Queensland Clinical Guidelines

Translating evidence into best clinical practice

Maternity and Neonatal **Clinical Guideline**

Guideline supplement: Perinatal care of the extremely preterm baby

Queensland Government

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1 Introduction

This document is a supplement to the Queensland Clinical Guideline (QCG) Perinatal care at extremely low gestation. It provides supplementary information regarding guideline development, makes summary recommendations, suggests measures to assist implementation and quality activities and summarises changes (if any) to the guideline since original publication. Refer to the guideline for abbreviations, acronyms, flow charts and acknowledgements.

1.1 Funding

The development of this guideline was funded by Healthcare Improvement Unit, Queensland Health. The consumer representative was paid a standard fee. Other working party members participated on a voluntary basis.

1.2 Conflict of interest

Declarations of conflict of interest were sought from expert panel members as per the Queensland Clinical Guidelines *Conflict of Interest* statement. No conflicts of interest were declared.

1.3 Review process

This version of the guideline followed the QCG peer review process.

1.4 Summary of changes

Queensland clinical guidelines are reviewed every 5 years or earlier if significant new evidence emerges. Table 1 provides a summary of changes made to the guidelines since original publication.

Table 1. Summary of change

Publication date *Endorsed by:*	**Identifier**	**Summary of major change**
September 2014	MN14.32-V1-R19	First publication
September 2020 *Statewide Maternity and Neonatal Clinical Network (QLD)*	MN20.32-V2-R25	Peer review. • Title changed from *Perinatal care at the threshold of viability* to *Perinatal care of the extremely preterm baby* • Term *threshold of viability* discontinued throughout guideline • Section 1: Introduction o Added information about international trends; Updated Queensland data • Section 2.6 Counselling o Added emotional wellbeing • Section 4.1 o Updated outcome data from ANZNN • Section 4.2 o Updated definition of severe impairment and intellectual disability • Section 5.2: Antenatal corticosteroids o Added evidence of benefit at lower gestations • Section 5.6 Care at birth o Added evidence for delayed cord clamping • Section 5.7: Resuscitation at birth o Amended less than 23+0 weeks FROM: not recommended TO: not usually recommended o Added Palliative care is usually recommended o Deleted for 23+0–23+6 weeks ‘Life sustaining interventions not usually recommended’ o Added for 23+0–23+6 weeks ‘Recommend counselling by practitioners experienced in the care of extremely premature babies’ • Section 6.1: Symptom management o Updated assessment of pain and discomfort o Replaced medicine details with reference to relevant NeoMedQ monographs • Appendices: o Updated with current information

Publication date *Endorsed by:*	**Identifier**	**Summary of major change**
		• Flow charts o Updated to align with content changes • References reviewed and updated • Minor formatting and branding

2 Methodology

Queensland Clinical Guidelines (QCG) follows a rigorous process of guideline development. This process was endorsed by the Queensland Health Patient Safety and Quality Executive Committee in December 2009. The guidelines are best described as 'evidence informed consensus guidelines' and draw from the evidence base of existing national and international guidelines and the expert opinion of the working party.

2.1 Topic identification

The topic was identified as a priority by the Queensland Clinical Guidelines Steering Committee in 2010.

2.2 Scope

The scope of the guideline was determined using the following framework.

Table 2. Scope framework

Scope framework	
Population	• Babies born before 25+6 weeks gestation • Pregnant women with gestations less than 25+6 weeks
Purpose	Identify evidence related to: • Good communication and relevant ethical and legal principles that inform decision making • Maternal, fetal and environmental factors affecting outcomes and long-term prognosis • Assessment and management of the woman and fetus during labour and the immediate postnatal period
Outcome	Support: • Best practice management during pregnancy, labour and postpartum • A consistent approach across Queensland to the counselling, management and early identification of newborns with extreme low gestation
Exclusions	• Care and treatment of a very preterm baby and their family beyond initial resuscitation • Care of the stillborn baby • Detailed discussion of ethical principles/positions

2.3 Clinical questions

The following clinical questions were generated to inform the guideline scope and purpose:

- What promotes and supports effective communication between all stakeholders when birth at extremely low gestation is anticipated/occurs?
- What factors influence critical care decision making when birth at extremely low gestation is anticipated/occurs?
- What care is appropriate when birth at extremely low gestation is anticipated/occurs?

2.4 Search strategy

A search of the literature was conducted during January-–September 2019. The QCG search strategy is an iterative process that is repeated and amended as guideline development occurs (e.g. if additional areas of interest emerge, areas of contention requiring more extensive review are identified or new evidence is identified). All guidelines are developed using a basic search strategy. This involves both a formal and informal approach.

Table 3. Basic search strategy

Step		Consideration
1.	Review clinical guidelines developed by other reputable groups relevant to the clinical speciality	• This may include national and/or international guideline writers, professional organisations, government organisations, state based groups. • This assists the guideline writer to identify: o The scope and breadth of what others have found useful for clinicians and informs the scope and clinical question development o Identify resources commonly found in guidelines such as flowcharts, audit criteria and levels of evidence o Identify common search and key terms o Identify common and key references
2.	Undertake a foundation search using key search terms	• Construct a search using common search and key terms identified during Step 1 above • Search the following databases o PubMed o CINAHL o Medline o Cochrane Central Register of Controlled Trials o EBSCO o Embase • Studies published in English less than or equal to 5 years previous are reviewed in the first instance. Other years may be searched as are relevant to the topic • Save and document the search • Add other databases as relevant to the clinical area
3.	Develop search word list for each clinical question.	• This may require the development of clinical sub-questions beyond those identified in the initial scope. • Using the foundation search performed at Step 2 as the baseline search framework, refine the search using the specific terms developed for the clinical question • Save and document the search strategy undertaken for each clinical question
4.	Other search strategies	• Search the reference lists of reports and articles for additional studies • Access other sources for relevant literature o Known resource sites o Internet search engines o Relevant text books

2.4.1 Keywords

The following keywords were used in the basic search strategy: viability, perinatal viability, preterm gestation, extremely low gestation, grey zone, threshold of viability, extremely preterm
Other keywords may have been used for specific aspects of the guideline.

2.5 Consultation

The clinical guideline was developed using the QCG peer review process.

Table 4. Guideline development processes

Process	Activity
Original development	• Original consultative and development processes occurred between November 2013 and June 2014. • This included formation of a working party and statewide consultation as per usual QCG process • A survey of clinician opinion was also conducted
Decision for peer review	• A review of the guideline scope, clinical questions and current literature was undertaken in November 2019 • Areas of clinical practice change were identified • Clinical leads o Reviewed the previous scope and version of the guideline o Reviewed identified areas of clinical practice change o Confirmed aspects of the guideline for update and new inclusions o Reached consensus agreement that a peer review process was appropriate
Consultation	• Expert clinicians and a consumer representative were identified by the clinical leads and invited to peer review the updated guideline in May 2020 • All invited members accepted

2.6 Endorsement

The guideline was endorsed by the:

- Queensland Clinical Guidelines Steering Committee in September 2020
- Statewide Maternity and Neonatal Clinical Network [Queensland] in September 2020

2.7 Citation

The recommended citation of Queensland Clinical Guidelines is in the following format:

> Queensland Clinical Guidelines. [**Insert Guideline Title**]. Guideline No. [**Insert Guideline Number**]. Queensland Health. [**Insert Year of Publication**]. Available from: www.health.qld.gov.au/qcg.
>
> **EXAMPLE:**
> Queensland Clinical Guidelines. Normal birth. Guideline No. MN17.25-V3-R22. Queensland Health 2017. Available from: www.health.qld.gov.au/qcg.

3 Levels of evidence

The levels of evidence identified by the GRADE system were used to inform the summary recommendations. Levels of evidence are outlined in Table 5. Levels of evidence (GRADE)and Summary recommendations are outlined in **Error! Reference source not found.**

Note that the 'consensus' definition in Table 5. Levels of evidence (GRADE) relates to forms of evidence that are not identified by the GRADE system and/or that arise from the clinical experience of the guideline's clinical lead(s) and working party

Table 5. Levels of evidence (GRADE)

Grade Levels of evidence	
1++	Evidence obtained from high quality meta-analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias.
1+	Evidence obtained from well conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias.
1	Evidence obtained from meta-analyses, systematic reviews or RCTs, or RCTs with a high risk of bias.
2++	Evidence obtained from high quality systematic reviews of case-control or cohort studies *or* high quality case-control or cohort studies with a very low risk of confounding, bias, or chance and a high probability that the relationship is causal.
2+	Evidence obtained from well conducted case-control or cohort studies with a low risk of confounding, bias, or chance and a moderate probability that the relationship is causal.
2-	Evidence obtained from case-control or cohort studies with a high risk of confounding, bias, or chance and a significant risk that the relationship is not causal.
3	Evidence obtained from non-analytic studies, e.g. case reports, case series.
4	Expert opinion.
Consensus	Agreement between clinical lead, working party and other clinical experts.

3.1 Summary recommendations

Summary recommendations and levels of evidence are outlined in Table 5.

Table 6. Summary recommendations

Recommendation		Grading of evidence
1	Use a family centred approach to the planning, delivery and evaluation of care.	**Consensus**
2	Using a multidisciplinary approach and in conjunction with the family, develop a plan of care at the earliest opportunity. Reassess the plan frequently with the family and document all decisions.	**Consensus**
3	If live birth occurs and resuscitation is unsuccessful or is not planned, provide palliative care.	**Consensus**
4	Where preterm birth before 26+0 weeks gestation is considered very likely and where life sustaining interventions are planned or may be a possibility, recommend in-utero transfer to a level 6 facility[1,2]	**2+**
5	Recommend magnesium sulfate to women at risk of preterm birth before 30+0 weeks gestation where birth is imminent and life sustaining interventions are planned or may be a possibility[3]	**I+**
6	Recommend corticosteroids to women who are at risk of preterm birth where life sustaining interventions are planned or may be a possibility[4]	**I+**
7	Counsel women that there is limited evidence for CTG interpretation at gestations less than 28 weeks.	**Consensus**
8	Caesarean section for fetal indication is: • Not recommended at less than 24+0 weeks gestation • Not usually recommended between 24+0 and 24+6 weeks gestation • May be recommended from 25+0 weeks gestation depending on individual circumstances	**Consensus**
9	Where gestation is uncertain, initiate life sustaining interventions until the clinical course is clearer.	**Consensus**
	At less that 23+0 weeks gestation, palliative care is generally recommended	**Consensus**
10	Consider individual circumstances when making recommendations about initiation of life sustaining interventions for babies born between 23+0 and 23+6 weeks gestation	**Consensus**
11	Between 24+0 and 24+6 weeks gestation, life sustaining interventions are generally recommended.	**Consensus**
12	Life sustaining interventions are recommended for all normally formed babies at gestations greater than or equal to 25+0 weeks.	**Consensus**
13	Individualise palliative care and bereavement support in a manner that promotes the comfort of the baby and the creation of positive memories for the family.	**Consensus**

4 Implementation

This guideline is applicable to all Queensland public and private maternity facilities. It can be downloaded in Portable Document Format (PDF) from www.health.qld.gov.au/qcg

4.1 Guideline resources

The following guideline components are provided on the website as separate resources:

- Flowchart: Antenatal care where birth imminent or indicated at less than 25 weeks and 6 days
- Flowchart: Consensus approach to resuscitation at extremely low gestation in Queensland
- Education resource: Perinatal care at extremely low gestation
- Knowledge assessment: Perinatal care at extremely low gestation
- Auditing resources: Perinatal care at extremely low gestation
- Parent information: Babies born very early

4.2 Suggested resources

During the development process stakeholders identified additional resources with potential to complement and enhance guideline implementation and application. The following resources have not been sourced or developed by QCG but are suggested as complimentary to the guideline:

- Care plan templates (e.g. antenatal care plans, palliative care)
- Recognised clinician training programs relevant to perinatal care

4.3 Implementation measures

Suggested activities to assist implementation of the guideline are outlined below.

4.3.1 Implications for implementation

The following areas may have implications for local implementation of the guideline recommendations. It is suggested they be considered for successful guideline implementation.

- Economic considerations including opportunity costs
- Human resource requirements including clinician skill mix and scope of practice
- Clinician education and training
- Equipment and consumables purchase and maintenance
- Consumer acceptance
- Model of care and service delivery

4.3.2 QCG measures

- Notify Chief Executive Officer and relevant stakeholders
- Monitor emerging new evidence to ensure guideline reflects contemporaneous practice
- Capture user feedback
- Record and manage change requests

4.3.3 Hospital and Health Service measures

Initiate, promote and support local systems and processes to integrate the guideline into clinical practice, including:

- Hospital and Health Service (HHS) Executive endorse the guidelines and their use in the HHS and communicate this to staff
- Promote the introduction of the guideline to relevant health care professionals
- Support education and training opportunities relevant to the guideline and service capabilities
- Align clinical care with guideline recommendations
- Undertake relevant implementation activities as outlined in the *Guideline implementation checklist* available at www.health.qld.gov.au/qcg

4.4 Quality measures

Auditing of guideline recommendations and content assists with identifying quality of care issues and provides evidence of compliance with the National Safety and Quality Health Service (NSQHS)Standards[5] [refer to Table 7. NSQHS Standard 1]. Suggested audit and quality measures are identified in Table 8. Clinical quality measures.

Table 7. NSQHS Standard 1

NSQHS Standard 1: Clinical governance	
Clinical performance and effectiveness	
Criterion 1.27:	**Actions required:**
Evidence based care	a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice
	b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care

The following clinical quality measures are suggested:

Table 8. Clinical quality measures

No	Audit criteria	Guideline Section
1.	Proportion of families at risk of preterm birth who have a formal plan of care developed prior to birth *Consider frequency of review and update* *Involvement of the parents in development*	Section 2.4 Decision making
2.	Proportion of preterm births less than 26+0 weeks gestation occurring in level 1-5 neonatal services, (where life sustaining interventions were planned or considered a possibility) *Consider reasons for non-transfer to a level 6 facility (e.g. transport unavailable, rapid progression to birth)*	Section 5.1 In-utero transfer
3.	The proportion of women with preterm labour at less than 34+0 weeks who received corticosteroid therapy *Consider: Were repeat doses administered if risk of preterm birth continued beyond 7 days*	Section 5.2 Antenatal corticosteroids
4.	The proportion of women with preterm labour at less than 30+0 weeks of gestation who received Magnesium Sulfate *Consider adherence to locally agreed protocols*	Section 5.3 Magnesium sulfate for neuroprotection
5.	Proportion of families who experienced a perinatal death who are counselled about post-mortem examination *Consider the clinical experience/expertise of the person providing the counselling*	Section 6 Palliative care
6.	Proportion of perinatal deaths where post-mortem examination is undertaken *Consider if counselling was offered/provided*	Section 6 Palliative care
7.	Proportion of babies receiving palliative care who were assessed for pain using recognised pain scales *Consider: Frequency of assessment, frequency, type and route of administration of medications*	Section 6.1 Symptom management
8.	Proportion of health professionals who have completed a recognised training program or education in perinatal care, mortality, palliative care or related field *Consider attendance rates at for example: IMPROVE (Improving Perinatal Mortality Review and Outcomes Via Education) workshop*	Section 1.3 Clinical standards

4.5 Areas for future research

During development the following areas where identified as having limited or poor quality evidence to inform clinical decision making. Further research in these areas may be useful.

- Long term outcomes at follow-up of babies born at extremely low gestation
- Influence of mode of birth on outcomes

4.6 Safety and quality

In conjunction with the Queensland Clinical Guideline *Standard care*[6], implementation of this guideline provides evidence of compliance with the National Safety and Quality Health Service Standards and Australian Council on Healthcare Standards (ACHS) Evaluation and Quality Improvement Program (EQuIP) National accreditation programs.[5,7]

Table 9. NSQHS/EQuIPNational Criteria

NSQHS/EQuIPNational Criteria	Actions required	☑ Evidence of compliance
NSQHS Standard 1: Clinical governance		
Patient safety and quality systems Safety and quality systems are integrated with governance processes to enable organisations to actively manage and improve the safety and quality of health care for patients.	**Diversity and high risk groups** 1.15 The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using its services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care	☑ Assessment and care appropriate to the cohort of patients is identified in the guideline ☑ High risk groups are identified in the guideline ☑ The guideline is based on the best available evidence
Clinical performance and effectiveness The workforce has the right qualifications, skills and supervision to provide safe, high-quality health care to patients.	**Evidence based care** 1.27 The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care	☑ Queensland Clinical Guidelines is funded by Queensland Health to develop clinical guidelines relevant to the service line to guide safe patient care across Queensland ☑ The guideline provides evidence-based and best practice recommendations for care ☑ The guideline is endorsed for use in Queensland Health facilities. ☑ A desktop icon is available on every Queensland Health computer desktop to provide quick and easy access to the guideline
	Performance management 1.22 The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system	☑ The guideline has accompanying educational resources to support ongoing safety and quality education for identified professional and personal development. The resources are freely available on the internet http://www.health.qld.gov.au/qcg
Patient safety and quality systems Safety and quality systems are integrated with governance processes to enable organisations to actively manage and improve the safety and quality of health care for patients.	**Policies and procedures** 1.7 The health service organisation uses a risk management approach to: a. Set out, review, and maintain the currency and effectiveness of, policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols	☑ QCG has established processes to review and maintain all guidelines and associated resources ☑ Change requests are managed to ensure currency of published guidelines ☑ Implementation tools and checklist are provided to assist with adherence to guidelines ☑ Suggested audit criteria are provided in guideline supplement

	c. Review compliance with legislation, regulation and jurisdictional requirements	☑ The guidelines comply with legislation, regulation and jurisdictional requirements
NSQHS/EQuIPNational Criteria	**Actions required**	☑ **Evidence of compliance**
NSQHS Standard 2: Partnering with Consumers		
Health literacy Health service organisations communicate with consumers in a way that supports effective partnerships.	**Communication that supports effective partnerships** 2.8 The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community 2.9 Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review 2.10 The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided on discharge	☑ Consumer consultation was sought and obtained during the development of the guideline. Refer to the acknowledgement section of the guideline for details ☑ Consumer information is developed to align with the guideline and included consumer involvement during development and review ☑ The consumer information was developed using plain English and with attention to literacy and ease of reading needs of the consumer
Partnering with consumers in organisational design and governance Consumers are partners in the design and governance of the organisation.	**Partnerships in healthcare governance planning, design, measurement and evaluation** 2.11 The health service organisation: a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community 2.14 The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce	☑ Consumers are members of guideline working parties ☑ The guideline is based on the best available evidence ☑ The guidelines and consumer information are endorsed by the QCG and Queensland Statewide Maternity and Neonatal Clinical Network Steering Committees which includes consumer membership
NSQHS Standard 4: Medication safety		
Clinical governance and quality improvement to support medication management Organisation-wide systems are used to support and promote safety for procuring, supplying, storing, compounding, manufacturing, prescribing, dispensing, administering and monitoring the effects of medicines	**Integrating clinical governance** 4.1 Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management	☑ The guideline provides current evidence based recommendations about medication

NSQHS/EQuIPNational Criteria	Actions required	☑ Evidence of compliance
NSQHS Standard 5: Comprehensive care		
Clinical governance and quality improvement to support comprehensive care Systems are in place to support clinicians to deliver comprehensive care	**Integrating clinical governance** 5.1 Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for comprehensive care b. Managing risks associated with comprehensive care c. Identifying training requirements to deliver comprehensive care **Partnering with consumers** 5.3 Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	☑ The guideline has accompanying educational resources to support ongoing safety and quality education for identified professional and personal development. The resources are freely available on the internet http://www.health.qld.gov.au/qcg ☑ The guideline provides evidence-based and best practice recommendations for care ☑ Consumer information is developed for the guideline
NSQHS Standard 6: Communicating for safety		
Clinical governance and quality improvement to support effective communication Systems are in place for effective and coordinated communication that supports the delivery of continuous and safe care for patients.	**Integrating clinical governance** 6.1 Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication **Partnering with consumers** 6.3 Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making **Organisational processes to support effective communication** 6.4 The health service organisation has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes	☑ Requirements for effective clinical communication by clinicians are identified ☑ The guideline provides evidence-based and best practice recommendations for communication between clinicians ☑ The guideline provides evidence-based and best practice recommendations for communication with patients, carers and families ☑ The guideline provides evidence-based and best practice recommendations for discharge planning and follow –up care

NSQHS/EQuIPNational Criteria	Actions required	☑ Evidence of compliance
NSQHS Standard 6: Communicating for safety (continued)		
Communication of critical information Systems to effectively communicate critical information and risks when they emerge or change are used to ensure safe patient care.	**Communicating critical information** 6.9 Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to: a. Clinicians who can make decisions about care b. Patients, carers and families, in accordance with the wishes of the patient 6.10 The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians	☑ Requirements for effective clinical communication of critical information are identified ☑ Requirements for escalation of care are identified

NSQHS/EQuIPNational Criteria	Actions required	☑ Evidence of compliance
NSQHS Standard 8: Recognising and responding to acute deterioration		
Clinical governance and quality improvement to support recognition and response systems Organisation-wide systems are used to support and promote detection and recognition of acute deterioration, and the response to patients whose condition acutely deteriorates.	**Integrating clinical governance** 8.1 Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for recognising and responding to acute deterioration b. Managing risks associated with recognising and responding to acute deterioration c. Identifying training requirements for recognising and responding to acute deterioration **Partnering with consumers** 8.3 Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making **Recognising acute deterioration** 8.4 The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to: a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient	☑ The guideline is consistent with National Consensus statements recommendations ☑ The guideline recommends use of tools consistent with the principles of recognising and responding to clinical deterioration ☑ Consumer information is developed for the guideline

EQuIP Standard 12 Provision of care		
Criterion 1: Assessment and care planning 12.1 Ensuring assessment is comprehensive and based upon current professional standards and evidence based practice	12.1.1 Guidelines are available and accessible by staff to assess physical, spiritual, cultural, physiological and social health promotion needs	☑ Assessment and care appropriate to the cohort of patients is identified in the guideline ☑ The guideline is based on the best available evidence

5 References

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