Queensland Clinical Guidelines

Translating evidence into best clinical practice

Maternity and Neonatal **Clinical Guideline**

Standard care

Queensland Government

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Cultural acknowledgement

The Department of Health acknowledges the Traditional Custodians of the lands, waters and seas across the State of Queensland on which we work and live. We also acknowledge First Nations peoples in Queensland are both Aboriginal Peoples and Torres Strait Islander Peoples and pay respect to the Aboriginal and Torres Strait Islander Elders past, present and emerging.

Disclaimer

This guideline is intended as a guide and provided for information purposes only. The information has been prepared using a multidisciplinary approach with reference to the best information and evidence available at the time of preparation. No assurance is given that the information is entirely complete, current, or accurate in every respect.

The guideline is not a substitute for clinical judgement, knowledge and expertise, or medical advice. Variation from the guideline, taking into account individual circumstances, may be appropriate.

This guideline does not address all elements of standard practice and accepts that individual clinicians are responsible for:

- Providing care within the context of locally available resources, expertise, and scope of practice
- Supporting consumer rights and informed decision making, including the right to decline intervention or ongoing management
- Advising consumers of their choices in an environment that is culturally appropriate and which enables comfortable and confidential discussion. This includes the use of interpreter services where necessary
- Ensuring informed consent is obtained prior to delivering care
- Meeting all legislative requirements and professional standards
- Applying standard precautions, and additional precautions as necessary, when delivering care
- Documenting all care in accordance with mandatory and local requirements

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Flowchart: Summary of standard care

Standard 1 Clinical governance	**Supporting reliable, safe, quality maternity care** • Applicable standards and guidelines • Leadership and systems • Clinical workforce and practice • Healthcare environment
Standard 2 Partnering with consumers	**Supporting families** • Partnerships in healthcare delivery • Respect for privacy and confidentiality • Informed decision-making • Consent
Standard 3 Preventing and controlling infections	**Preventing and controlling infection** • Standard and transmission based precautions • Aseptic technique/clean and safe environment • Invasive medical devices • Workforce screening and immunisation
Standard 4 Medication safety	**Prescribing and administering medications safely** • Approved prescribing and medication charts • Medication administration practices • Allergy and adverse drug reactions • Patient education
Standard 5 Comprehensive care	**Coordinating complex and comprehensive healthcare** • Principles of care • Appropriate models of care • Culturally safe care • Continuity of care and carer
Standard 6 Communicating for safety	**Communicating effectively** • Clinical communication • Communication with patients and families • Patient identification • Sex and gender
Standard 7 Blood management	**Supporting safe blood and blood product use** • National Blood Authority guidelines • Massive transfusion protocols • Blood and blood products use and patient response • Alternative blood products where indicated
Standard 8 Recognising and responding to acute deterioration	**Managing clinical deterioration** • Clinical deterioration • Escalation of care • Approved tools and forms

Flowchart: F22-50-1-V1-R27

Table of Contents

List of Tables

Abbreviations

ADR	Adverse drug reaction
CSCF	Clinical Services Capability Framework
EPDS	Edinburgh Postnatal Depression Score
FGM	Female genital mutilation
GP	General practitioner
NMBA	Nursing and Midwifery Board of Australia
MBA	Medical Board of Australia
NSQHS	National Safety and Quality Health Service Standards
PPE	Personal protective equipment
QCG	Queensland Clinical Guidelines
QH	Queensland Health
RCA	Root cause analysis
RSQ	Retrieval Services Queensland
SBAR	Situation, Background, Assessment, Recommendation(s)

Definitions

Carer	A person (excluding employees, volunteers or students) who provides personal care, support and assistance to another who may be, but is not necessarily, a family member.
Family	People close to the patient including parents, siblings, grandparents, aunts, uncles, cousins, friends, other kin, and may also include carers.
Informed decision-making[1]	The two-way communication process between a patient and one or more healthcare providers that is central to patient-centred healthcare. Includes the right to accept or to decline the offer of certain healthcare and to change that decision. Patients require information relevant to them about risks, benefits, options and alternatives
Policy	Formal document representing a statement of intent or principles that reflect the organisations' mission and direction for a particular outcome.[2,3]
Procedure	Organisation specific set of instructions to make policies and protocols operational.[2,3]
Protocol or work instruction	Established set of rules to complete tasks.[2]
Obstetrician	In QCG guidelines the term obstetrician includes specialist obstetricians, consultants, senior registrars, obstetric fellows or general practitioner obstetricians. Specific roles and responsibilities may be assigned according to their specific practitioner group requirements and/or local facility requirements.
Skills and knowledge	Experience: possession of knowledge or skill in a particular field or activity gained over time.[4] Competence: combination of knowledge, skills, abilities and attributes required for the clinician to be successful in their role.[2] Credentialed: clinician has undergone a formal process to verify qualifications, skills, experience to ensure safe, high quality healthcare within a specific setting and role.[5,6]
Woman/women	In QCG documents, the terms *woman* and *women* include people who do not identify as women but who are pregnant or have given birth.

1 Introduction

This guideline defines and describes generic healthcare concepts, standards and practices assumed to be common knowledge or in common use (standard care) in Queensland maternity and neonatal services. The aim is to facilitate a common understanding of expected standard health care delivery, promote consistency, and reduce duplication within Queensland Clinical Guidelines (QCG) documents and associated resources. This guideline is integral to and is to be read in conjunction with all other QCG guidelines.

The National Safety and Quality Health Service (NSQHS) Standards produced by the Australian Commission of Safety and Quality in Heath Care are used as a framework to describe *standard* or *usual* care.[2]

2 Clinical governance

Standard 1: This element encompasses leadership, culture, safety and quality systems, workforce and the health environment. It devolves responsibility to leaders at all levels to ensure systems are used to provide and improve quality healthcare for patients.[2]

2.1 Standards and guidelines

Table 1. Standards and guidelines

Aspect	Considerations
Queensland Clinical Guidelines (QCG)	• Are endorsed for use in all Queensland Health facilities • Are accompanied by parent/consumer information and clinician education resources (e.g. PowerPoint presentation and knowledge assessment) • Includes NeoMedQ for neonatal medicine monographs • Are systematically developed and evidence informed to guide/assist clinician and consumer decisions about best practice healthcare in specific circumstances • They do not: o Replace clinical judgement, knowledge or expertise o Mandate actions or care (except where compliance with legislation or professional accountability is required) • Variation from guideline recommendations may be appropriate in individual circumstances
Australian Commission on Safety and Quality in Healthcare	• Provide care within the eight National Safety and Quality Health Service (NSQHS) Standards[2] • As required refer to: o Clinical Care Standards[7] for specific clinical conditions or defined pathways (e.g. Clinical Care Standards for Sepsis, Acute Anaphylaxis, Stillbirth, Third and Fourth Degree Perineal Tears) o National Consensus Statements (e.g. Essential elements for recognising and responding to acute physiological deterioration[6]) o Indicators, measurement and reporting for quality improvement initiatives o Initiatives (e.g. National Hand Hygiene Initiative[8])
Other forms of guidance	• If recommendations for specific clinical care are not provided then as required: o Refer to guidance from relevant professional, national and/or international organisations o Follow locally developed guidance, protocols, or work instructions or procedures o Seek expert clinical advice
Recommendation	• Refer to QCG guidelines to guide best practice in maternity and neonatal care (where applicable guidelines exist) • Exercise professional judgement and adapt guideline recommendations when indicated by individual clinical circumstances and consistent with best practice

2.2 Leadership and systems

Table 2. Leadership and systems

Aspect	Consideration
Workplace culture	• Support, model and communicate[9] o Respectful and culturally appropriate interactions with other members of the workforce, and with women and their families using woman-centred language o A 'no blame' culture o A multidisciplinary and collegial approach to healthcare o Non-discriminatory language and behaviour • Effective communication in healthcare settings builds workplace culture and impacts on the quality and safety of healthcare[10] • Refer to: o Section 7 Communication for safety o Queensland's Aboriginal and Torres Strait Islander Health Equity Framework[11] o Queensland Health Ryan's Rule[12]
Risk management[2]	• Follow local policy, protocols and systems to: o Identify, assess and document clinical and other risks o Act to prevent, minimise or eliminate risks appropriate to the circumstances o Report and review incidents and complaints • Comply with patient safety notices issued by Patient Safety and Quality Improvement Service (intranet only)[13]
Performance review[2]	• Undertake clinical audit and other quality review activities to improve healthcare delivery and safety including (but not limited to): o Perinatal morbidity and mortality meetings o Root cause analysis (RCA) o Identifying, reporting and reviewing clinical data • Utilise open disclosure frameworks and processes • Refer to suggested quality measures in the supplement of the relevant QCG guideline to aid practice review
Clinical services capability framework (CSCF)[14]	• Consider the level of CSCF when providing obstetric and neonatal care to women and babies o Plan to provide care congruent with the facility and service CSCF • Care beyond the capability of the service may at times be required[14] o Use clinical judgement and local risk management responses to determine the need for transfer to a facility with a higher level of care capability[14] • Where appropriate, liaise with higher level facilities for advice, consultation and referral • Relevant to the service level, consider o Workforce requirements including training and education, levels of competence and skills maintenance, available skill mix and staffing levels o Ability to comply with legislation, and standards and guidelines applicable to the service o Availability of support services o Environmental considerations including equipment and facilities

2.3 Clinical workforce

Table 3. Healthcare team members

Aspect	Definition
Maternity and/or neonatal healthcare providers	• A person who has undertaken a recognised program of health education and training that enables registration with the relevant professional entity and/or regulatory body[15-17] (e.g. medical practitioner, midwife, nurse)
Specialist practitioner	• A healthcare provider who has undertaken a recognised program of additional advanced health education and training o Specialist medical practitioner (e.g. obstetrician, neonatologist, paediatrician, anaesthetist, maternal fetal medicine, general practitioner) o Nurse practitioner
Aboriginal and Torres Strait Islander health practitioner	• Aboriginal and/or Torres Strait Islander person registered with the Aboriginal and/or Torres Strait Islander Board of Australia, who enhances holistic health to their community in a culturally safe manner[18]
Cultural support worker	• May include (but not limited to): o Culturally linked liaison officers o Aboriginal Heath Care Workers o Indigenous hospital liaison officers (IHLO's) o Multicultural nurse or midwifery navigation services o Migrant resource supports o Other religious, spiritual or faith based supports (e.g. chaplains)
Allied health practitioner	• A qualified healthcare provider with specialised expertise in preventing, diagnosing and treating a range of conditions and illnesses • Includes pharmacist, dietitian/nutritionist, physiotherapist, occupational therapist, speech pathologist, social worker, psychologist and other disciplines[19]
Multidisciplinary team	• Team of healthcare professionals from multiple disciplines including (but not limited to): o Nurses, doctors, midwives, social workers, Aboriginal and/or Torres Strait Islander health practitioners, pharmacists, physiotherapists, perinatal and infant mental health clinicians • Work together to deliver comprehensive woman and family centred care[2]
Student	• Participant in an approved program of study that leads to eligibility for registration as a healthcare professional, who is undertaking clinical training[20]
Doula	• An unregulated worker who provides non-medical support and information to women and their partners during pregnancy, birth and the postnatal period • Clinical tasks, (e.g. vaginal examinations and fetal heart rate monitoring, medical/midwifery advice, or diagnosing and second opinions) are outside their scope of practice[21]

2.3.1 Clinician practice

Table 4. Clinician practice

Aspect	Comment
Scope of practice	• The roles, functions, responsibilities and activities that a healthcare professional is educated and competent to carry out o Includes legislative requirements, professional standards and local and organisational policy[2] • Includes scope of practice for the profession as well as the individual[22] • Individual scope of practice varies depending on the[16,22]: o Context where the care is provided o Health needs of women and babies o Level of competence and confidence of the healthcare provider o Policy requirements of the service provider
Education and development	• Complete education and development training required for care provision including: o Continuing professional development applicable to registration and scope of practice o Mandatory training[5] (e.g. annual competency in normal birth, basic and advanced neonatal life support) o Use of equipment and technology o Legislative requirements • Support the acquisition of skills, knowledge and behaviours that support and improve the planning and delivery of culturally respectful and appropriate care[23] • Facilitate access to employee assistance services as required
Recommendation	• Provide autonomous and collaborative care within scope of practice, level of competence and legislative requirements

2.4 Health environment

Table 5. Health environment

Aspect	Consideration
Maternity and neonatal environment	• The setting within which maternity care is provided can have a significant impact on the woman's pregnancy and birth experience • Women have unique views on what constitutes a safe and comfortable environment[24] • Consider aspects that enhance a woman's sense of safety and reduce stress and fear (including but not limited to): o Aesthetics of the clinical environment (e.g. display of clinical resources) o Factors that impact on normal physiological coping mechanisms (e.g. privacy, reduced clinical noise, continuity of carer) o A woman's preferences for birth environment (e.g. lighting, music) o Equipment that enhances a woman's options during birth (e.g. bath for water immersion during labour) • Support care provision close to home wherever possible • When nursery admission is required for the baby, welcome and invite involvement in care provision • Utilise expert networked care in non-birthing sites (e.g. Retrieval Services Queensland, QuMid)
Equipment and consumables	• Ensure equipment is suitable and appropriate for the intended population (e.g. neonatal sized equipment for neonates) • Ensure required equipment is available in the clinical area it is needed (e.g. fetal monitoring devices in birthing areas, neonatal resuscitation equipment in birthing suites and neonatal units) • Use and maintain equipment as per manufacturer's instructions (e.g. storage, calibration, servicing, recalls) • Check essential equipment is functional as per local policies and work instructions (e.g. resuscitation equipment check list) • Use recommended consumable where these are specified in QCG guidelines (e.g. neonatal filters during COVID-19)

3 Partnering with consumers

Standard 2: Partnering with consumers aims to ensure active partnerships between health services and consumers across planning, design, delivery and evaluation of healthcare.[2]

Table 6. Consumer partnerships

Aspect	Consideration
Healthcare rights	• The Australian Charter of Healthcare Rights (the Charter) is the framework within which maternity care is provided[25] • Rights include access, safety, respect, partnership, information, privacy and feedback • Facilitate access to and knowledge of the Charter for consumers and clinicians
Consumer representative	• May include o Person who has used or may potentially use health services o Family members or carers for a woman/baby of a health service[2] o Individuals, groups or communities such as women and/or their families, representatives and significant others who work in partnership with health professionals to plan and receive healthcare[26] • Involve consumers in healthcare planning and decisions (e.g. from commencement of planning, inclusion of consumer representatives on committees and in decision making groups) • Reflect the diversity of the local population accessing the maternity care within local consumer representation • Incorporate the views and experiences of consumers into workforce training and education (e.g. during development of clinician education by including consumer voice from commencement and in content)
Health literacy	• Includes knowledge of when and where to seek health information and personal skills (e.g. assertiveness, capacity to process, and retain and apply information) o Impacted by culture, language, writing, reading and numeracy skills • Actively seek to identify barriers to health literacy • Consider: o Skills, abilities and individual capacity to understand health information o Specific needs of women and families from culturally and linguistically diverse backgrounds[23,27] • Refer to Section 7.2 Effective communication

3.1 Privacy

Includes respect for body, personal space and information. Refer to Section 7 Communication for safety

Table 7. Privacy of body and information

Aspect	Consideration
Confidential care	• Ensure surroundings where care is provided enables private and confidential consultations, treatment and management and discussions (e.g. avoid clinical discussions in open multi-bed areas)
Physical privacy	• Obtain consent for all personal/intimate examinations and care o Refer to Section 3.3 Consent • Offer the presence of a chaperone • If the gender of the healthcare provider is not acceptable to the woman (e.g. for religious, cultural or other reason), make arrangements for a healthcare provider of the preferred gender o If delayed, discuss risks and benefits of waiting, or declining the examination or care • Conduct personal/intimate examinations in environments that: o Maintain dignity and minimise embarrassment o Enable private discussions o Facilitate cultural safety
Information privacy	• Maintain privacy and confidentiality of information in relation to collection, storage, access and disclosure of information as per Australian Privacy Principles[28] and Information Privacy Act 2009[29] • Seek and document informed consent before disclosing information • Maintain awareness that women and children may be subject to domestic violence, protective court orders and other complex situations requiring additional vigilance around privacy and confidentiality of information

3.2 Informed decision-making

Table 8. Informed decision making

Aspect	Consideration
System level	• Informed decision-making is enhanced when system/organisational structures and processes are integrated into clinical care: o Standard evidence informed information is provided (or identified for individuals to access) in antenatal and postnatal preparation classes/sessions/groups o Information sharing occurs early and is repeated in the antenatal period o Woman and family focused resources are available and accessible to support standardised information sharing (e.g. decision aids, consumer information sheets) o Antenatal outpatient care is structured to facilitate individual counselling (e.g. length of appointment allows time and opportunity, multidisciplinary team case conference can occur) o Scheduling of multiple appointments is coordinated to minimise travel and impact on the woman (e.g. appointments occur on same day) • Care is based on trust, respect and familiarity with services and provider/s o Refer to Section 6.3 Continuity of care • Refer to: o Queensland Health: *Guide to Informed decision-making in healthcare*[1] o QCG: *Parent information*
Individual level	• Individual clinicians engage in interactive communication: o In a transparent, nondirective, non-judgemental manner based on best available evidence • Utilise effective communication techniques o Refer to Section 7 Communication for safety • Communication includes assessment of the woman's: o Needs, wishes and priorities and health literacy o Medical history, family, social, cultural, religious/faith and occupational circumstances

3.3 Consent

Table 9. Consent

Aspect	Consideration
Context	• Other than in exceptional circumstances, adults have the right to determine what will be done to their bodies and what healthcare treatments and interventions they will undergo • Obtaining properly informed consent is a legal, ethical and professional requirement for all treating healthcare providers • Refer to Queensland Health: *Guide to Informed decision-making in healthcare*[1]
Consent	• A person's decision, given voluntarily, to agree to a healthcare treatment, procedure or other intervention • The person has legal capacity to consent o If legal capacity is uncertain escalate as required • The decision is made: o After provision of accurate and relevant information about the healthcare intervention and alternative options available o With adequate knowledge and understanding of the benefits and risks relevant to the individual's values, preferences and circumstances o At an appropriately timed opportunity, with the chance to ask questions and discuss concerns
Tailor the process	• Use an interpreter or other communication aid as required (e.g. decision aids, woman/parent information sheets, aural and visual aids, languages other than English) • Personalise the information to the circumstances of the individual woman • Ideally commence discussions about intrapartum treatments and interventions during the antenatal period
Declining care	• Women may choose to decline all or part of care offered, or to withdraw consent at any time • Refer to Queensland Health guideline: *Partnering with the woman who declines recommended maternity care*[1]
Baby	• Obtain informed consent from women/parents for interventions, medications and care • Parents may choose to refuse treatment(s) for their baby[30] o If parental decisions are considered to not be in the baby's best interests, escalate as required • Obtain parental consent before taking clinical photographs, images, video or other permanent recordings of a baby
Document	• Use Queensland Health (QH) standard consent forms (where relevant) • Contemporaneously document consent discussions • Include all written consent in the health record
Recommendation	• Properly obtain informed consent for all treatments and interventions including medications and other therapeutic substances o May be verbal, written or implied • Discuss and incorporate: o Each available treatment or intervention option o A balanced perspective of both risks and benefits of each option o The woman's values, preferences and circumstances • Refer to Section 3.2 Informed decision-making

4 Preventing and controlling infections

Standard 3: Preventing and controlling infections which aims to reduce the risk to patients, consumers and members of the workforce acquiring preventable healthcare associated infections, manage infections effectively if they occur, and limit the development of antimicrobial resistance through the appropriate prescribing and use of antimicrobials.[2]

Table 10. Infection management

Aspect	Consideration
Standard and transmission based precautions	• Follow national standards and local policies and procedures[31] • Identify and manage risks associated with infections o Use personal protective equipment (PPE) in accordance with standard and transmission based precautions for procedures and patient contact in line with national guidelines, standards and local procedures[31] o Perform hand hygiene before, during and after every episode of personal contact[31,32] as per the '5 moments of hand hygiene' o Use aseptic technique when providing treatments and interventions where this applies • Refer to: ACSQHC: *Sepsis Clinical care Standard* and related resources[7]
Antimicrobial stewardship	• Adhere to the principles of antimicrobial stewardship to improve patient outcomes, minimise adverse events and decrease the rate of antimicrobial resistance[33] • Provide the correct antibiotic to treat the condition at the right dose, the right route, at the right time and for the right duration to women and babies with bacterial infections • Accurately assess and provide timely review to reduce risk of adverse effects and reduce the emergence of antibiotic resistance[34] • Consult with infectious diseases team as required
Invasive medical devices and safe clean environment	• Follow national standards and local policies and procedures for[31]: o Reprocessing reusable equipment and instruments o Disposing of sharps o Environmental cleaning o Waste management o Linen handling
Workforce screening and immunisations	• Healthcare professionals and other non-clinical workforce personnel have immunisation status consistent with the recommendations in The Australian Immunisation Handbook and QH requirements for vaccine-preventable diseases relevant to their area of work
Newborn immunisations	• Promote and offer newborn immunisations as per the Queensland Immunisation schedule[35]

5 Medication safety

Standard 4: Medication safety which aims to ensure that clinicians are competent to safely prescribe, dispense and administer appropriate medicines, and monitor medicine use. It also aims to ensure that consumers are informed about medicines, and understand their own medicine needs and risks.[2]

Table 11. Medication management

Aspect	Consideration
Context	• QCG guidance regarding medications is based on the best available evidence, expert advice and consensus of the working party • Drug information is abbreviated and provided as a guide only • Refer to a current copy of an Australian or other pharmacopeia for detailed information • Manage medications (prescribe, dispense and administer) within the individual health practitioner's scope of practice
Medication history	• Record a patient's best possible medication history when commencing an episode of care • Ensure the medication history, and information relating to medicine allergies and adverse drug reactions are available to clinicians
Prescribing	• Prescribe according to specific indications including off-label indications • Be aware of possible allergies, adverse reactions and precautions • Consider benefits versus risks of medication • Follow general principles of drug prescribing (i.e.name of drug (generic), route, dose, dose calculation, frequency, duration[30])
Medication charts and forms	• Use standard prescription/medication forms: o National hospital medication chart o Digital medication chart (approved locally) o Pharmaceutical benefits scheme hospital medication chart[36] • Use approved terminology, abbreviations and symbols[30] • Use standard administration forms for prophylactic and therapeutic medications where they exist and are age appropriate (e.g. Queensland Clinical Guideline: *Insulin intravenous Infusion (Maternity) Order/Intrapartum Blood Glucose Record*)[37] • Use clinical discretion and consider the individual woman/baby when using the chart for personalised medication management in acute care settings[36]
Administration	• Follow local protocols for medication management and administration including. o Standing orders o *'Rights'* of medication administration (right patient, right drug (check expiry date), right time, right dose, right route, right to refuse, right documentation) o Storage and access to controlled medications • Check for and record known allergies • Use medication delivery devices (where appropriate) o As per manufactures recommendations o In accordance with medication library safety settings (where relevant) • Trace all intravenous (IV) lines from their source (e.g. infusion pump) to the access point into the body prior to making connections or administering medications, to avoid incorrect route error
Extended practice authority	• Manage medicines within the circumstances, context, place scope, conditions and supervision arrangements specified in the relevant extended practice authority (EPA)
Continuity	• Review current medications on admission and discharge • Document details in the medical record (i.e. name, route, indication, duration and plan for review[34]) • Provide a medicines list to the patient and the receiving clinician when handing over care • At discharge, provide a medicines list and information to the woman and to relevant community healthcare providers about ongoing medication, any changes, risks and if review is required

5.1 Neonatal medicines

Table 12. Neonatal medicines

Aspect	Description
Context	• Neonates are at greater risk of sustaining a medication error than other members of the population • Refer to Queensland Clinical Guideline *Neonatal medicines*[38]
Neonatal medicines	• Refer to NeoMedQ for individual neonatal medicine monographs • For babies, consider weight (birth weight or actual as appropriate), gestational age, current gestational age, dose calculation and frequency where appropriate[39,40] • Seek advice from relevant clinician/service (e.g. neonatologist via Retrieval Services Queensland (RSQ), pharmacist,) as required

5.2 Allergy and adverse drug reactions

Table 13. Allergy and adverse drug reactions

Aspect	Description
Context	• May arise from a drug, food, plant, animal, insect or other substance • May contribute to a drug-drug, drug-food or drug-disease interaction
Adverse drug reaction (ADR)	• Includes all unintended side effects • **Type A** ADRs are reactions that are dose dependent and known/expected to occur due to the properties of the medicine[41] • **Type B** ADRs are unpredictable[41] and may include reactions due to hypersensitivity and drug intolerance • Therapeutic failures, intentional overdose, abuse of the drug and errors in administration are not ADRs
Allergy/ hypersensitivity reactions	• Broad term for unpredictable adverse drug reactions caused by immune-mediated or other mechanisms[42] • May be due to o Non-allergic (non-immune mediated) medication hypersensitivity o Medication allergy (immune mediated) in a sensitised person[42] • Reactions may be[43]: o Immediate–IgE mediated o Non-immediate–due to activation of cellular immunity o Symptoms range from mild to moderate to life threatening reactions and may worsen or lessen over time
Sensitivity	• Also termed intolerance • Pharmacological, not immune mediated response[43] • Can occur at low or normal dose
Documentation	• Document the type and nature of any known allergies or ADR o The first clinician taking a health history, also documents the absence of any known allergy or ADR • Include: o Name of causative agent, reaction symptoms, date and timeframe of reaction o Ideally identify severity, reaction type, management required, source of allergy history (e.g. parent) • Follow local protocols for: o Reporting new or suspected ADR or allergy o Placement of medication allergy/ADR stickers and electronic system notifications o Use of medication action plans and responsibility for completion o Use of patient identification bands that include allergy alerts
Recommendation	• For women with medication allergy, in particular antibiotics, consider referral to an infectious disease specialist or immunologist for expert advice about: o Allergy delabelling and desensitising o Alternative antibiotic treatments

6 Comprehensive care

Standard 5: Health service organisations set up and maintain systems and processes to support clinicians deliver comprehensive care. Systems are also set up and maintained to prevent and manage specific risks of harm to patients during the delivery of healthcare. The workforce uses the systems to deliver comprehensive care and manage risk[2]

6.1 Principles of maternity and neonatal care

Table 14. Principles of care

Aspect	Consideration
Woman centred care[2]	• Acknowledge pregnancy and birth as a significant life event that can influence the woman's future physical and emotional health and wellbeing and that affects the entire family • Provide care in a respectful environment that supports and protects the dignity, and individual physical, psychological and emotional wellbeing of the woman • Apply the principles in the Queensland Clinical Guideline *Normal birth*[44] to support normal physiological processes regardless of how a woman enters or progresses during labour and birth • Base care on the best available evidence and the woman's: o Individual needs and preferences o Empowerment in informed decision making o Preferred partnerships with care providers • Provide an opportunity for women to: o Make an informed choice regarding treatment options o Delay decision making when safe to do so
Assessment[7]	• Undertake comprehensive history taking, screening, examination and assessment as indicated o Refer to relevant QCG guidelines • Routinely screen/assess cognitive, behavioural, psychological and physical conditions including to: o Inform prevention and management of pressure injuries o Prevent falls and harm from falls o Identify and manage cognitive impairment o Prevent self-harm or harm to baby o Screen for domestic and family violence, o Maintain nutrition and hydration needs relevant to the individual and their circumstances • Use validated and/or recommended assessment tools wherever possible • Escalate (refer, consult or transfer) care as necessary
Planning	• Involve women and families in planning care using the principles of informed consent and decision making o Refer to Section 3.2 Informed decision-making • Use a multidisciplinary team approach, involving members of the healthcare team as relevant to the circumstances • For First Nations women, plan care in a manner that supports culturally safe and appropriate care • Discuss the benefits and possible outcomes of normal physiological pregnancy as well as the benefits and risks of anticipated interventions or treatments • Document an agreed plan of care and update at regular intervals o Include antenatal discussions and the woman's preferences o Maintain flexibility and acknowledge the woman's right to amend or alter the birth plan at any time
Healthcare records	• Maintain contemporaneous and accurate individual person healthcare documentation in accordance with local policy and procedure • Comply with security and privacy regulations about the collection, review and release of personal health information • Use standard and accepted nomenclature, abbreviations, clinical forms and documents

6.2 Models of care

Regardless of the model, maternity and newborn care may be provided in the community (including outreach clinics), hospital or the woman's home.[45,46] Generally, postnatal care is not provided in hospital outpatient clinics. Some women may choose private birthing at home under the care of a private practice midwife. Others may choose 'free birthing', although this option is not recommended because of safety concerns for the woman and her baby due to the absence of immediate access to a qualified and regulated health practitioner (i.e. midwife or obstetrician).

Table 15. Models of care

Aspect	Description
Collaborative care	• Dynamic process to facilitate communication, trust and pathways to provide safe, woman centred care • Enables women to be active participants in their care • Has clearly defined roles and responsibilities for everyone • Involves clinical networks and systems for timely referral and transfer of the woman and baby when required • May be provided in the private or public sector, or in combined models incorporating multiple disciplines
Family centred care	• Encourage women, parents and families to participate in care and decision making at the level they choose[47] • Share information in a complete, unbiased and timely manner to support effective participation in care and decision making • Seek parental consent for newborn baby care, investigations and treatments • Listen to and acknowledge parental views and choices regarding planning and delivery of care

6.3 Continuity of care and carer

Table 16. Continuity of care

Aspect	Description
Continuity of care	• Care is provided by a team without a designated named carer • All healthcare providers involved in the woman's care have a shared understanding of care pathways for the woman's care • Aims to reduce fragmented care and conflicting advice[45]
Continuity of carer	• A healthcare provider is known by the woman and provides her care o Enables relationship development[45] o Continues to provide care over the full episode of care, even when other caregivers are required
Midwife led continuity of care[48]	• A Cochrane review[48] (15 studies, n=17,674) identified that compared to women who had other models of care, women who received midwife led continuity models of care are: o Less likely to experience regional analgesia, instrumental birth or episiotomy, a preterm birth less than 37 weeks, or a fetal loss or neonatal death before or after 24 weeks o More likely to experience spontaneous vaginal birth and have a longer mean length of labour o No difference in rate of caesarean births or intact perineum or adverse effects
Recommendation	• Promote continuity of care[49] and carer**[48]** as the optimal model of care for women and their families • Promote 'all risk' models that incorporate continuity of care or carer, including midwife continuity of carer for women receiving maternal fetal medicine care and women who have experienced previous fetal or neonatal loss • Provide option of continuity of care or carer for all First Nations women[50]

6.4 Culturally safe care

Table 17. Culturally safe care

Aspect	Consideration
Context	• Culture has a major role in the way a woman perceives and prepares for pregnancy, labour birth and the postpartum period • There are many values, beliefs and practices related to pregnancy, birth and newborn care that differ between cultures
Cultural assessment	• Provide care that acknowledges and respects cultural norms, beliefs and practices • Ask about key cultural aspects of maternity care during the antenatal period (e.g. management of the placenta, infant feeding, food customs, presence of the partner at birth, female genital mutilation (FGM), taboos)[23,27] • Offer and anticipate the need for interpreter services, especially during sensitive discussions and for complex care
Clinically important ethnic variation	• Maintain awareness that some ethnic groups have an increased risk of genetic conditions or other diseases • Individualise care taking into account the risk of increased adverse outcomes (e.g. alpha thalassemia in women from Southeast Asia, incidence of consanguinity) • Refer to Migrant and Refugee Women's Health Partnership: Culturally responsive clinical practice: Working with people from migrant and refugee backgrounds[51]
Female genital mutilation (FGM)	• For care of pregnant and birthing women who have experienced FGM, refer to Queensland Clinical Guideline: *Perineal care*[52]
Social and emotional wellbeing	• Women from culturally and linguistically diverse (CALD) backgrounds may experience unique stressors related to multiple factors (e.g. pre-immigration experiences of war or refugee camps, adjustment to Australian environment, lack of knowledge of services, lack of family support)[53] • Where possible, use validated cross cultural screening tools for psychological wellbeing[53] • Offer and advise on culturally acceptable networks, supports and resources
Imparting sad news	• In some cultures, sad or bad news is not told directly to the woman, but rather close family or friends are informed first • Take into account cultural nuances and practices when disclosing sad or sensitive information • Seek advice from relevant cultural support services and appropriate resources
Aboriginal and/or Torres Strait Islander women	• Promote local community based care that incorporates and respects cultural values (e.g. *Birthing on Country* or *Birthing in Our Community*) • If a woman identifies as Aboriginal and/or Torres Strait Islander, offer support from identified advanced healthcare workers, IHLO, Indigenous midwife or nurse navigation services at entry point to service delivery (where available) • Refer to o Aboriginal and Torres Strait Islander patient care guideline[54] o Growing Deadly Families Aboriginal and Torres Strait Islander maternity services strategy 2019–2025[50] o Sad News, Sorry Business: Guidelines for caring for Aboriginal and Torres Strait Islander people through death and dying[55] o Queensland Health: Making tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033: Policy and accountability framework[56] o Queensland Health: Making tracks together: Queensland's Aboriginal and Torres Strait Islander health equity framework[11] o National Safety and Quality Health Service Standards User Guide for Aboriginal and Torres Strait Islander Health[57]

6.5 Specific clinical circumstances

The following clinical care circumstances provides generic guidance. More detailed considerations may be contained as relevant in other QCG resources.

6.5.1 Planned transfer for birth

Table 18. Transfer for birthing services

Aspect	Consideration
Context	• Some communities routinely recommend pregnant women are transferred to another location/facility to await the onset of labour and birth (e.g. from 37 weeks gestion) • Women may also have individual health circumstances where transfer of care is recommended during pregnancy and planned in advance • This can lead to dislocation from partner, other children, family and known supports as well as financial and emotional hardship
Recommendation	• Where transfer for birth is known or expected o Co-design a care plan with the woman in advance of expected transfer (e.g. by 36 weeks gestation) o Review the plan weekly or more frequently as clinically appropriate o Involve support services (e.g. patient travel subsidy scheme) as required o Take into consideration family, social, cultural and financial issues relevant to the woman's circumstances o For Aboriginal and/or Torres Strait Islander women, facilitate culturally appropriate supports and environment • Refer to Section 6.4 Culturally safe care

6.5.2 Skin to skin contact

Support skin to skin contact immediately after birth for a minimum of one hour, and during ongoing care for both preterm and term babies when clinically safe to do so.

Table 19. Skin to skin contact

Aspect	Consideration
Benefits	• Enhancement of maternal-infant bonding and wellbeing[58] • Breastfeeding (increased duration and effectiveness)[58] • Higher blood sugar levels[59] • Maintenance of thermoregulation[58] • Reduction in maternal and infant stress[58] • Improved cardiovascular stability[58]
Safety during skin to skin	• Follow local protocols for supervision during skin to skin contact o Requires frequent visual observations of the baby • Assess individual circumstances to identify risk factors which may raise safety issues during skin to skin contact (e.g. maternal fatigue, pain, sedation, mental health concerns, limited mobility, concerns with health of baby) • Position woman and baby so that baby: o Has face visible o Cannot fall on to the floor o Cannot become trapped in bedding or by the woman's body o Has head supported so airway does not become obstructed • Perform observations throughout the period of skin to skin contact and interrupt skin to skin contact if the health of either the woman or the baby gives rise to concern • Refer to Queensland Clinical Guideline: *Safer infant sleep*[60]

6.5.3 Infant feeding

Support a woman's choice of feeding method using a non-judgemental and positive approach.

Table 20. Infant feeding

Aspect	Consideration
Breastfeeding	• Promote breastfeeding and breastmilk as the optimal source of nutrition for most babies • Offer support and assistance for breastfeeding/expressing breast milk as required o Refer for expert advice during and following inpatient admission as required (e.g. lactation consultant) • Refer to Queensland Clinical Guidelines: o *Establishing breastfeeding*[61] o *Perinatal substance use:maternal*[62]
Formula feeding	• Provide information for hygienic and safe preparation of formula milk including (but not limited to) expected intake volume and frequency, cleaning and sterilisation of equipment, positioning during feed

6.5.4 Neonatal unit admission

Table 21. Neonatal unit admission

Aspect	Consideration
Admission	• Admission criteria as per CSCF and local policy • Perform observations as clinically indicated • Refer to NeoMedQ monographs for medicine information • Refer to Section Table 15. Models of care
Emotional support	• Recognise admission is a stressful time for parents/carers and family o Particularly if transfer/retrieval is required • Encourage interactions and involvement in care (e.g. video links, photographs, recognition of important milestones) • Provide information to parents about standard care requirements including o Visitor policy o Importance of infection prevention and control o Developmental care o Links and information about relevant support groups, and special needs groups and organisations o Supports for continued breastfeeding (as relevant) • Involve social supports in care provision as required (e.g. social worker) • Employ techniques for effective communication

6.5.5 Perinatal mental health

Table 22. Perinatal mental health

Aspect	Consideration
Assessment	• Routinely assess social and emotional wellbeing during each care contact in the antenatal and postnatal periods (including rescreening for domestic and family violence) • Screen for perinatal mental health using validated tools (e.g. Edinburgh Postnatal Depression Scale (EPDS), Kimberly Mum's Moods Scale) at routine and opportunistic points of care • Refer and consult as indicated by individual circumstances
Avoid separation	• Keep mother and baby together whenever possible[63] • Complex care circumstances (e.g. substance use, existing mental health concerns) may require innovative and unique models of support and care provision

6.5.6 Child protection and safety

Table 23. Child safety

Aspect	Consideration
Context	• Some circumstances may require a proactive approach to prevent harm • Mandatory reporting of child safety concerns is a legal requirement for healthcare providers[64]
Assessment and reporting	• Undertake a child safety assessment in accordance with duty of care responsibilities • Report to the Department of Communities, Child Safety and Disability Services, all reasonable suspicions that the child has suffered, is suffering or is at unacceptable risk of suffering significant harm where there is no parent/carer able and willing to protect the child from harm, make a [64] • Involve members of the multidisciplinary team as required o Include primary and local service providers in planning (e.g. general practitioner (GP), community child health services) o Support access to early intervention services to minimise the potential for future harm to the child

6.5.7 Discharge

Table 24. Discharge

Aspect	Consideration
Planning	• Commence discharge planning for both woman and baby early in the inpatient stay relevant to the individual circumstances (e.g. referrals, parental education for discharge, documentation) o Avoid overload of information on day of discharge • Communicate expected duration of stay, timing of discharge, and criteria or circumstances impacting on discharge to aid expectation management • Involve women and families in discharge decisions and consider factors relevant to the timing of discharge (e.g. distance to travel, availability or access to follow-up and support services) • Involve members of the multidisciplinary team as required (e.g. social worker, home visiting service)
Routine screening	• Routinely recommend newborn screening tests to families in a manner that supports informed decision making o Refer to Section 3.2 Informed decision-making and Section 3.3 Consent • Plan for and discuss all routine newborn baby screenings including: o Neonatal bloodspot screening (and follow-up if required) o Healthy hearing screening o Critical congenital heart disease screening • Document consent/declined screening test as per local policy/procedures
Parental education	• Provide routine neonatal education to parent/carer, including about: o Cardiopulmonary resuscitation (CPR) o Safer infant sleep and the risk of sudden unexpected death of an infant (SUDI)[60] o Childhood immunisation schedule[35] o Signs of illness and when to seek medical review
Care in the community	• Support establishment of GP relationship (if not already established) for ongoing care • Refer to relevant community health services (e.g. child health) • Refer parent/carer to available services for parenting and other ongoing information and advice as required (e.g. perinatal and infant mental health services)

7 Communication for safety

Standard 6: Communicating for safety aims to ensure that there is effective communication between patients, carers and families, multidisciplinary teams and clinicians, and across the health service organisation to support continuous, coordinated and safe care for patients.[2]

7.1 Clinical communication

Clinical handover is the transfer of professional responsibility and accountability for some or all aspects of care for a patient or group of patients, to another person or professional group on a temporary or permanent basis.[2]

Table 25. Clinical communication

Aspect	Consideration
Context	• Effective communication is critical to the delivery of safe patient care and to the woman's experience of care • A breakdown in the transfer of information is a major contributing factor to adverse clinical events and inadequate or poor documentation of clinical information can result in errors, misdiagnosis and inappropriate treatment[2]
Requirements for clinical handover[2]	• Use a structured and consistent format to communicate during the transfer professional responsibility and accountability for care (e.g. SBAR[65,66]; is a tool that presents information related to **S**ituation, **B**ackground, **A**ssessment, **R**ecommendation) • Identify minimum data sets that ensures important clinical information is handed over relevant to the patient condition (e.g. checklist or standard form) • Involve all relevant clinicians in the handover • Follow local policy and protocols for timing of shift handovers • If possible and safe to do so, include the woman and partner in a bedside handover • Refer to patient documentation during handover
Communication between care providers	• Develop local protocols and pathways to facilitate communication about the woman's and baby's care o Between emergency, outpatient and maternity departments o At discharge to community healthcare providers (e.g. private midwives, midwifery group practice midwives, GP, child health nurse) • Use endorsed paper or electronic forms in written communications including, but not limited to: o Pregnancy health record o Early labour record; intrapartum record; clinical pathways o Medication charts o Early warning tools [refer to Section 9 Recognising and responding to acute deterioration] o Baby's Personal health record (*Red Book)*

7.2 Effective communication

Table 26. Effective communications

Aspect	Consideration
Context	• Effective communication builds trust, reduces unnecessary angst and improves the healthcare experience[10] • Involves talking, listening, body language (non-verbal), consultation, exchange of information and includes use of other visual mediums (e.g. music, film)
Clinician education	• Clinician communication training can enhance the quality of information sharing with the woman and family, and between clinicians
Listening	• Focus on the person, what is being said and the emotions and meaning being conveyed • Strategies include o Stop talking, avoid interrupting o Check for understanding, paraphrase meaning o Show interest with body language and facial expression (e.g. open body stance, nod, smile) o Be personal and recognise the potential for a power imbalance between clinician and the woman
Compassion and respect	• Use a positive attitude and encouragement to build confidence and reduce anxiety • Show empathy and compassion • Show cultural and religious awareness • Practice self-reflection to aid recognition of communication patterns and usual triggers for stressful and emotional reactions
Language	• Use clear unambiguous language (plain English) sensitive to the context • Be honest about what is known or uncertain and avoid evasive answers or explanations • Convey complex information and concepts at a slower pace • Establish understanding by checking back and repetition • Avoid o Language that suggests judgement o Words that may cause distress (e.g. ‘products of conception’ rather than ‘baby’)
Interpreter services	• Offer interpreter services as required to women and families where English is not the first language • Avoid using family members as interpreters, especially for sensitive communications
Environment and context	• Consider the physical setting relevant to the communication (e.g. privacy, noise level) • Avoid rushed or hurried communications • Allow time for questions and discussion to aid decision making • Involve others in communications in accordance with the woman’s preferences (e.g. social worker, family members, Aboriginal and Torres Strait Islander liaison worker) • Use space to facilitate rapport (e.g. not sitting behind desk, sit at equal eye level)
Non-verbal	• Be cognisant of own and others non-verbal communication (e.g. facial expression, body language) • Avoid negative body language (e.g. eye rolling) or body language not congruent with words • Provide information at a level of health literacy appropriate for the circumstances (e.g. use images, diagrams, video, and written text

7.3 Patient identification

Table 27. Patient identification

Aspect	Consideration
Clinical standard	• Follow local policies and procedures • Apply identification bands on admission or at time of birth • Use at least three points of identification[2] o Family name o Date of birth o Hospital record number o Baby is normally identified as 'baby of [mother's name]' during inpatient stay
Identification checks	• Check identification when care, medication, therapy or other services are provided o Care, therapy, investigations, surgery or services o Information about results o Discharge documentation/ referral letters • Use for clinical handover, and transfer or generation of discharge documentation[2] • Check prior to labelling and administration of: o Medications o Breast milk o Blood products

7.4 Sex and gender

Appropriate recognition of gender, transgender and gender diverse people supports positive and respectful relationships and facilitates positive health outcomes.[67]

Table 28. Sex and gender

Aspect	Consideration
Terminology	• Gender and sex are terms often used interchangeably but are two different concepts[67] • Sex[67] o Defined by person's chromosomal, gonadal and anatomical characteristics of their biological sex (i.e. male, female, intersex) • Gender[67] o A person's social and personal identity o Expressed in different ways (e.g. behaviour or physical appearance) o Does not necessarily equate with sex characteristics or sexuality • Some words can have both sexed and gendered meaning (e.g. woman can mean an adult with a gender identity of 'woman' and mother can mean a parent with gender identify of 'woman'[68]
Gender diverse people	• Defined as where a person's gender differs from the sex assigned at birth • Other terms that may be used are transgender, trans, non-binary, gender queer, gender fluid, agender • An Aboriginal and/or Torres Strait Islander person may call themselves Brotherboy or Sistergirl • Surgery or hormones are not required to identify as gender diverse
Human rights	• Gender diverse people are protected from discrimination by law[69]
Use in QCG documents	• In QCG documents, the terms woman, newborn, baby, partner/carer and family are used to: o Support plain English use and health literacy o Avoid dehumanising and diminishing references to women • Use of these terms should be taken to include people who do not identify as women but who are pregnant or have given birth
Recommendation	• If relevant to clinical care[68] identify the sex of individuals (e.g. for Rh D immunoglobulin) • If a person or their partner identifies as gender diverse: o Ask what gender the person identifies as o Use the person's preferred pronouns

8 Blood management

Standard 7: Blood management aims to ensure that patients' own blood is safely and appropriately managed, and that any blood and blood products that patients receive are safe and appropriate[2]

Table 29. Blood

Aspect	Consideration
Context	• Follow local policies and protocols for the storage, administration and disposal of blood and blood products • Refer to the National Blood Authority for guidelines and specific product information specifically: o Patient Blood Management Guidelines: Module 5. Obstetrics and Maternity[70] o Patient Blood Management Guidelines: Module 6: Neonatal and Paediatric[71] o Prophylactic use of Rh D Immunoglobulin in pregnancy care[72]
Clinical care	• Follow local protocols • Monitor and record baseline observations[73] and continue clinical surveillance of: o Temperature o Pulse o Respiratory rate o Blood pressure o Oxygen saturation • Document blood or blood product administration, and clinical response • If signs of adverse reaction: o Discontinue transfusion o Notify relevant medical officer o Report to facility's pathology service o Retain remaining blood components for investigation
Consent for blood products	• Follow usual processes for obtaining consent including providing written information • Discuss with women who are Jehovah's Witnesses blood product alternatives during the antenatal period • If indicated, discuss an advanced healthcare directive[74] or a statement of choice with the woman • Refer to Queensland Health guideline: *Partnering with the woman who declines recommended maternity care*[1]

9 Recognising and responding to acute deterioration

Standard 8: Recognising and responding to acute deterioration which aims to ensure that acute deterioration in a patient's physical, mental or cognitive condition is recognised promptly and appropriate action is taken.[2]

Table 30. Clinical deterioration

Aspect	Consideration
Escalation	• Follow local protocols regarding escalation of care of the woman or baby with deterioration in clinical status • When indicated, initiate basic and advanced life support according to standard protocols • Provide information to women and families about Ryan's Rule[12]
Retrieval and transfer	• If indicated, contact RSQ, for advice and/or escalation to higher level facility for maternal and or neonatal care • Arrange transfer/transport in a culturally safe environment guided by health workers as appropriate • Consider the needs of women, partners and family (e.g. for accommodation at destination, transport, breastmilk transport, care of other children)
Clinician education	• Facilitate access to clinician training that assists recognition and response to acute deterioration (including but not limited to) o Graded assertiveness o Obstetric emergency training o Mandatory training (e.g. neonatal resuscitation) o Multi-disciplinary training
Clinical surveillance	• Use clinical judgement • Vary recommendations contained in Queensland Clinical Guidelines, as appropriate to the clinical circumstances (e.g. increase frequency, add monitoring of additional observations) • Maintain awareness for subtle, unusual or masked signs and symptoms of deterioration beyond routine observation (including as reported by family/visitors/support people)
Documentation tools	• Use approved and recommended forms, for recording the woman's or baby's observations and responding to clinical deterioration[33,75]: o Maternity early warning tool (MEWT) o Neonatal early warning tool (NEWT) o Mental health recognised tools (e.g. EPDS, Kimberley Mum's Mood Scale) o Emergency specific tools (e.g. postpartum haemorrhage, shoulder dystocia, neonatal seizures) • Review trends over time and actual observations

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