Queensland Clinical Guidelines

Translating evidence into best clinical practice

Maternity and Neonatal **Clinical Guideline**

Guideline supplement: Normal birth

Queensland Government

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1 Introduction

This document is a supplement to the Queensland Clinical Guideline (QCG) *Normal birth.* 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 clinical leads and working party members and managed in accordance with the Queensland Clinical Guidelines *Conflict of Interest* statement. No conflicts of interest were declared.

1.3 Guideline review

Queensland clinical guidelines are reviewed every five 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**
April 2012	MN12.25-V1-R17	First publication
November 2017 *Endorsed by Statewide Maternity and Neonatal Clinical Network (QLD)*	MN17.25-V2-R22	Full review at five year scheduled review point.
June 2018	MN17.25-V3-R22	Water immersion: risks and benefits amended · From: “May increase genital tract trauma” · To: “Conflicting evidence about effect on perineal trauma” · Added: Refer to Queensland Clinical Guideline: *Perineal care guideline* References updated: · Cluett ER, Burns E, Cuthbert A. Immersion in water in labour and birth. Cochrane Database of Systematic Reviews (2018) · RANZCOG Water immersion during labour and birth (2017) Supplement updated · Section 5.6 Safety and Quality updated with 2017 National Safety and Quality Health Service Standards

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	· Women birthing at term (37–42 weeks)
Purpose	· Identify relevant evidence related to supporting normal birth
Outcome	· Supports: o Incorporation into clinical practice of factors that promote normal birth o Safe assessment and care of women during normal birth
Exclusions	· Women who do not meet the inclusion criteria for normal birth. o Refer to the ACM Consultation and Referral Guidelines for explicit exclusions

2.3 Clinical questions

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

- What aspects of woman centred care support normal birth?
- What assessment and care is required during the first stage of labour?
- What assessment and care is required during the second stage of labour?
- What assessment and care is required during the third stage of labour?
- What assessment and care is required during the fourth stage of labour?

2.4 Search strategy

A search of the literature was conducted during January-May 2017. 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 Resources commonly found in guidelines such as flowcharts, audit criteria and levels of evidence o Common search and key terms o 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: Pregnancy; woman; physiological birth; physiological; labour; labor; obstetric; collaboration; woman centred; caesarean; caesarean section
Other keywords may have been used for specific aspects of the guideline.

2.4.2 MeSH terms

Australia; Delivery, Obstetric; Humans; Mothers; Pregnancy; Parturition; Labor; Caesarean section; Iatrogenic disease; Breast feeding

3 Consultation

Major consultative and development processes occurred between January 2017 and July 2017. These are outlined in Table 4.

Table 4. Major guideline development processes

Process	Activity
Clinical lead	· The nominated Clinical Lead was approved by QCG Steering Committee
Consumer participation	· 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	· An EOI for working party membership was distributed via email to Queensland clinicians and stakeholders in May 2017 · 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	· Consultation was invited from Queensland clinicians and stakeholders during May 2017 – July 2017 · Feedback was received primarily via email · All feedback was compiled and provided to the clinical lead and working party members for review and comment

3.1 Endorsement

The guideline was endorsed by the:

- Queensland Clinical Guidelines Steering Committee in August 2017
- Statewide Maternity and Neonatal Clinical Network (Queensland) in October 2017

3.2 Publication

The guideline and guideline supplement were published on the QCG website in November 2017
The guideline can be cited as:

Queensland Clinical Guidelines. Normal birth. Guideline No. MN17.25-V3-R22. Queensland Health.2017. Available from: http://www.health.qld.gov.au/qcg/

The guideline supplement can be cited as:

Queensland Clinical Guidelines. Supplement: Normal birth. Guideline No. MN17.25-V3-R22. Queensland Health. 2017. Available from: http://www.health.qld.gov.au/qcg/ .

4 Levels of evidence

The levels of evidence identified by the Royal Australian and New Zealand College of Obstetricians and Gynaecologist (RANZCOG) in Table 5 and the Society of Obstetricians and Gynaecologists of Canada (SOGC) in Table 6 were used to inform the summary recommendations. In addition some consensus recommendations are opinions based on respected authorities, descriptive studies, reports of expert committees or the clinical experience of the working party.

Table 5. RANZCOG levels of evidence and grades for recommendation

Recommendation category		Description
Evidence-based recommendation	**A**	Body of evidence can be trusted to guide practice
	B	Body of evidence can be trusted to guide practice in most situations
	C	Body of evidence provides some support for recommendation(s) but care should be taken in its application
	D	The body of evidence is weak and the recommendation(s) must be applied with caution
Consensus-based recommendation		Consensus-based recommendations based on expert opinion where the available evidence was inadequate or could not be applied in the Australian and NZ healthcare content
Good practice note		Practical advice and information based on an expert opinion to aid in the implementation of the guideline

Table 6. SOGC levels of evidence and grades of recommendations

Quality of evidence assessment		Classification of recommendations	
I	Evidence obtained from at least one properly randomized controlled trial	**A**	There is good evidence to recommend the clinical preventive action
II-1	Evidence from well-designed controlled trials without randomization	**B**	There is fair evidence to recommend the clinical preventive action
II-2	Evidence from well-designed cohort (prospective or retrospective) or case-control studies, preferably from more than one centre or research group	**C**	The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making
II-3	Evidence obtained from comparisons between times or places with or without intervention. Dramatic results in uncontrolled experiments could also be included in this category	**D**	There is fair evidence to recommend against the clinical preventive action
III	Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees	**E**	There is good evidence to recommend against the clinical preventive action
		L	There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making

[a]The quality of evidence reported has been adapted from the Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care
[b]Recommendations included have been adapted from the Classification of recommendations criteria described in the Canadian Task Force on Preventive Health Care

4.1 Summary recommendations

Table 7. Summary recommendations

1. Overarching principles		Grading of evidence
1.1	· Pregnancy, birth and the postnatal period are normal physiological processes[1]	**Consensus**
1.2	· Provision of woman centred care protects, promotes and supports normal birth[1-3]	**Consensus**
1.3	· Inform the woman that giving birth is safe if she is at low risk of complications[4]	**Consensus**
1.4	· Clear communication and collaboration is the cornerstone of excellence in maternity care[1,5,6]	**Consensus**
2. Pregnancy preparation		**Grading of evidence**
2.1	· Women and health care providers should have information about coping strategies for early labour and mechanisms for accessing support from caregivers[7]	**III-A**
2.2	· Each woman should be provided with evidence-based information about labour analgesia options prior to the onset of labour and offered ample opportunity to discuss the risks and benefits of each option available at her planned site of birth[7]	**III-A**
3. Labour support care		**Grading of evidence**
3.1	· Continuous labour support is recommended for all women in active labour. Each labour unit should aim to provide the opportunity for each woman to receive continuous one to one labour support[7]	**I-A**
3.2	· Women should be informed of the benefits of upright positioning in labour and encouraged and assisted to assume whatever positions they find most comfortable[7]	**I-B**
3.3	· Women who are at low risk of requiring general anaesthesia should have the choice to eat or drink as desired or tolerated in labour[7]	**I-A**
3.4	· When appropriate, health care providers should support women in their choice of analgesic options in labour. These may include pharmacological and non-pharmacological measures[7]	**III-A**
4. Fetal surveillance		**Grading of evidence**
4.2	· Intermittent auscultation is an appropriate method of intrapartum fetal monitoring in women without recognised risk factors[8]	**B**
5. Second stage		**Grading of evidence**
5.1	· Delayed pushing (passive second stage) is preferred when the woman has no urge to push, particularly if the presenting part is above station +2 and/or in a non-occiput anterior position, assuming the fetus does not display abnormal monitoring and the pregnant woman's status is satisfactory[7]	**I-A**
6. Third stage		**Grading of evidence**
6.1	· Prophylactic oxytocics should be given after the birth of the baby[7]	**I-A**
6.2	· In term and preterm infants who do not require neonatal resuscitation, delayed umbilical cord clamping for at least 60 seconds is recommended irrespective of the mode of birth[7]	**I-B**
6.3	· Active management (early cord clamping) is no longer recommended for routine management of the third stage[4,9-11]	**Consensus/Strong recommendation[9]**

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: Initial assessment
- Flowchart: First stage
- Flowchart: Second stage
- Flowchart: Third and fourth stage
- Education resource: Normal birth
- Knowledge assessment: Normal birth
- Parent information: Early 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:

- Documentation tools
  - Pregnancy Health record (PHR)
  - Antenatal assessment form
  - Early labour record
  - Intrapartum record
  - Vaginal birth clinical pathway
  - Neonatal clinical pathway
- Local escalation pathways and management when women decline recommended care

5.3 Implementation measures

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

5.3.1 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

5.3.2 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

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)Standards[12] [refer to Table 8]. Suggested audit and quality measures are identified in Table 9. Clinical quality measures.

Table 8. 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 for low risk women:

- Compare with other Queensland maternity facilities and statewide percentages

Table 9. Clinical quality measures

No	Audit criteria	Guideline Section
1.	Proportion of women in active labour who have one to one care and support from an assigned midwife.[13]	Section 2.5 Support during labour and birth
2.	Proportion of women at low risk of complications who have routine cardiotocography as part of the initial assessment of labour.[13] (low expected)	Section 4.2 Assessment
3.	Proportion of women at low risk of complications and who are progressing normally in labour, who have their labour augmented (ARM or oxytocin) .[13] (low expected)	Section 5 First stage Section 6 Second stage
4.	Proportion of women who have all components of the package of care referred to as 'modified active management of third stage' · Waiting 1-3 minutes after the birth of the baby or until cord pulsation ceases and then · Administration of an uterotonic before clamping and cutting of the cord · Controlled cord traction optional · Do not have the cord clamped earlier than 1 minute after the birth unless there is concern about cord integrity or the baby's heartbeat.[13]	Section 7 Third stage
5.	Proportion of women who are offered skin to skin contact with their babies after the birth.[13]	Section 8.1 Newborn care and assessment
6.	The frequency, indication and number of vaginal examination in the low risk woman	Section 4.3 Vaginal examination

5.5 Areas for future research

Areas of interest for future development include

- Levels of staff uptake, use and satisfaction with the Normal birth guideline
- Levels of collaborative decision making when using the guideline[14]

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.

- Risks and benefits of water birth
- Effectiveness of comfort methods and strategies for pain management in labour including:
  - Transcutaneous electrical nerve stimulation (TENS)
  - Sterile Water Injections
  - Hypnosis
  - Hydrotherapy
  - Aromatherapy
  - Massage/Yoga/Breathing
- Risks and benefits of paracetamol use in early labour
- Risks and benefits to the newborn of Lotus birth
- Risks and benefits of placentophagy (ingesting placenta)
- Short and long term effects of oxytocin administration on the newborn
- Short and long term risks and benefits of a ‘longer’ duration of second stage in women and their babies for example:
  - Pelvic floor functioning following longer second stage
  - Newborn condition at birth,
  - Impact on the use of other interventions (e.g. CS, assisted birth)
  - Women’s preferences and satisfaction
- Risks and benefits of amniotomy when first stage of labour is prolonged

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.[12,15]

Table 10. NSQHS/EQuIPNational Criteria

NSQHS/EQuIPNational Criteria	Actions required	þ 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	þ Assessment and care appropriate to the cohort of patients is identified in the guideline þ High risk groups are identified in the guideline þ 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	þ Queensland Clinical Guidelines is funded by Queensland Health to develop clinical guidelines relevant to the service line to guide safe patient care across Queensland þ The guideline provides evidence-based and best practice recommendations for care þ The guideline is endorsed for use in Queensland Health facilities. þ 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	þ 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	þ QCG has established processes to review and maintain all guidelines and associated resources þ Change requests are managed to ensure currency of published guidelines þ Implementation tools and checklist are provided to assist with adherence to guidelines þ Suggested audit criteria are provided in guideline supplement þ The guidelines comply with legislation, regulation and jurisdictional requirements

NSQHS/EQuIPNational Criteria	Actions required	þ 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	þ Consumer consultation was sought and obtained during the development of the guideline. Refer to the acknowledgement section of the guideline for details þ Consumer information is developed to align with the guideline and included consumer involvement during development and review þ 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	þ Consumers are members of guideline working parties þ The guideline is based on the best available evidence þ 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	þ The guideline provides current evidence based recommendations about medication

NSQHS/EQuIPNational Criteria	Actions required	þ 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	þ 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 þ The guideline provides evidence-based and best practice recommendations for care þ 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	þ Requirements for effective clinical communication by clinicians are identified þ The guideline provides evidence-based and best practice recommendations for communication between clinicians þ The guideline provides evidence-based and best practice recommendations for communication with patients, carers and families þ The guideline provides evidence-based and best practice recommendations for discharge planning and follow –up care

NSQHS/EQuIPNational Criteria	Actions required	þ 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	þ Requirements for effective clinical communication of critical information are identified þ Requirements for escalation of care are identified
Communicating at clinical handover Processes for structured clinical handover are used to effectively communicate about the health care of patients.	**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	þ 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	þ 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	þ The guideline is consistent with National Consensus statements recommendations þ The guideline recommends use of tools consistent with the principles of recognising and responding to clinical deterioration þ 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	þ Assessment and care appropriate to the cohort of patients is identified in the guideline þ The guideline is based on the best available evidence

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