

Queensland Clinical Guidelines

Translating evidence into best clinical practice

Maternity and Neonatal **Clinical Guideline**

Guideline supplement: Intrapartum fetal surveillance (IFS)

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1 Introduction

This document is a supplement to the Queensland Clinical Guideline (QCG) *Intrapartum fetal surveillance (IFS)*. 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. Consumer representatives were 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 working party members as per the Queensland Clinical Guidelines [Conflict of Interest](#) statement. No conflict of interest was identified.

1.3 Review process

- A review of the guideline scope, clinical questions and current literature was undertaken in September 2019.
- The clinical lead was consulted and reviewed the previous version of the guideline.
- The QCG steering committee and SMNCN re-endorsed the guideline and supplement.

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 <i>Endorsed by:</i>	Identifier	Summary of major change
August 2010	MN1008.15-V1-R13	First publication
August 2011	MN10.15-V2-R15	Review date extended. Identifier updated. Program name updated. Amendment to Appendix A: Reduced and Absent baseline variability—added “For longer than 40 minutes” to end of each definition
November 2012	MN10.15-V3-R15	Section 2.1 Antenatal risk factors. Amended to include diabetes/gestational diabetes on <i>oral hypoglycaemics</i>
June 2015	MN.15.15-V4-R20	Changes to risk factors requiring continuous CTG monitoring in labour Amendments to interpretation of CTG with regard to baseline, baseline variability and decelerations Inclusion of additional information regarding: <ul style="list-style-type: none"> • Intrapartum fetal blood sampling and paired umbilical blood gas or lactate analysis • Recommendations for documentation and clinical handover • Multiple pregnancies and preterm labour
December 2018	MN.15.15-V5-R20	To align definitions of labour with QCG <i>Normal birth</i> : Definition of terms <ul style="list-style-type: none"> • From: Early labour: Regular painful contractions (i.e. every five minutes and persisting for longer than 30 minutes) which may be associated with a show, intact membranes or some cervical changes (not full effacement), and or less than 4 cm dilatation. To: Early labour (latent first stage): Irregular painful contractions which may be associated with a show, intact membranes or some cervical changes (not full effacement), and or less than 4–6 cm dilatation. • From Established labour: Regular painful contractions (which may be associated with a show, ruptured membranes or cervical changes (full effacement, 4 cm or more dilatation). To: Established labour (active first stage): Regular painful contractions (which may be associated with a show, ruptured membranes or cervical changes (full effacement, 4–6 cm or more dilatation). <p>Table 3 Risk factors Intrapartum: From:</p> <ul style="list-style-type: none"> • Prolonged first stage of labour <ul style="list-style-type: none"> ○ Less than 0.5 cm per hour in active phase (cervix greater than or equal to 4 cm and effaced

		<ul style="list-style-type: none"> · Prolonged second stage where birth is not imminent <ul style="list-style-type: none"> ○ Greater than 1 hour in a multiparous woman ○ Greater than 2.5 hours in a primiparous woman <p>To:</p> <ul style="list-style-type: none"> · Prolonged first or second stage of labour <ul style="list-style-type: none"> ○ Refer to Queensland Clinical Guideline: <i>Normal birth</i> <p>Minor formatting updates</p>
<p>November 2019</p> <p><i>Endorsed by QCG Steering Committee</i></p>	MN19.15-V6-R24	<p>Flowchart: Abnormal fetal heart (Fetal Blood Sampling Guide) Deleted: Abnormal urgent birth and pH and lactate values</p> <p>Table 2 Facility responsibilities Added to Systems row</p> <ul style="list-style-type: none"> · Refer to Appendix A Interpretation of CTG <ul style="list-style-type: none"> ○ Using a <i>traffic light</i> system can assist effective interpretation of a CTG <p>Table 5 Principles of intermittent auscultation Added to Transition to continuous monitoring–</p> <ul style="list-style-type: none"> · Hypertension: <ul style="list-style-type: none"> ○ Systolic greater than or equal to 160 mmHg or diastolic greater than or equal to 110mmHg between contractions or ○ Systolic greater than or equal to 140 mmHg or diastolic greater than or equal to 90mmHg on two consecutive readings taken 30 minutes apart between contractions · Hypertonus or tachysystole · Confirmed delay in first or second stage of labour <p>Table 14 Intrapartum fetal blood sampling Acute meningoencephalitis deleted from risks</p> <p>Section 7 Other methods of fetal monitoring From: Intrauterine pressure catheters (IUPC) To: Intrauterine pressure catheters (IUPC) may be considered for use on obese women where palpation of contractions is difficult</p> <p>Minor formatting</p> <p>Reference to <i>Standard care</i> guideline added</p> <p>Relevant references updated</p>
December 2019	MN19.15-V7-R24	<ul style="list-style-type: none"> · ‘Hypersystole’ replaced with ‘tachysystole’ in flowchart <i>Mode of fetal monitoring</i> and Appendix B

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 Statewide Maternity and Neonatal Clinical Network at a forum in 2009.

2.2 Scope

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

Table 2. Scope framework

Scope framework	
Population	Pregnant women during the intrapartum period
Purpose	Identify relevant evidence related to: <ul style="list-style-type: none"> · Risk factors (antenatal and intrapartum) indicative of the need for IFS · Clinical surveillance during the intrapartum period
Outcome	Support: <ul style="list-style-type: none"> · Accurate assessment of antenatal and intrapartum risk factors · Implementation of best practice intrapartum fetal surveillance protocols · Early detection of fetal compromise
Exclusions	<ul style="list-style-type: none"> · How to use CTG machines · Antenatal fetal surveillance

2.3 Clinical questions

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

- What risk factors may indicate an increased risk for intrapartum fetal compromise
- What clinical surveillance recommendations are indicated for women without risk factors during the intrapartum period?
- What clinical surveillance recommendations are indicated for women with risk factors during the intrapartum period?
- What are the modes of IFS?
- What is best practice with regards to CTG interpretation and subsequent action?
- What are the features of a normal CTG?
- What are the features and management of an abnormal CTG?
- What additional tests may be performed?
- What are the special considerations for multiple pregnancies and preterm labours?

2.4 Search strategy

A search of the literature was conducted during December 2014 and January 2015. A further search was conducted in 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	<ul style="list-style-type: none"> • This may include national and/or international guideline writers, professional organisations, government organisations, state based groups. • This assists the guideline writer to identify: <ul style="list-style-type: none"> ○ The scope and breadth of what others have found useful for clinicians and informs the scope and clinical question development ○ Identify resources commonly found in guidelines such as flowcharts, audit criteria and levels of evidence ○ Identify common search and key terms ○ Identify common and key references
2.	Undertake a foundation search using key search terms	<ul style="list-style-type: none"> • Construct a search using common search and key terms identified during Step 1 above • Search the following databases <ul style="list-style-type: none"> ○ PubMed ○ CINAHL ○ Medline ○ Cochrane Central Register of Controlled Trials ○ EBSCO ○ 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Search the reference lists of reports and articles for additional studies • Access other sources for relevant literature <ul style="list-style-type: none"> ○ Known resource sites ○ Internet search engines ○ Relevant text books

2.4.1 Keywords

The following keywords were used in the basic search strategy: auscultation, cardiotocograph, CTG, doppler, electronic monitoring, fetal heart, fetal monitoring, fetal surveillance, intrapartum, labour, Pinard. Other keywords may have been used for specific aspects of the guideline.

2.5 Consultation

Major consultative and development processes occurred between January 2015 and May 2015. These are outlined in Table 4. The clinical lead reviewed the guideline in October 2019 and did not recommend any changes to the guideline.

Table 4. Major guideline development processes

Process	Activity
Clinical lead	<ul style="list-style-type: none"> The nominated Clinical Lead was approved by QCG Steering Committee
Consumer participation	<ul style="list-style-type: none"> Consumer participation was invited from a range of consumer focused organisations who had previously accepted an invitation for on-going involvement with QCG
Working party	<ul style="list-style-type: none"> An EOI for working party membership was distributed via email to Queensland clinicians and stakeholders in February 2015 The working party was recruited from responses received Working party members who participated in the working party consultation processes are acknowledged in the guideline Working party consultation occurred in a virtual group via email
Statewide consultation	<ul style="list-style-type: none"> Consultation was invited from Queensland clinicians and stakeholders during March 2015–May 2015 Feedback was received primarily via email All feedback was compiled and provided to the clinical lead and working party members for review and comment
Review	<ul style="list-style-type: none"> A literature review and consultation with the clinical lead was undertaken in September–October 2019

2.6 Endorsement

The guideline was endorsed by the:

- Queensland Clinical Guidelines Steering Committee in November 2019
- Statewide Maternity and Neonatal Clinical Network [Queensland] in November 2019

2.7 Publication and recommended citation

The guideline and guideline supplement were published on the QCG website in December 2019.

The guideline can be cited as:

Queensland Clinical Guidelines. Intrapartum fetal surveillance (IFS). Guideline No. MN19.15-V7-R24. Queensland Health. 2019. Available from: <http://www.health.qld.gov.au/qcg>.

The guideline supplement can be cited as:

Queensland Clinical Guidelines. Supplement: Intrapartum fetal surveillance (IFS). Guideline No. MN19.15-V7-R24. Queensland Health. 2019. Available from: <http://www.health.qld.gov.au/qcg>.

3 Levels of evidence

The levels of evidence identified in the National Health and Medical Research Council (NHMRC), Levels of evidence and grades for recommendations for developers of guidelines (2009)¹ or the GRADE system were used to inform the summary recommendations. Levels of evidence are outlined in Table 5. Levels of evidence (NHMRC).

Note that the 'consensus' definition* in Table 5. Levels of evidence (NHMRC) is different from that proposed by the NHMRC. Instead, it relates to forms of evidence that are not identified by the NHMRC and/or that arise from the clinical experience of the guideline's clinical lead and working party. Summary recommendations are outlined in Table 6. Summary recommendations.

Table 5. Levels of evidence (NHMRC)

Levels of evidence	
I	Evidence obtained from a systematic review of all relevant randomised controlled trials.
II	Evidence obtained from at least one properly designed randomised controlled trial.
III-1	Evidence obtained from well-designed pseudo randomised controlled trials (alternate allocation or some other method).
III-2	Evidence obtained from comparative studies including systematic review of such studies with concurrent controls and allocation not randomised (cohort studies), case control studies or interrupted time series with a control group.
III-3	Evidence obtained from comparative studies with historical control, two or more single arm studies, or interrupted time series without parallel control group.
IV	Evidence obtained from case series, either post-test or pre-test and post-test.
Consensus*	Opinions based on respected authorities, descriptive studies or reports of expert committees or clinical experience of the working party.

4 Summary recommendations

Summary recommendations and levels of evidence are outlined in Table 6. Summary recommendations

Table 6. Summary recommendations

Recommendation		Grading of evidence
1	During pregnancy, women are offered information on intrapartum fetal surveillance by those responsible for provision of maternity care. ²	Consensus-based (Level IV)
2	Fetal surveillance in labour, whether by intermittent auscultation or electronic fetal monitoring is discussed with and recommended to all women. ²	C (Level III-3)
3	Intermittent auscultation is an appropriate method of intrapartum fetal monitoring in women without recognised risk factors. ²	B (Level 1)
4	Women receive 1:1 midwifery intrapartum care. Cardiotocography is not a substitute for adequate intrapartum midwifery staffing. ²	Good practice note (Consensus based)
5	CEFM is recommended when either risk factors for fetal compromise have been detected antenatally, are detected at the onset of labour or develop during labour. ²	B (Level 1)
6	CTG interpretation is included in bedside handovers between clinicians.	Good practice note (Consensus based)
7	Paired (arterial and venous) umbilical cord blood gas or lactate analysis are taken at delivery where available when any of the following are present: <ul style="list-style-type: none"> • Apgar score less than 4 at 1 minute • Apgar score less than 7 at 5 minutes • Fetal scalp sampling performed in labour • Operative delivery undertaken for fetal compromise Where paired umbilical cord blood gas or lactate analysis is taken at delivery as part of a clinical audit regimen, this process should not interfere with management of the third stage of labour. ²	C (Level III-3)
8	Recognised intrapartum fetal surveillance education programs are provided to all clinicians by facilities providing intrapartum care.	Good practice note (Consensus based)
9	Multidisciplinary practice review meetings including reviews of CTG and intrapartum interventions are held regularly dependent on local circumstances. ²	Consensus based

5 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

5.1 Guideline resources

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

- Flowchart: Intrapartum fetal surveillance–Mode of fetal heart rate monitoring
- Flowchart: Intrapartum fetal surveillance–Abnormal fetal heart
- Education resource: Intrapartum fetal surveillance (IFS)
- Knowledge assessment: Intrapartum fetal surveillance (IFS)
- Parent information: Fetal monitoring in labour

5.2 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:

- Local communication strategies and protocols for escalation of abnormal CTG
- Template or standardised form for capture of CTG reporting and documentation
- Patient information on intrapartum fetal surveillance
- Fetal surveillance education program that aligns with Queensland Clinical Guideline IFS
- Protocol for monitoring multiple pregnancy
- Procedure for paired cord blood sampling
- Lanyard card with guideline Appendix A Interpretation of CTG

5.3 Implementation measures

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

5.3.1 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

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

5.3.2 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

5.3.3 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
- 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

5.4 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) Standards³ [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.	Percentage of women who are provided with information regarding IFS. Consider: <ul style="list-style-type: none"> · <i>Provided during antenatal period</i> · <i>Multidisciplinary input</i> 	1.2
2.	Percentage of women in established labour who receive close one-to-one midwifery care.	1.2
3.	Percentage of women with risk factors who have continuous CTG. Consider factors identified: <ul style="list-style-type: none"> · <i>Antenatally</i> · <i>At onset of labour</i> · <i>During labour</i> 	2.0
4.	Percentage of women with no risk factors who have continuous CTG.	3.2
5.	Percentage of paired umbilical cord blood gas or lactate analysis where indicated. Consider: <ul style="list-style-type: none"> · <i>Apgar score less than 4 at 1 minute or less than 7 at 5 minutes</i> · <i>FBS taken during labour</i> · <i>Operative birth for fetal compromise</i> 	6
6.	Percentage of staff completing annual IFS education. Consider: <ul style="list-style-type: none"> · <i>Multidisciplinary-obstetric and midwifery including students and trainees</i> · <i>On-line and face to face</i> 	1.3
7.	Number and content of multidisciplinary meetings held. Consider: <ul style="list-style-type: none"> · <i>Membership includes obstetric and midwifery staff</i> · <i>CTGs reviewed and labelled correctly</i> · <i>Evidence of CTG interpretation included at bedside handovers</i> · <i>All clinical incidents reviewed and recommendations discussed</i> · <i>Intrapartum interventions and outcomes</i> 	1.3
8.	Was the Queensland Clinical Guideline <i>Intrapartum fetal surveillance</i> useful for clinicians in guiding clinical practice related to IFS?	All sections

5.5 Areas for future research

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

- Computer assisted CTG interpretation in labour

5.6 Safety and quality

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.^{3,4}

Table 9. NSQHS/EQuIP National Criteria

NSQHS/EQuIP National 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	<ul style="list-style-type: none"> ⊐ 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	<ul style="list-style-type: none"> ⊐ 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	<ul style="list-style-type: none"> ⊐ 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 c. Review compliance with legislation, regulation and jurisdictional requirements	<ul style="list-style-type: none"> ⊐ 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 ⊐ The guidelines comply with legislation, regulation and jurisdictional requirements

NSQHS/EQUIPNational Criteria	Actions required	Evidence of compliance
NSQHS Standard 2: Partnering with Consumers		
<p>Health literacy Health service organisations communicate with consumers in a way that supports effective partnerships.</p>	<p>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</p>	<ul style="list-style-type: none"> ⊖ 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
<p>Partnering with consumers in organisational design and governance Consumers are partners in the design and governance of the organisation.</p>	<p>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</p>	<ul style="list-style-type: none"> ⊖ 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		
<p>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</p>	<p>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</p>	<ul style="list-style-type: none"> ⊖ The guideline provides current evidence based recommendations about medication

NSQHS/EQUIPNational Criteria	Actions required	Evidence of compliance
NSQHS Standard 5: Comprehensive care		
<p>Clinical governance and quality improvement to support comprehensive care Systems are in place to support clinicians to deliver comprehensive care</p>	<p>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</p>	<ul style="list-style-type: none"> ⊖ 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		
<p>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.</p>	<p>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</p>	<ul style="list-style-type: none"> ⊖ 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)		
<p>Communication of critical information Systems to effectively communicate critical information and risks when they emerge or change are used to ensure safe patient care.</p>	<p>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</p>	<ul style="list-style-type: none"> ⌋ Requirements for effective clinical communication of critical information are identified ⌋ Requirements for escalation of care are identified
<p>Correct identification and procedure matching Systems to maintain the identity of the patient are used to ensure that the patient receives the care intended for them.</p>	<p>Correct identification and procedure matching 6.5 The health service organisation: a. Defines approved identifiers for patients according to best-practice guidelines b. Requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated</p>	<ul style="list-style-type: none"> ⌋ Requirements for safe and for correct patient identification are identified
<p>Communicating at clinical handover Processes for structured clinical handover are used to effectively communicate about the health care of patients.</p>	<p>Clinical handover 6.7 The health service organisation, in collaboration with clinicians, defines the: a. Minimum information content to be communicated at clinical handover, based on best-practice guidelines b. Risks relevant to the service context and the particular needs of patients, carers and families c. Clinicians who are involved in the clinical handover 6.8 Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care</p>	<ul style="list-style-type: none"> ⌋ The guideline acknowledges the need for local protocols to support transfer of information, professional responsibility and accountability for some or all aspects of care

NSQHS/EQUIPNational Criteria	Actions required	Evidence of compliance
NSQHS Standard 8: Recognising and responding to acute deterioration		
<p>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.</p>	<p>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</p> <p>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</p> <p>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</p>	<ul style="list-style-type: none"> ⌋ 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
EQIP Standard 12 Provision of care		
<p>Criterion 1: Assessment and care planning 12.1 Ensuring assessment is comprehensive and based upon current professional standards and evidence based practice</p>	<p>12.1.1 Guidelines are available and accessible by staff to assess physical, spiritual, cultural, physiological and social health promotion needs</p>	<ul style="list-style-type: none"> ⌋ Assessment and care appropriate to the cohort of patients is identified in the guideline ⌋ The guideline is based on the best available evidence

6 References

1. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. [Internet]. 2009 [cited 2019 October 14]. Available from: <https://www.nhmrc.gov.au>.
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3. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. [Internet]. 2017 [cited 2019 September 19]. Available from: <http://www.safetyandquality.gov.au>.
4. The Australian Council on Healthcare Standards. EQUIPNational. [Internet]. 2016 [cited 2019 September 19]. Available from: <http://www.achs.org.au>.