Queensland Clinical Guidelines

Translating evidence into best clinical practice

Maternity and Neonatal **Clinical Guideline**

Standard care

Queensland Government

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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 in partnership with healthcare practitioners, 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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Abbreviations

CSCF	Clinical services capability framework
GP	General practitioner
NMBA	Nursing and Midwifery Board of Australia
MBA	Medical Board of Australia
NSQHS	National Safety and Quality Health Service Standards
QCG	Queensland Clinical Guidelines
RSQ	Retrieval Services Queensland
SBAR	Situation, Background, Assessment, Recommendation(s)

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Introduction

This guideline applies to the content included in all Queensland Clinical Guidelines (QCG) and associated resources.

The intent of this guideline is to define or describe generic healthcare concepts (standard care), standards or practices assumed to be common knowledge or in common use in Queensland maternity and neonatal service delivery. This will facilitate a common understanding of care delivery expectations and meaning, within QCG documents, promote consistency across documents and reduce duplication. The National Safety and Quality Health Service (NSQHS) Standards produced by the Australian Commission of Safety and Quality in Heath Care have been used as a framework for this guideline.[1]

1 Clinical governance

Standard 1: Clinical Governance aims to ensure that there are systems in place within health service organisations to maintain and improve the reliability, safety and quality of health care.[1]

1.1 Health care provider

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[2-4]. For example:

- Medical practitioner (e.g. general practitioner (GP))
- Midwife
- Nurse

A specialist practitioner is a health care provider who has undertaken a recognised program of additional advanced health education and training. For example

- Specialist medical practitioner (e.g. obstetrician, neonatologist, paediatrician, anaesthetist)
- Nurse practitioner

1.1.1 Other health care team members

Table 1. Other healthcare team

Aspect	Definition
Aboriginal and Torres Strait Islander health practitioner	· Aboriginal and/or Torres Strait Islander person registered with the Aboriginal and Torres Strait Islander Board of Australia who enhances holistic health to their community in a culturally safe manner[5]
Allied health practitioner	· A qualified health practitioner with specialised expertise in preventing, diagnosing and treating a range of conditions and illnesses, including pharmacy, physiotherapy, occupational therapy, speech pathology and other disciplines[6]
Consumer	· Person who has used or may potentially use health services' · Includes family members or carers for a client/patient of health service[1] · 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 health care[7]
Doula	· Provides non-medical support and information to women and their partners during birth and the postnatal period · Clinical tasks, including vaginal examinations and fetal heart rate monitoring, medical advice or diagnosing and second opinions, are outside their scope of practice[8]
Multidisciplinary team	· Team of health care professionals from multiple disciplines including (but not limited to): o Nurses, doctors, midwives, social workers, Aboriginal and Torres Strait Islander health practitioners, pharmacists, physiotherapists · Work together to deliver comprehensive patient care[1]
Student	· Participant in an approved program of study that leads to eligibility for registration as a health care professional who are undertaking clinical training[9]
Social worker	· Social workers support people to make change in their lives to improve their personal and social well-being[10]

1.1.2 Workforce

Table 2. Workforce

Aspect	Consideration
Education/ training	· Provide staff with opportunities for education and training to meet legislative, mandatory and requisite training relevant to their role and scope of practice
Staff debriefing	· Provide opportunities for staff debriefing following critical incidents and other situations where staff are required to provide care in stressful circumstance (e.g. stabilisation of sick preterm baby in regional unit prior to retrieval) · Involve appropriate staff, for example retrieval services to assist with the debrief · Ensure staff have access to employee assistance services as required

1.1.3 Scope of practice

Table 3. Scope of practice

Aspect	Comment
Context	· The boundaries within which the profession is educated, competent and permitted to perform by law · The roles, functions, responsibilities and activities that a health care professional is educated and competent to carry out · Includes: o Legislative requirements o Professional standards o Local and organisational policy[1,2,11,12] · Includes scope of practice for the profession as well as the individual[11] · Individual scope of practice varies depending on the: o Context where the care is provided o Health needs of the women and babies o Level of competence and confidence of the practitioner o Policy requirements of the service provider[2,11]
Aboriginal and Torres Strait Islander health practitioner	· Provide health care to Aboriginal and Torres Strait Island people in community health clinics and communities
Medical	· Work within level of competence to provide safe and appropriate care[4] · Not specifically defined by MBA · Expected–professional judgement is used · Complies with college guidelines regarding the attributes of fellows of relevant colleges, e.g. Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), Royal Australian College of Physicians, Royal Australian College of General Practitioners[3,13,14]
Midwife[11,12,15]	· Provide women-centred care across the woman's full continuum of pregnancy, labour and birth, postnatally and transition to parenting · Practise in any setting to promote holistic health, provide counselling and education for the woman, her family and the community in the areas of women's health, sexual or reproductive health and child care · Refer also to the International Confederation of Midwives[16]
Nursing	· Provides autonomous and collaborative care in a variety of settings including hospitals, outpatient departments, patients' homes and community settings · Includes: o Direct clinical care o Health promotion; illness prevention o Advocacy[11]

1.1.4 Competency

Table 4. Competency

Aspect	Comment
Experienced	· Possession of knowledge or skill in a particular field or activity gained over time[17]
Competent	· Combination of knowledge, skill, abilities and attributes required for the clinician to be successful in their role[1]
Credentialed	· Clinician has undergone a formal process to verify qualifications, skills, experience to ensure safe, high quality healthcare within a specific setting and role[18,19]
Education and training	· Health professionals are expected to have completed appropriate education and training in line with care provision including: o Continuing professional development applicable to registration and scope of practice o Mandatory training[18]

1.2 Clinical services capabilities framework

Table 5. Clinical services capability framework

Aspect	Consideration
Context	· Sets of minimum patient safety criteria by service capability level to inform health service planning and delivery · Short term care, for women and babies with complex health issues, beyond the capability service level may be required[20] 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[20] · Consider the level of clinical service capability framework (CSCF) when providing obstetric and neonatal care to women and babies · Provide all care within the facility and service CSCF
Key elements	· Consider[20]: o Workforce requirements including training and education, levels of competence and skills maintenance 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 o Available skill mix and staffing levels

1.3 Standards and guidelines

Table 6. Clinical standards

Aspect	Good practice point
Context	· Provide care based on available evidence, clinical judgement and the individual circumstances of the woman, baby and family · Levels of evidence used may range from: o High–level 1 based (randomised controlled trial), to low–consensus (expert opinion of clinicians) when no other level of evidence is available
National consensus statements	· Follow the recommendations of the National Consensus Statements specifically: o Recognising and responding to clinical deterioration[21] o Essential elements for safe and high-quality end-of-life care[22,23] o Essential elements for recognising and responding to deterioration in a person's mental state[21] · Use approved forms and documents[24-29] (e.g. medication charts, clinical pathways, early warning tools) [refer to Table 18. Clinical deterioration]
Clinical care standards	· Follow local evidence based protocols, guidelines and policies · Consider NSQHS Standards[1] in provision of clinical care to women and babies · Follow local evidence based protocols regarding the risk assessment and management of; o Falls o Pressure areas · Follow local evidence based protocols regarding patient and manual handling practices
National guidelines	· Consider recommendations of national guidelines including: o Clinical practice guidelines: Pregnancy care[30] o Patient blood management guidelines[31,32] o Management of perinatal infections guideline[33] · Consider recommendations of recognised Australian professional and other bodies including RANZCOG; Australian College of Midwives (ACM); Australian College of Neonatal Nurses (ACNN); Australian and New Zealand Committee on Resuscitation (ANZCOR); National Health and Medical Research Council (NHMRC)[15,34-37]

2 Partnering with consumers

Standard 2: Partnering with consumers which aims to ensure that there are systems in place within health service organisations to maintain and improve the reliability, safety and quality of health care.[1]

Table 7. Consumers

Aspect	Consideration
General principles[38,39]	· Design care to suit the needs of the women, babies and families (not the healthcare providers) · Recognise diversity · Include consumers in care planning and decision making · Ensure informed consent · Provide information in easy to understand terms · Treat women and babies with dignity and provide care that is respectful · Share useful information · Support and encourage women, partners and families · Encourage positive experiences · Emphasise safety · Incorporate consumer views and experiences into care
Health literacy	· Provide consumers with easy to understand information about health and healthcare to help them make decisions [40,41] (e.g., consent forms, patient/ consumer information) · Provide culturally appropriate resources · If required involve interpreter services
Cultural safety	· Provide care that is respectful of cultural norms and beliefs and identifies differences and needs of individuals and groups · Consider specific needs of Aboriginal and Torres Strait women, babies and families[42] · Consider specific needs of women and families form culturally and linguistically diverse backgrounds[42,43]

2.1 Consent

Table 8. Consent

Aspect	Good practice point
Informed consent[1]	· Follow policy and guidance about informed consent to ensure women and families receive and understand information about their health care, make informed decisions and have their decisions respected [44] · Provide the woman and her family (as appropriate) with relevant information[44]: o To make informed choices and decisions regarding all aspects of care including investigations, interventions, procedures and examinations o Withdraw consent at any time · Include in the discussion: o Care processes o Available and alternate options including no action o Potential outcomes § Risks and benefits § Success rates § Side effects
Informed decision making[45]	· The woman's values, goals and concerns are integrated with the best available evidence of benefits, risks and uncertainties of treatment to make appropriate care decisions · The woman (and family) with support from clinicians make care decisions · Encourage the woman (and family) to communicate care preferences
Baby	· Obtain informed consent from parents · Parents may choose to refuse treatment(s) for their baby[23] o If parental decisions are considered to not be in the baby's best interests escalate as indicated for advice
Declining care	· Women may decline all or part of care offered if they choose · Refer to *Declining care guideline*[46]

3 Preventing and controlling healthcare infection

Standard 3: Preventing and controlling health-care associated infection which aims to reduce the risk of patients getting 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.[1]

Table 9. Infection management

Aspect	Good practice point
Infection control	· Follow national standards and local policies and procedures including: o Standard precautions[47] § Use personal protective equipment for all procedures and patient contact in line with national standards and local procedures[47] · Perform hand hygiene before and after every episode of patient contact[47,48]
Antimicrobial stewardship	· Adhere to the principles of antimicrobial stewardship to improve patient outcomes, minimise adverse events and decrease the rate of antimicrobial resistance[49] · 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 woman and babies with bacterial infections · Accurately assess and provide timely review to reduce risk of adverse effects and reduce the emergence of antibiotic resistance[50]
Equipment	· Follow national standards and local policies and procedures for: o Processing reusable equipment and instruments o Disposing of sharps o Environmental cleaning o Waste management o Linen handling[47]

4 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.[1]

Table 10. Medication management

Aspect	Good practice point
Context	· QCG guidance regarding medications is based on the best available evidence, expert advice and consensus of the working party. · Drug information is provided as a guide only
Drug information	· Refer to a current copy of an Australian or other pharmacopeia
Clinical standards	· Documentation of medication: o Use approved terminology, abbreviations and symbols[51] o Follow general principle of drug prescribing–name of drug (generic), route, dose, frequency, duration[51] · Administer according to specific indications including off-label indications · Be aware of possible adverse reactions and precautions · Consider benefits versus risks of medication · Follow local protocols for medication management and administration, including. standing orders, drug therapy protocols; '*rights'* of medication administration (right patient, right drug (check expiry date), right time, right dose, right route, right to refuse, right documentation)
Implementation	· Use standard prescription/medication order forms: o National hospital medication chart o Pharmaceutical benefits scheme hospital medication chart[25] § Use clinical discretion and consider the individual patient when using the chart for patient medication management in acute care settings[25] § Digital medication chart (approved locally) · Document in the medical record: o Drug name and route of administration o Indication for the medication o Intended duration o Plan for review[50] · For babies, note: date of birth, weight, gestational age, basis for dose calculation (e.g. mg/kg–if appropriate) and dose in units of mass (e.g. 150 mg per dose, given four times a day) where appropriate [24,52] o Where appropriate, use international units (e.g. insulin) or volume of a particular strength (e.g. mL/kg intragram 10%) · Use standard administration forms for prophylactic and therapeutic medications where they exist and are age appropriate (e.g. insulin, heparin) · Comply with local protocols · Seek advice from relevant clinician/service (e.g. neonatologist, Retrieval Services Queensland (RSQ), pharmacist,)

5 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 health care. The workforce uses the systems to deliver comprehensive care and manage risk.[1]

5.1 Principles of clinical care

Table 11. Principles of care

Aspect	Good practice point
Privacy and confidentiality	· Follow local policies and protocols regarding the handling, storage and destruction of healthcare records o Refer to Privacy and confidentiality in Queensland Health policy[53] · Comply with relevant legislation regarding privacy: o Information Privacy Act 2009[54] o Part 7 of the Hospital and Health Boards Act 2011[55] o Public Health Act 2005[56]
Privacy principles	· Protect the privacy of women and families · Seek and document informed consent before disclosing information · Ensure surroundings where care is provided enables private and confidential consultations, care and discussions o Consider shared space or multiple women (and families/friends) in close environs[57] · Consider privacy issues, including the presence of other healthcare providers, for the woman during birthing and/or intimate examinations · Consider wishes of the woman regarding healthcare provider
Culturally appropriate care	· Provide care to women and families that acknowledges and respects their cultural beliefs and practices · If required, access and provide appropriate interpreter services
Child safety	· Follow legislation and local protocols regarding reporting of child safety concerns · Follow instructions regarding visitation and contact of parent(s) or others as required
Quality and safety	· Follow local protocols for: o Identifying, reporting and reviewing clinical risks o Reporting and reviewing clinical incidents o Root cause analysis (RCA) · Review clinical care in appropriate forums including Perinatal Morbidity and Mortality meetings
Patient safety	· Comply with patient safety notices issued by Patient Safety and Quality · Familiarise staff with the use of clinical equipment including, but not limited to, infusion devices, monitors and resuscitation equipment

5.2 Models of care

Regardless of the model, maternity care may be provided in the community (including outreach clinics), hospital or the woman's home.[30,58] Intrapartum care is provided in a public or private hospital that provides birthing services.[20] Generally, postnatal care is not provided in hospital outpatient clinics.

Table 12. Maternity care

Aspect	Comment
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[30]
Continuity of care and carer	· Continuity of care o Care is provided by a team without a designated named carer o The team have a common philosophy and shared understanding of care pathways for all healthcare providers involved in the woman's care o Aims to reduce fragmented care and conflicting advice[30] · Continuity of carer o A healthcare provider is known by the woman and provides her care o Enables relationship development[30] o Continues to provide care even when other caregivers are required over the full episode of care
Bundles of care[59]	· Based on Level 1 evidence (randomised controlled trials) · Structured process of improving care and care outcomes · Focus is on *how* to deliver best care, not *what* the care should be · Small set of evidence-based practices (generally three–five) · Success requires all steps to be completed · Improve patient outcomes when performed collectively and reliably
Woman-centred care[45]	· Care is based on woman's: o Individual needs and preferences o Empowerment in decision making o Best available evidence o Partnership with care providers

5.2.1 Maternity models of care

Table 13. Maternity models of care

Aspect	Comment
Private midwifery care[30,58]	· All care is provided by a privately practicing midwife or group of midwives in collaboration with medical officers where there are identifiable risk factors
Private obstetric care[30,58]	· Care is provided by a privately practicing obstetrician with intrapartum and postnatal care supported by hospital midwives
GP obstetrician care[30,58]	· Care is provided by a GP obstetrician with intrapartum and postnatal care supported by hospital midwives
Shared care[3][30,58]	· Care provided by community based obstetrician or GP and/or midwife in collaboration with hospital based obstetricians and midwives
Combined care[30,58]	· Antenatal and postnatal care provided by private maternity provider with intrapartum care provided by hospital midwives and doctors
Public hospital care[30,58]	· Antenatal, intrapartum and postnatal care provided by public hospital midwives and doctors. Intrapartum care is provided in hospital and antenatal and postnatal care is provided in outreach clinics, community or the woman's home depending on local arrangements
Public hospital high risk care[30,58]	· Care for women with complex or high risk pregnancies is provided by specialist obstetricians and or fetal maternal medicine specialist in collaboration with midwives. Intrapartum and postnatal care is provided by hospital doctors and midwives with postnatal care provided in the woman's home, community or hospital depending on local arrangements
Team midwifery care[30,58]	· Care is provided by a small team of hospital midwives in collaboration with medical officers where there are identifiable risk factors
Midwifery group practice (caseload care)[30,5**8**]	· Care is provided by a known midwife with backup from other midwife/midwives and in collaboration with medical officers where there are identifiable risk factors
Joint private obstetrician/private midwife care[30,58]	· Care is provided collaboratively by private obstetrician and private midwife with intrapartum and postnatal care supported by hospital midwives
Remote area maternity care[30,58]	· Antenatal and postnatal care is provided in remote areas by midwife(s) or nurse(s) in collaboration with a doctor. Intrapartum care and early postnatal care is provided in regional or metropolitan hospital by hospital midwives and doctors, with temporary relocation prior to labour
Other models	· Combinations of obstetric, midwifery, maternal fetal medicine, obstetric medicine, general practice, drug and alcohol, mental health and other clinicians

6 Communication for safety

Standard 6: Communicating for safety which 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.[1]

6.1 Documents

Table 14. Documents

Aspect	Definitions
Policy	· Formal document representing a statement of intent or principles that reflect the organisations' mission and direction for a particular outcome[1,60]
Guideline	· Systematically developed statements to assist clinician and consumer decisions about best practice health care for specific circumstances[1,60]
Procedure	· Organisation specific set of instructions to make policies and protocols operational[1,60]
Protocol	· Established set of rules to complete tasks[1]

6.2 Clinical communication

Table 15. Communication

Aspect	Good practice point
Context	· Provide effective communication between health care providers and with women and families · Provide information that is: relevant, respectful, timely, non-judgemental and non-biased
SBAR[61,62]	· Example of a basic communication and information sharing model for urgent and non-urgent communication · Refers to: o Situation–concise statement of the problem o Background–brief, pertinent situational information o Assessment–what was found o Recommendation–what needs to be done · Tool for: o Verbal and written interactions o Use for clinical handover
Clinical handover[1]	· 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[63] · Use SBAR[61,62] or other relevant communication tool: o At change of shift o Between health care disciplines and teams Between health care providers and organisations (e.g. with GP, different HHS service provider or retrieval services) o On receipt of pathology or other diagnostic results · If possible include the woman and partner (where appropriate) in bedside handover · Refer to patient documentation during handover · Provide timely discharge information to the woman and baby's GP and/ or other healthcare provider
Documentation	· Adhere to local policies and protocols regarding the use of terminology, abbreviations and symbols in documentation · Document contemporaneously in paper based or electronic health record · If available and where indicated use endorsed paper or electronic forms[64], for example: o Pregnancy health record o Early labour record; intrapartum record; clinical pathways o Medication charts o Early warning tools (refer to Section 8 Recognising and responding to acute deterioration)

6.3 Patient identification

Table 16. Patient identification

Aspect	Good practice point
Clinical standard	· Follow local policies and procedures · Apply identification bands on admission or at time of birth · Use at least three points of identification[1] 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 when care, medication, therapy and other service is provided · Use for clinical handover and transfer or generation of discharge documentation[1] · Check prior to labelling and administration of: o Blood products o Breast milk o Medications · When providing: o Care, therapy or services o Information about results o Discharge documentation/ referral letters

7 Blood management

Standard 7: Blood management which 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.[1]

Table 17. Blood

Aspect	Good practice point
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[31] o Patient Blood Management Guidelines: Module 6: Neonatal and Paediatric[32] o Guidelines on the Prophylactic use of RhD Immunoglobulin (Anti-D) in Obstetrics[65]
Clinical care	· Follow local protocols · Monitor and record baseline observations and every 15 minutes[66]: o Temperature o Pulse o Respiratory rate o Blood pressure o Oxygen saturation · Document blood or blood product administration and clinical response · Discontinue transfusion if signs of adverse reaction and notify relevant medical officer · Report adverse reactions to facility's pathology service o Retain remaining blood components for investigation
Consent	· Follow usual processes for obtaining consent including providing written information · Discuss with Jehovah's Witness women during the antenatal period blood product alternatives o Refer to pathology services[67] · Consider discussing an advanced healthcare directive[68] or a statement of choice with the woman if indicated · Refer to *Declining care* guideline[46]

8 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.[1]

Table 18. Clinical deterioration

Aspect	Good practice point
Context	· Refer to: o NSQHS Standard 8[1] o NSQHS Consensus statement[21] · Provide information to women and families about Ryan's Rule[69] · Provide training to staff regarding graded assertiveness
Documentation	· Use approved and recommended forms, if available and where indicated, for recording the woman's or baby's observations and responding to clinical deterioration[27]: o Maternity early warning tool (MEWT) o Neonatal early warning tool (NEWT)
Management	· Follow local protocols regarding escalation of care of the woman or baby with deterioration in clinical status · If required use graded assertiveness (e.g. use PACE model–probe, alert, challenge, emergency) · Use communication tools such as SBAR (refer to Table 15. Communication) · Contact RSQ for advice and contact with relevant clinician (e.g. neonatologist) at higher level facility

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