Queensland Clinical Guidelines

Translating evidence into best clinical practice

Maternity and Neonatal **Clinical Guideline**

Guideline Supplement: Obesity and pregnancy (including post bariatric surgery)

Queensland Government

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1 Introduction

This document is a supplement to the Queensland Clinical Guideline (QCG) *Obesity and pregnancy (including post bariatric surgery).* 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 Development process

This version of the guideline followed the full review process.

- A review of the guideline scope, clinical questions and current literature was commenced in June 2020.
- The clinical leads were consulted and reviewed the previous version of the guideline.
- A peer review panel of expert clinicians and consumer representatives reviewed the guideline, supplement and other resources.
- 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 *Endorsed by:*	**Identifier**	**Summary of major change**
March 2010 *Statewide Maternity and Neonatal Clinical Network (Qld)*	MN1003.14-V1-R13	First publication
August 2011 *QCG Steering Committee*	MN10.14-V2-R13	Review date extended. Identifier updated. Program name updated
September 2011 *Statewide Maternity and Neonatal Clinical Network (Qld)*	MN10.14-V3-R15	Appendix B: Modifications to wording of "Suggested responsibilities for referral" to indicate *optional* nature of transfer and referral based on BMI and the need for *individual assessment*
March 2013 *QCG Steering Committee*	MN10.14-V4-R15	Section 1. General principles of care added Appendix B: Suggested responsibilities for referral removed. Local strategies to optimise care added
December 2015 *Statewide Maternity and Neonatal Clinical Network (Qld)*	MN15.14-V5-R20	Full review and update Flowchart added. Additional detail on weight management strategies. Supplement created.
July 2021 *QCG Steering Committee* *Statewide Maternity and Neonatal Clinical Network (Qld)*	MN21.14-V6-R26	Full review and update • Title amended FROM *Obesity in pregnancy* TO *Obesity and pregnancy (including bariatric surgery)* • Additional information on pregnancy and bariatric surgery added • Standard care elements removed and referenced to *Standard care* guideline

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 initially 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 or women who are planning a pregnancy who: o Are overweight or obese o Have had bariatric surgery
Purpose	• Identify evidence relevant to the woman and her baby about: o The risks related to pregnancy of obesity or previous bariatric surgery o Diagnosis, assessment and management across the pregnancy continuum for women who are overweight, obese or have had bariatric surgery
Outcome	• Increased awareness among all women and clinicians of the benefits/importance of weight management in relation to pregnancy • Early identification and management of risks for pregnant women who are overweight, obese or who have had previous bariatric surgery
Exclusions	• Standard care as outlined in the Queensland Clinical Guidelines *Standard care* guideline • Routine antenatal, intrapartum and postpartum care • Management of pregnant women considered underweight • Detailed preconception counselling • Detailed infertility management • Detailed weight management counselling and pregnancy • Specialist dietary and nutrition support • Detailed anaesthetic management

2.3 Clinical questions

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

- How should weight be assessed and monitored during pregnancy?
- What are the health risks of obesity for pregnancy?
- What preconception care is recommended for overweight/obese women planning pregnancy?
- What antenatal care is recommended for overweight and obese women?
- What intrapartum care is recommended for overweight and obese women?
- What postpartum care is recommended for overweight and obese women?
- What are the recommendations relating to pregnancy and previous bariatric surgery?

2.4 Search strategy

A search of the literature was conducted during June 2020–February 2021. A further search was conducted in April 2021. 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 textbooks

2.4.1 Keywords

The following keywords were used in the basic search strategy: overweight, obesity, obesity in/and pregnancy, bariatric surgery and pregnancy, gestational weight gain, maternal obesity, postpartum weight retention, weight stigma.

These terms were combined with other terms such as risks, complications, caesarean, induction of labour, mental health, childhood obesity, clinical outcomes, clinical guidelines. Other keywords may have been used for specific aspects of the guideline.

2.5 Consultation

Major consultative and development processes occurred between February 2021 and May 2021.

Table 4. Major guideline development processes

Process	Activity
Clinical lead	• The nominated Clinical Leads were 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 February 2021 • 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 February 2021–May 2021 • Feedback was received primarily via email • All feedback was compiled and provided to the clinical lead and working party members for review and comment

2.5.1 Additional consultation specific to language and terminology

Table 5. Language and terminology

Process	Activity
Information gathering	• An initial literature review was undertaken as part of the foundational search strategy • The clinical term *obesity* was considered appropriate in the guideline title o Consistent with previous title o Inform clinicians of the guideline content (as the intended audience the guideline) • The term *larger bodies* (as per National Eating Disorders Collaboration) was utilised in the first draft as a mechanism to minimise negative connotations and weight stigma associated with the term *obesity* • More consumer-focused language was used for the consumer information brochure
Initial consultation	• During the first round of consultation, feedback from the working party was mixed about the use of the term *larger bodies*
Background paper and survey	• Further focussed literature was undertaken about weight stigma and language • A background paper was prepared, and this was distributed to the working party o The background paper is available on request • An online survey was developed seeking the opinions/preferences of the working party about preferred terminology • A survey report was compiled to inform and support final decision-making on terminology to be used in the guideline o The report is available on request
Final decision making	• The terminology used in the guideline was informed by the literature, feedback from the working party, including the opinion survey results, and other factors identified by stakeholders

2.6 Endorsement

The guideline was endorsed by the:

- Queensland Clinical Guidelines Steering Committee in July 2021
- Statewide Maternity and Neonatal Clinical Network (Queensland) in August 2021

2.7 Citation

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

> Queensland Clinical Guidelines. Obesity and pregnancy (including post bariatric surgery). Guideline No. MN21.14-V6-R26. Queensland Health. 2021. Available from: www.health.qld.gov.au/qcg.
>
> **EXAMPLE:**
> Queensland Clinical Guidelines. Normal birth. Guideline No. MN17.25-V3-R22. Queensland Health 2017. Available from: www.health.qld.gov.au/qcg.

3 Levels of evidence

The levels of evidence as identified by The Society of Obstetricians and Gynaecologists of Canada (SOGC) were used to inform the summary recommendations.[1,2]

Note that the 'consensus' definition in Table 5. Levels of evidence (The Society of Obstetricians and Gynaecologists of Canada) relates to forms of evidence not identified by this system and arises from the clinical experience of the guideline's clinical lead(s) and working party.

Table 5. Levels of evidence

Quality of evidence assessment		Classification of recommendations	
I	Evidence obtained from at least 1 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 1 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 (such as the results of treatment with penicillin in the 1940s) could also be included in the 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
Consensus		Agreement between clinical lead, working party and other clinical experts.	

3.1 Summary recommendations

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

Table 6. Summary recommendations

Recommendations		Grading of evidence
1.	Weight management strategies prior to pregnancy may include dietary, exercise, medical, and surgical approaches. When pursued before pregnancy, health benefits may carry forward into future pregnancies	III B
2.	As obesity carries many medical risks, assessment for conditions of the cardiac, pulmonary, renal, endocrine, and skin systems, as well as nutritional deficiencies and obstructive sleep apnoea, is warranted in the pre-pregnancy period	II-3 B
3.	It is recommended that both monitoring of gestational weight gain and approaches for gestational weight gain management be formally integrated into routine prenatal care	III A
4.	Use sensitive language and health care strategies to minimise weight stigma	Consensus
5.	There is good evidence to support the role of exercise in pregnancy	I A
6.	Increased fetal surveillance for well-being is suggested if reduced fetal movements are reported, given the increased rate of stillbirth	II-3
7.	Aspirin prophylaxis can be recommended for women with obesity when other risk factors are present for the prevention of preeclampsia	I A
8.	Women with obesity may benefit from higher dosage of preoperative antibiotics for caesarean birth	I A
9.	Counselling regarding weight management in the postpartum period is suggested in order to minimize risks in subsequent pregnancies	II-2 A
10.	Women with obesity should be screened for depression and anxiety given that maternal obesity is a risk factor for these conditions	II-2 A

4 Implementation

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

4.1 Guideline resources

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

- Flowchart: Obesity and pregnancy (including post bariatric surgery)
- Education resource: Obesity and pregnancy (including post bariatric surgery)
- Knowledge assessment: Obesity and pregnancy (including post bariatric surgery)
- Auditing resources: Obesity and pregnancy (including post bariatric surgery)
- Parent information: Pregnancy after bariatric surgery or with a weight above a healthy range

4.2 Suggested resources

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

- Culturally specific parent information (e.g. for Aboriginal and Torres Strait Islander people)
- Healthy pregnancy healthy baby – Healthy pregnancy weigh gain training Healthy Pregnancy Healthy Baby - Metro North Health

4.3 Implementation measures

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

4.3.1 Implications for implementation

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

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

4.3.2 QCG measures

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

4.3.3 Hospital and Health Service measures

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

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

4.4 Quality measures

Auditing of guideline recommendations and content assists with identifying quality of care issues and provides evidence of compliance with the National Safety and Quality Health Service (NSQHS) Standards[3] [Refer to Table 7. NSQHS Standard 1]. Suggested audit and quality measures are identified in Table 8. Clinical quality measures.

Table 7. NSQHS Standard 1

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

The following clinical quality measures are suggested:

Table 8. Clinical quality measures

No	Audit criteria	Guideline section
1.	Proportion of pregnant women with pre/early pregnancy weight and BMI recorded and at least three weight measurements during the antenatal period	Section 4.2.1 Monitoring gestational weight gain
2.	Proportion of pregnant women with a BMI equal to or greater than 25 kg/m^2 who were offered: Discussion about recommended gestational weight gain Weight measurement and review at each antenatal appointment	Section 4.2.1 Monitoring gestational weight gain
3.	Proportion of pregnant women with a BMI equal to or greater than 30 kg/m^2 who were offered/recommended: • Screening for diabetes mellitus on entry to pregnancy care • Assessment of venous thromboembolism (VTE) risk	Section 7 Antenatal care
4.	Proportion of pregnant women with a BMI equal to or greater than 40 kg/m^2 who were offered an anaesthetic review	Section 2.3 Referral pathways
5.	Proportion of pregnant women with a history of bariatric surgery offered: • Alternate testing for gestational diabetes • Assessment for micronutrient deficiencies • Referral to: o Obstetric team o Dietician	Section 10 Bariatric surgery and pregnancy
6.	Proportion of pregnant women with a BMI equal to or greater than 40 kg/m^2 who were offered continuous fetal monitoring during labour	Section 8 Intrapartum care
7.	Proportion of postpartum women with a BMI equal to or greater than 30 kg/m^2 offered: • VTE risk assessment • Ongoing breastfeeding support • Diabetes mellitus screening at six (6) weeks postpartum • Information on the benefits of inter-pregnancy weight loss	Section 9 Postpartum care

4.5 Areas for future research

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

- For women during (and pre) pregnancy what is the *most* appropriate and sensitive language for women regarding living with obesity or elevated BMIs?
- Exact supplement type and dosage recommendation to increase serum folate to provide protective benefits for NTD.
- Lifestyle intervention (detailing exact details of the 'how, when, what' and cost effectiveness) to improve clinical outcomes relating to perinatal mortality and morbidity
- Benefits of expressing breast milk from 37 weeks gestation in the event of an LGA infant or admission to a neonatal nursery
- In pregnant women with prior bariatric surgery:
  - What nutritional supplementations are routinely recommended?
  - Recommendations for biochemical and nutritional screening
  - Pregnancy specific reference ranges for nutrient and biochemical screening

4.6 Safety and quality

In conjunction with the Queensland Clinical Guideline *Standard care*[4], implementation of this guideline provides evidence of compliance with the National Safety and Quality Health Service Standards.[3]

Table 9. NSQHS/EQuIP National Criteria

NSQHS	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

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

NSQHS	Actions required	☑ Evidence of compliance
NSQHS Standard 6: Communicating for safety (continued)		
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

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