Queensland Clinical Guidelines

Translating evidence into best clinical practice

Maternity and Neonatal **Clinical Guideline**

Guideline supplement: Vaginal birth after caesarean (VBAC)

Queensland Government

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1 Introduction

This document is a supplement to the Queensland Clinical Guideline (QCG) *Vaginal birth after caesarean (VBAC).* 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. One conflict of interest was declared and was managed in accordance with the statement.

1.3 Review process

- A review of the guideline scope, clinical questions and current literature was undertaken in November 2019.
- The clinical leads were consulted and reviewed the previous version of the guideline.
- The QCG steering committee and Statewide Maternity and Neonatal Clinical Network 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 *Endorsed by:*	**Identifier**	**Summary of major change**
December 2009	MN0911.12-V1-R11	First publication
August 2011	MN09.12-V2-R11	New website. Name and format changes
September 2011	MN09.12-V3-R14	Review date extended
June 2015	MN15.12-V4-R19	First full review of original publication • Guideline supplement published • Considerations of planned VBAC following two previous caesarean sections included • Increased focus on shared decision making • Expanded Sections: o Flow chart o Antenatal care o Discussion and planning o Induction of labour o Uterine rupture • Section Intrapartum care: aligned to QCG Normal birth guideline where appropriate
September 2020 *Statewide Maternity and Neonatal Clinical Network*	MN20.12-V5-R25	Second full review • Added sections o Flow chart: Decision making framework for women with previous caesarean section (CS) o Additional risk benefit considerations for planned VBAC versus elective repeat caesarean section (ERCS) o Antenatal counselling o New appendices • Updated: o Formatting and style o Risks and benefits of planned VBAC and ERCS o Induction and augmentation of labour o Pain relief for VBAC

Publication date *Endorsed by:*	**Identifier**	**Summary of major change**
		o Intrapartum care recommendations: ▪ Consideration of intravenous cannulation and collection of bloods ▪ Vaginal examination recommendations • Removed o Sections covered by Queensland Clinical Guideline *Standard care*[1]

2 Methodology

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 planning their next birth after a CS
Purpose	Identify relevant evidence related to: • Risks and benefits of a VBAC versus ERCS
Outcome	Guidance and evidence-based information for clinicians to provide women: • Support in making informed choices for their birth after one or more caesarean sections • Care associated with the key considerations of: o VBAC antenatal care o VBAC intrapartum care
Exclusions	• Pregnant women or babies with rare conditions or with complex or unusual comorbidities (e.g. congenital heart disease) • Women with clinical conditions that arise during pregnancy (e.g. pre-eclampsia, gestational diabetes) which require specialist care • Antenatal and intrapartum conditions/factors (e.g. pre-eclampsia) that would affect the likelihood of the woman being assessed as requiring a planned or emergency caesarean section • Routine antenatal, intrapartum, and postnatal care • Emergency antenatal, intrapartum, and postnatal care • Management of uterine rupture

2.3 Clinical questions

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

- What are the risks and benefits of VBAC to the woman and baby?
- What is the risk of uterine rupture in VBAC?
- What are the rates of VBAC?
- What are the risks and benefits of an elective repeat ERCS?
- How should women be counselled about VBAC and ERCS?
- What are the risks of induction of labour (IOL) after one or more CS?
- What are the key components of intrapartum and postpartum care for VBAC?
- What clinical considerations are required for VBAC in special circumstances?

2.4 Search strategy

A search of the literature was conducted during October 2019 to February 2020. 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: VBAC, vaginal birth after caesarean, next birth after caesarean, trial of labour after caesarean, trial of scar, uterine rupture.
Other keywords may have been used for specific aspects of the guideline.

2.5 Consultation

Major consultative and development processes occurred between March 2020 and August 2020. These are outlined in Table 4.

Table 4. Major guideline development processes

Process	Activity
Clinical lead	• The nominated clinical leads were approved by the 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 March 2020 • 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 March 2020–August 2020 • 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	• A literature review and consultation with the clinical leads was undertaken in October 2019

2.6 Endorsement

The guideline was endorsed by the:

- Queensland Clinical Guidelines Steering Committee in [insert month & year here]
- 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: http://www.health.qld.gov.au/qcg.
>
> **EXAMPLE:**
> Queensland Clinical Guidelines. Normal birth. Guideline No. MN17.25-V3-R22. Queensland Health 2017. Available from: http://www.health.qld.gov.au/qcg.

3 Levels of evidence

The levels of evidence identified by the Society of Obstetricians and Gynaecologists in Canada (SOGC) were used to inform the summary recommendations.[3] Levels of evidence are outlined in Table 5.

Table 5. SOGC levels of evidence and grades for recommendation

Quality of evidence assessment		Classification of recommendations	
I	Evidence obtained from at least one properly randomised controlled trial	**A**	There is good evidence to recommend the clinical preventive action
II-1	Evidence from well-designed controlled trials without randomisation	**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, preferable 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 the 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
		I	There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision making

4 Summary recommendations

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

Table 6. Summary recommendations

Recommendations		Grading of evidence
1.	Provided there are no contraindications, offer a trial of labour* after caesarean to all women with one previous low-segment transverse caesarean section after appropriate discussion and documentation of maternal and perinatal risks and benefits. This discussion should be documented.	II-2B
2.	Trial of labour* after caesarean is recommended in women without contraindications to labour, with a previous vaginal birth, and/or those who present in spontaneous labour as they are good candidates for a trial of labour* after caesarean and have a higher vaginal birth after caesarean rate.	II-2B
3.	Women with factors negatively affecting their likelihood of vaginal birth after caesarean can be offered a trial of labour* after caesarean. However, they should be informed that they have a lower chance of vaginal birth after caesarean and have an increased risk of complications and repeat caesarean birth.	II-2A
4.	Inform women that the relative risk of maternal death is higher for elective repeat caesarean section and the risk of uterine rupture and composite serious maternal morbidity is higher for trial of labour* after caesarean, but the absolute risks of these outcomes are low.	II-2B
5.	Inform women with one prior low transverse caesarean section that the baseline risk of uterine rupture with a trial of labour* after caesarean is 0.47%.	II-2A
6.	Inform women that most other maternal complications are not significantly different between elective repeat caesarean section and trial of labour* after caesarean.	II-2B
7.	Induction of labour is not contraindicated in women undergoing a trial of labour* of labour after caesarean.	II-2B
8.	Inform women that induction of labour is associated with a lower vaginal birth after caesarean rate and an increased risk of uterine rupture and should be used carefully after appropriate counselling.	II-2B
9.	Use of oxytocin for induction or augmentation is not contraindicated in women undergoing a trial of labour* after caesarean. However, use of oxytocin is associated with an increased risk of uterine rupture and should be used carefully after appropriate counselling.	II-2B
10.	Women with two prior caesarean sections appear to have similar vaginal birth after caesarean rates as those with 1 prior caesarean section. Inform women of a higher risk of uterine rupture in trial of labour* after caesarean with more than one caesarean section.	II-2B
11.	It is not an absolute contraindication for women with a breech presentation to undergo a trial of labour* after caesarean. However, women should be advised that there is insufficient information to assess risks of a trial of labour* after caesarean with a breech presentation.	III-B
12.	Multiple pregnancy is not a contraindication to a trial of labour* after caesarean.	II-2B

*QCG recommends and uses the term ‘planned VBAC’ in preference to ‘trial of labour’

Recommendations		Grading of evidence
13.	Although there is a relationship between lower uterine thickness and risk of uterine rupture, the absolute cut-off between safe and unsafe trial of labour* after caesarean does not exist. Therefore, at this time, we cannot use ultrasonographic measurements of the lower uterine segment to counsel women to either have or not have a trial of labour* after caesarean with confidence.	II-2B
14.	Women with a classical caesarean section should not have a trial of labour* after caesarean.	II-2A
15.	Every effort should be made to obtain the previous caesarean operative report to determine the type of uterine incision used. In situations where the scar is unknown, information concerning the circumstances of the previous delivery is helpful in determining the likelihood of a lower transverse incision. If the likelihood of a lower transverse incision is high, trial of labour* after caesarean can be offered.	II-2B
16.	Women planning a trial of labour* after caesarean should be advised that the relative risk of perinatal mortality and serious morbidity is higher with trial of labour* after caesarean compared to elective repeat caesarean section, but the absolute risk is low.	II-2B
17.	Women should be informed that the risk of placenta previa and placenta accreta increases with increasing number of caesarean sections.	II-2A
18.	The process and documentation of informed consent with appropriate discussion of the maternal and perinatal risks and benefits of trial of labour* after caesarean and elective repeat caesarean section should be a part of the care plan in a woman with a previous caesarean section.	III-A
19.	Continuous electronic fetal monitoring of women having a trial of labour* after caesarean is necessary, as changes to the fetal heart rate tracing are one of the key indicators of the presence of a uterine rupture.	II-2A
20.	To optimise maternal and neonatal outcomes in situations of uterine rupture, a woman having a trial of labour* after caesarean should be cared for in a hospital that has resources to perform an immediate caesarean section.	III-B

*QCG recommends and uses the term ‘planned VBAC’ in preference to ‘trial of labour’

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: Decision making framework for women with previous caesarean section
- Flowchart: Planned Vaginal birth after caesarean (VBAC)
- Education resource: Vaginal birth after caesarean (VBAC)
- Knowledge assessment: Vaginal birth after caesarean (VBAC)
- Parent information: Vaginal birth after caesarean (VBAC)

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 procedure for requesting and obtaining operation reports from previous CS
- Local audit reports of VBAC rates to inform counselling
- Standardised counselling checklist and management plan template for pregnant women with history of previous CS
- Local policy and procedure for Category 1 CS and management of uterine rupture
- Local policy and procedure for water immersion and birth in setting of VBAC and recommendation for continuous electronic fetal monitoring

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

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
- 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 http://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[2] [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.	Planned VBAC rate	Section 1 Section 4
2.	Proportion of women with documented discussion of risks and benefits of VBAC versus ERCS using standardised checklist/documentation	Section 2
3.	VBAC rates in for both: o Spontaneous labour o Induced labour	Section 3
4.	Proportion of women attempting VBAC who had: • One on one midwifery care • Continuous electronic fetal monitoring	Section 6
5.	Proportion of VBAC labours where there is documented discussion with the woman and consultation with a senior obstetrician prior to augmentation	Section 4

5.5 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.

- Safety, risks and benefits of VBAC:
  - Following two, three or more CS
  - In multiple birth
  - For breech presentation
- The impact of VBAC and ERCS on neonatal respiratory morbidity
- The relationship between continuity of care and VBAC rates
- The relationship between models of care and VBAC rates
- The validity of predictive calculators in the Australian and Queensland context
- VBAC rates in Queensland and Australia

5.6 Safety and quality

In combination with the QCG *Standard care* guideline[1], 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.[2,3]

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 c. Review compliance with legislation, regulation and jurisdictional requirements	☑ 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		
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
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.	**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	☑ Requirements for safe and for correct patient identification 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	☑ 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		
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

References

1. Queensland Clinical Guidelines. Standard care. Guideline No. MN18.50-V1-R23. [Internet]. Queensland Health. 2018. [cited 2020 Aug 31]. Available from: http://www.health.qld.gov.au
2. 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.
3. The Australian Council on Healthcare Standards. EQuIPNational. [Internet]. 2016 [cited 2019 September 19]. Available from: http://www.achs.org.au.
3. Dy J, DeMeester S, Lipworth H, Barrett J. No. 382-Trial of Labour After Caesarean. J Obstet Gynaecol Can 2019;41(7):992-1011.