vi] *Wellingham, Tracey, Rea, Gribben, 2003*
[vii] *National Health and Medical Research Council, 2010*
[viii] *National Collaborating Centre for Primary care, 2006*
[ix] *Health care that counts: A framework for vulnerable children, 2015*
[x] *National Maternity Services Plan, 2011*
[xi] *Aboriginal Competence Framework, 2008*
[xii] *Phiri, Dietsch, E, Bonner, 2010*
[xiii] Aboriginal Competence Framework, 2008
[xiv] Cultural responsiveness framework: Guidelines for Victorian Health Services, 2011
[xv] State Government of Victoria, *Resource Guide: Improving identification of Aboriginal and Torres Strait Islander babies in Victorian maternity services*, 2015.
[xvi] Victorian Governments Aboriginal Inclusion Matrix
http://www.dpc.vic.gov.au/images/documents/Aboriginal_Affairs/Aboriginal-Inclusion-Framework-Matrix-Nov-2011.pdf
[xvii] State Government of Victoria, *Using Interpreter Services, Victorian Government Guidelines on Policy and Procedures.*
[xviii] (*Haller, Garnerin, Morales, Pfister, Berner, Irion, Clergue and Kern, 2008*

21 Continuity of Care