Queensland Clinical Guidelines

Translating evidence into best clinical practice

Maternity and Neonatal **Clinical Guideline**

Guideline Supplement: Syphilis in pregnancy

Queensland Government

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1 Introduction

This document is a supplement to the Queensland Clinical Guideline (QCG) *Syphilis in pregnancy.* It provides supplementary information regarding guideline development, makes summary recommendations, suggests measures to assist implementation and quality activities and summarises changes (if any) to the guideline since original publication. Refer to the guideline for abbreviations, acronyms, flow charts and acknowledgements.

1.1 Funding

The development of this guideline was funded by Communicable Diseases Branch, Prevention Division, Queensland Department of Health. Consumer representatives were paid a standard fee. Other working party members participated on a voluntary basis.

1.2 Conflict of interest

Declarations of conflict of interest were sought from working party members as per the Queensland Clinical Guidelines *Conflict of Interest* statement. No conflict of interest was identified.

1.3 Development process

This version of the guideline followed the QCG Change Request process

1.4 Summary of change

Queensland clinical guidelines are reviewed every 5 years or earlier if significant new evidence emerges. Table 1 provides a summary of changes made to the guidelines since original publication.

Table 1. Summary of change

Publication date *Endorsed by:*	**Identifier**	**Summary of major change**
December 2018 *Statewide Maternity and Neonatal Clinical Network (QLD)* *Communicable Diseases Branch Queensland Health*	MN18.44-V1-R23	First publication
December 2020 *Queensland Neonatal Statewide Advisory Group (QNSAG)*	MN18.44-V2-R23	Change request to flowcharts and guideline • Added: empirical treatment is indicated if maternal treatment for syphilis in pregnancy is inadequate • Update: benzyl penicillin dose for treatment of congenital syphilis amended FROM 50 mg/kg TO 30 mg/kg IV • Update: precautionary single dose of benzathine penicillin dose for treatment of congenital syphilis amended FROM 50 mg/kg IM once TO 37.5 mg/kg (50,000 units/kg) IM once
February 2021	MN18.44-V3-R23	Change request to flowchart and guideline • Added: guidance for administration of benzathine penicillin for late latent syphilis in pregnancy o One dose every 7 days for a total of 3 doses o If dose is missed or interval between doses is 9 or more days, recommend the full course is restarted • Update: flowchart to reflect above

Publication date *Endorsed by:*	**Identifier**	**Summary of major change**
July 2021	MN18.44-V4-R23	Change request to guideline • Added: clearer guidance for administration of benzathine penicillin for late latent syphilis in pregnancy o Optimal interval is one dose every 7 days for a total of 3 doses • If the interval between doses is 8 or 9 days o Consider restarting the entire course o Liaise with an expert practitioner about the decision to restart • If the interval between doses is more than 9 days o Restart the entire course o Administer as divided dose of two injections of 900 mg each (1.2 million units) one in each of the ventrogluteal regions or upper outer quadrant of each buttock[40]
October 2022	M18.44-V5-R23	Change request received from Queensland Maternal and Perinatal Quality Council (QMPQC) • Recommend for all women (irrespective of risk), routine antenatal screening at 28 weeks gestation • Amendments to reflect above to: Flowchart *Syphilis in pregnancy*, Table 10. Recommended screening by risk group, Table 19 Birth considerations • Risk groups modified FROM: universal, increased and high TO: universal and high
August 2023	M18.44-V6-R23	Change request received from Queensland Maternal and Perinatal Quality Council (QMPQC) • Recommend for all women (irrespective of risk), routine antenatal screening also at 36 weeks gestation • Amendments reflecting recommendation to: Flowchart *Antenatal care,* Table 10. Recommended screening by risk group, Table 19 Birth considerations

2 Methodology

Queensland Clinical Guidelines (QCG) follows a rigorous process of guideline development. This process was endorsed by the Queensland Health Patient Safety and Quality Executive Committee in December 2009. The guidelines are best described as 'evidence informed consensus guidelines' and draw from the evidence base of existing national and international guidelines and the expert opinion of the working party.

2.1 Topic identification

The topic was identified as a priority by the Communicable Diseases Branch and the Queensland Syphilis Surveillance Service as an action arising from the Queensland Sexual Health Strategy and the North Queensland Aboriginal and Torres Strait Islander Sexually Transmissible Infections Action Plan 2016–2021.

2.2 Scope

The scope of the guideline was determined using the following framework.

Table 2. Scope framework

Scope framework	
Population	• Pregnant women • Newborn babies born to women with syphilis
Purpose	• Identify relevant evidence related to: o Assessment and diagnosis of syphilis o Implications for maternity care of syphilis in pregnancy o Initial assessment and management of newborn babies at risk of congenital syphilis
Outcome	• Support: o Identification of screening regimens for the detection of syphilis in high and low risk populations o Assessment and correct diagnosis of syphilis o Maternity care provision for women with syphilis o Initial assessment and management of newborn babies with possible, probably or confirmed congenital syphilis
Exclusions	• Detailed contact management strategies • Routine antenatal, intrapartum and postpartum care of the woman and her newborn baby • Public health education/preventative strategies

2.3 Clinical questions

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

- What is the aetiology, transmission and classification of syphilis in pregnancy?
- How is syphilis diagnosed in pregnancy?
- When should syphilis testing be recommended in pregnancy?
- What is the best practice management of syphilis in pregnancy and immediately postpartum?
- What is the best practice management of babies born to mothers with syphilis?

2.4 Search strategy

A search of the literature was conducted during January-March 2017 and again December 2017-January 2018. The QCG search strategy is an iterative process that is repeated and amended as guideline development occurs (e.g. if additional areas of interest emerge, areas of contention requiring more extensive review are identified or new evidence is identified). All guidelines are developed using a basic search strategy. This involves both a formal and informal approach.

Table 3. Basic search strategy

Step		Consideration
1.	Review clinical guidelines developed by other reputable groups relevant to the clinical speciality	• This may include national and/or international guideline writers, professional organisations, government organisations, state based groups • This assists the guideline writer to identify: o The scope and breadth of what others have found useful for clinicians and informs the scope and clinical question development o Identify resources commonly found in guidelines such as flowcharts, audit criteria and levels of evidence o Identify common search and key terms o Identify common and key references
2.	Undertake a foundation search using key search terms	• Construct a search using common search and key terms identified during Step 1 above • Search the following databases o PubMed o CINAHL o Medline o Cochrane Central Register of Controlled Trials o EBSCO o Embase • Studies published in English less than or equal to 5 years previous are reviewed in the first instance. Other years may be searched as are relevant to the topic • Save and document the search • Add other databases as relevant to the clinical area
3.	Develop search word list for each clinical question.	• This may require the development of clinical sub-questions beyond those identified in the initial scope • Using the foundation search performed at Step 2 as the baseline search framework, refine the search using the specific terms developed for the clinical question • Save and document the search strategy undertaken for each clinical question
4.	Other search strategies	• Search the reference lists of reports and articles for additional studies • Access other sources for relevant literature o Known resource sites o Internet search engines o Relevant text books

2.4.1 Keywords

Combinations of the following keywords were used in the basic search strategy: syphilis, pregnan*, *Treponema pallidum,* Jarisch-Herxheimer reaction, treponemal, congenital syphilis, RPR, VDRL

Other keywords may have been used for specific aspects of the guideline.

2.5 Consultation

Major consultative and development processes occurred between February 2018 and June 2018 These are outlined in Table 4.

Table 4. Major guideline development processes

Process	Activity
Clinical lead	• The nominated co-clinical leads were approved by QCG Steering Committee
Consumer participation	• Consumer participation was invited from a range of consumer-focused organisations who had previously accepted an invitation for on-going involvement with QCG
Working party	• An EOI for working party membership was distributed via email to Queensland clinicians and stakeholders (~1000) in March 2018 • The working party was recruited from responses received • Working party members who participated in the working party consultation processes are acknowledged in the guideline • Working party consultation occurred in a virtual group via email
Statewide consultation	• Consultation was invited from Queensland clinicians and stakeholders (~1000) during May to June 2018 • Feedback was received primarily via email • All feedback was compiled and provided to the clinical lead and working party members for review and comment
Final consultation	• In addition to the working party, targeted feedback was also sought from a broad range of experts including from pathology, sexual health, infectious disease, maternity and neonatal clinicians

2.6 Endorsement

The guideline was endorsed by the:

- Queensland Clinical Guidelines Steering Committee in December 2018
- Statewide Maternity and Neonatal Clinical Network [Queensland] in December 2018
- Communicable Diseases Branch in December 2018

2.7 Citation

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

> Queensland Clinical Guidelines. [**Insert Guideline Title**]. Guideline No. [**Insert Guideline Number**]. Queensland Health. [**Insert Year of Publication**]. Available from: www.health.qld.gov.au/qcg.
>
> **EXAMPLE:**
> Queensland Clinical Guidelines. Normal birth. Guideline No. MN17.25-V3-R22. Queensland Health 2017. Available from: www.health.qld.gov.au/qcg.

3 Levels of evidence

The levels of evidence identified in the *United Kingdom national guidelines on the management of syphilis 2015* were used to inform the summary recommendations.[1]

Note: the 'consensus' definition* relates to forms of evidence that arose from the clinical experience of the guideline's co-clinical leads and/or working party.

Table 5. Grade of recommendation)

Grade	Quality of evidence and implications
1A	**Strong recommendation, high quality evidence** Strong recommendations, can apply to most patients in most circumstances without reservation. Clinicians should follow a strong recommendation unless a clear and compelling rationale for an alternative approach is present.
1B	**Strong recommendation, moderate quality evidence** Strong recommendation and applies to most patients. Clinicians should follow a strong recommendation unless a clear and compelling rationale for an alternative approach is present.
1C	**Strong recommendation, low quality evidence** Strong recommendation, and applies to most patients. Some of the evidence base supporting the recommendation is, however, of low quality.
2A	**Weak recommendation, high quality evidence** Weak recommendation, best action may differ depending on circumstances or patients or societal values.
2B	**Weak recommendation, moderate quality evidence** Weak recommendation, alternative approaches likely to be better for some patients under some circumstances.
2C	**Weak recommendation, low quality evidence** Very weak recommendation; other alternatives may be equally reasonable.
***Consensus**	Opinions based on respected authorities, descriptive studies or reports of expert committees or clinical experience of the working party.

3.1 Summary recommendations

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

Table 6. Summary recommendations

Recommendation		Grade of recommendation
1.	Recommend universal screening to pregnant women in the first trimester, at 28 and 36 weeks	**1A/Consensus**
2.	For pregnant women with an increased or higher risk for syphilis, recommend additional antenatal screening	**1A**
3.	Routinely offer pregnant women information about: • The importance of treating syphilis in pregnancy • Measures to prevent syphilis infection and reinfection	**Consensus**
4.	For pregnant women with positive syphilis serology, seek advice from an expert practitioner and QSSS about: • Staging of syphilis (including previous infection and treatment) • Contact management	**Consensus**
5.	The recommended treatment for infectious syphilis in pregnancy is benzathine penicillin 1.8 g intramuscular as a single dose.	**1B**
6.	If 36 week screen not completed, recommend testing at birth for all women	**Consensus**
7.	For babies born for to women with positive syphilis serology: • Routinely assess the baby for congenital syphilis both clinically and serologically • Recommend regular clinical and serological follow-up after birth	**1A**
8.	The recommended treatment for congenital syphilis in the newborn: • (0–7 days) is benzathine penicillin 30 mg/kg IV 12 hourly for a total of 10 days • (8–30 days) is benzathine penicillin 30mg/kg IV 8 hourly for a total of 10 days • (More than 30 days) is benzathine penicillin 30mg/kg IV 4-6 hourly for a total of 10 days	**Consensus**

4 Implementation

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

4.1 Guideline resources

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

- Flowcharts:
  - Antenatal Care
  - Newborn Care
- Education resource: Syphilis in pregnancy
- Knowledge assessment: Syphilis in pregnancy
- Parent information:
  - Syphilis in pregnancy
  - Jarisch Herxheimer Reaction

4.2 Suggested resources

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

- Culturally specific parent information (e.g. for Aboriginal and Torres Strait Islander people)

4.3 Implementation measures

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

4.3.1 QCG measures

- Notify Chief Executive Officer and relevant stakeholders
- Monitor emerging new evidence to ensure guideline reflects contemporaneous practice
- Capture user feedback
- Record and manage change requests
- Review guideline in 2023

4.3.2 Hospital and Health Service measures

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

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

4.4 Quality measures

Auditing of guideline recommendations and content assists with identifying quality of care issues and provides evidence of compliance with the National Safety and Quality Health Service (NSQHS)Standards[2] [Refer to Table 7]. Suggested audit and quality measures are identified in Table 8. Clinical quality measures.

Table 7. NSQHS Standard 1

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

Table 8. Clinical quality measures

No	Audit criteria	Guideline Section
1.	What proportion of antenatal women were screened for syphilis in the first trimester	Section 3.5 Risk groups and recommended screening for syphilis
2.	What proportion of women who: o Identify as Aboriginal and/or Torres Strait Islander or o Their partner identifies as Aboriginal and/or Torres Strait Islander were screened for syphilis • In the first trimester • Between 26 and 28 weeks gestation	Section 3.5 Risk groups and recommended screening for syphilis
3.	What proportion of women who were identified as high risk during pregnancy, had at least one criterion (as identified in the guideline) documented as the reason for high risk status	Section 3.5 Risk groups and recommended screening for syphilis
4.	What proportion of women who were identified as high risk (as defined in the guideline) received antenatal testing for syphilis at ALL of the following: • In the first trimester • Between 16–24 weeks gestation (ideally at 20 weeks) • Between 26–28 weeks gestation • Between 34–36 weeks gestation • At birth	Section 3.5 Risk groups and recommended screening for syphilis
5.	What proportion of women who were identified as increased risk (as defined in the guideline) AND who did NOT have testing for syphilis between 26–28 weeks gestation, were tested for syphilis at birth?	Section 3.5 Risk groups and recommended screening for syphilis
6.	In what proportion of women where a positive syphilis serology result was obtained during pregnancy, is there documented evidence in the health record of contact with an expert practitioner or advice from the QSSS	Section 1.4 Notifiable disease
7.	What proportion of women diagnosed with syphilis in pregnancy (as defined in the guideline), received adequate treatment (as defined in the guideline)	Section 2.1 Clinical stages of syphilis Section 4.3 Treatment of infectious syphilis in pregnancy

No	Audit criteria	Guideline Section
8.	What proportion of women who were diagnosed with syphilis in pregnancy (as defined in the guideline) after 20 weeks gestation, had at least one ultrasound scan	Section 2.1 Clinical stages of syphilis Section 4.2 Prenatal assessment
9.	What proportion of women diagnosed with syphilis in pregnancy (as defined in the guideline) had at birth • Placental histopathology requested • Serological testing for syphilis	Section 2.1 Clinical stages of syphilis Section 4.7 Birth considerations
10.	What proportion of at risk babies (as defined in the guideline) had: • Parallel syphilis serology testing of mother and baby's serum • Serum IgM for syphilis • Documented evidence that a clinical assessment for congenital syphilis was performed	Section 5 Congenital syphilis Section 5.1.2 Serology/histopathology
11.	What proportion of babies diagnosed with congenital syphilis were born to women who were: • Adequately treated for infectious syphilis in pregnancy (as defined in the guideline) • Inadequately or not treated or not diagnosed with infectious syphilis in pregnancy (as defined in the guideline)	Section 5.3 Diagnosis and treatment of congenital syphilis
12.	What proportion of babies diagnosed with congenital syphilis received the recommended antibiotic treatment (as defined in the guideline)	Section 5.3 Diagnosis and treatment of congenital syphilis
13.	What proportion of babies • Born to women with infectious syphilis in pregnancy AND • Who did not have a diagnosis of congenital syphilis had at least two documented follow-up serological tests for syphilis within 6 months of discharge	Section 5.5 Follow-up

4.5 Areas for future research

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

- For pregnant women with infectious syphilis, should a second dose of antibiotic treatment be routinely recommended?
- In pregnant women treated for infectious syphilis, what is the optimal frequency of fetal USS to monitor fetal well-being?
- What is the role of point of care testing for syphilis in pregnancy?
- In pregnant women treated for infectious syphilis, what is the optimal frequency of antenatal serological monitoring?

4.6 Safety and quality

In conjunction with the Queensland Clinical Guideline *Standard care*[2], implementation of this guideline provides evidence of compliance with the National Safety and Quality Health Service Standards and Australian Council on Healthcare Standards (ACHS).[1]

Table 9. NSQHS

NSQHS	Actions required	☑ Evidence of compliance
NSQHS Standard 1: Clinical governance		
Patient safety and quality systems Safety and quality systems are integrated with governance processes to enable organisations to actively manage and improve the safety and quality of health care for patients.	**Diversity and high risk groups** 1.15 The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using its services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care	☑ Assessment and care appropriate to the cohort of patients is identified in the guideline ☑ High risk groups are identified in the guideline ☑ The guideline is based on the best available evidence
Clinical performance and effectiveness The workforce has the right qualifications, skills and supervision to provide safe, high-quality health care to patients.	**Evidence based care** 1.27 The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care	☑ Queensland Clinical Guidelines is funded by Queensland Health to develop clinical guidelines relevant to the service line to guide safe patient care across Queensland ☑ The guideline provides evidence-based and best practice recommendations for care ☑ The guideline is endorsed for use in Queensland Health facilities. ☑ A desktop icon is available on every Queensland Health computer desktop to provide quick and easy access to the guideline
	Performance management 1.22 The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system	☑ The guideline has accompanying educational resources to support ongoing safety and quality education for identified professional and personal development. The resources are freely available on the internet http://www.health.qld.gov.au/qcg

NSQHS	Actions required	☑ Evidence of compliance
NSQHS Standard 1: Clinical governance		
Patient safety and quality systems Safety and quality systems are integrated with governance processes to enable organisations to actively manage and improve the safety and quality of health care for patients.	**Policies and procedures** 1.7 The health service organisation uses a risk management approach to: a. Set out, review, and maintain the currency and effectiveness of, policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation and jurisdictional requirements	☑ QCG has established processes to review and maintain all guidelines and associated resources ☑ Change requests are managed to ensure currency of published guidelines ☑ Implementation tools and checklist are provided to assist with adherence to guidelines ☑ Suggested audit criteria are provided in guideline supplement ☑ The guidelines comply with legislation, regulation and jurisdictional requirements
NSQHS Standard 2: Partnering with Consumers		
Health literacy Health service organisations communicate with consumers in a way that supports effective partnerships.	**Communication that supports effective partnerships** 2.8 The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community 2.9 Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review 2.10 The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided on discharge	☑ Consumer consultation was sought and obtained during the development of the guideline. Refer to the acknowledgement section of the guideline for details ☑ Consumer information is developed to align with the guideline and included consumer involvement during development and review ☑ The consumer information was developed using plain English and with attention to literacy and ease of reading needs of the consumer
Partnering with consumers in organisational design and governance Consumers are partners in the design and governance of the organisation.	**Partnerships in healthcare governance planning, design, measurement and evaluation** 2.11 The health service organisation: a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community 2.14 The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce	☑ Consumers are members of guideline working parties ☑ The guideline is based on the best available evidence ☑ The guidelines and consumer information are endorsed by the QCG and Queensland Statewide Maternity and Neonatal Clinical Network Steering Committees which includes consumer membership

NSQHS	Actions required	☑ Evidence of compliance
NSQHS Standard 4: Medication safety		
Clinical governance and quality improvement to support medication management Organisation-wide systems are used to support and promote safety for procuring, supplying, storing, compounding, manufacturing, prescribing, dispensing, administering and monitoring the effects of medicines	**Integrating clinical governance** 4.1 Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management	☑ The guideline provides current evidence based recommendations about medication
NSQHS Standard 5: Comprehensive care		
Clinical governance and quality improvement to support comprehensive care Systems are in place to support clinicians to deliver comprehensive care	**Integrating clinical governance** 5.1 Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for comprehensive care b. Managing risks associated with comprehensive care c. Identifying training requirements to deliver comprehensive care **Partnering with consumers** 5.3 Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	☑ The guideline has accompanying educational resources to support ongoing safety and quality education for identified professional and personal development. The resources are freely available on the internet http://www.health.qld.gov.au/qcg ☑ The guideline provides evidence-based and best practice recommendations for care ☑ Consumer information is developed for the guideline

NSQHS	Actions required	☑ Evidence of compliance
NSQHS Standard 6: Communicating for safety		
Clinical governance and quality improvement to support effective communication Systems are in place for effective and coordinated communication that supports the delivery of continuous and safe care for patients.	**Integrating clinical governance** 6.1 Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication **Partnering with consumers** 6.3 Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making **Organisational processes to support effective communication** 6.4 The health service organisation has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes	☑ Requirements for effective clinical communication by clinicians are identified ☑ The guideline provides evidence-based and best practice recommendations for communication between clinicians ☑ The guideline provides evidence-based and best practice recommendations for communication with patients, carers and families ☑ The guideline provides evidence-based and best practice recommendations for discharge planning and follow –up care
Communication of critical information Systems to effectively communicate critical information and risks when they emerge or change are used to ensure safe patient care.	**Communicating critical information** 6.9 Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to: a. Clinicians who can make decisions about care b. Patients, carers and families, in accordance with the wishes of the patient 6.10 The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians	☑ Requirements for effective clinical communication of critical information are identified ☑ Requirements for escalation of care are identified

NSQHS	Actions required	☑ Evidence of compliance
NSQHS Standard 6: Communicating for safety (continued)		
Correct identification and procedure matching Systems to maintain the identity of the patient are used to ensure that the patient receives the care intended for them.	**Correct identification and procedure matching** 6.5 The health service organisation: a. Defines approved identifiers for patients according to best-practice guidelines b. Requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated	☑ Requirements for safe and for correct patient identification are identified
Communicating at clinical handover Processes for structured clinical handover are used to effectively communicate about the health care of patients.	**Clinical handover** 6.7 The health service organisation, in collaboration with clinicians, defines the: a. Minimum information content to be communicated at clinical handover, based on best-practice guidelines b. Risks relevant to the service context and the particular needs of patients, carers and families c. Clinicians who are involved in the clinical handover 6.8 Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care	☑ The guideline acknowledges the need for local protocols to support transfer of information, professional responsibility and accountability for some or all aspects of care

NSQHS	Actions required	☑ Evidence of compliance
NSQHS Standard 8: Recognising and responding to acute deterioration		
Clinical governance and quality improvement to support recognition and response systems Organisation-wide systems are used to support and promote detection and recognition of acute deterioration, and the response to patients whose condition acutely deteriorates.	**Integrating clinical governance** 8.1 Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for recognising and responding to acute deterioration b. Managing risks associated with recognising and responding to acute deterioration c. Identifying training requirements for recognising and responding to acute deterioration **Partnering with consumers** 8.3 Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making **Recognising acute deterioration** 8.4 The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to: a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient	☑ The guideline is consistent with National Consensus statements recommendations ☑ The guideline recommends use of tools consistent with the principles of recognising and responding to clinical deterioration ☑ Consumer information is developed for the guideline
EQuIP Standard 12 Provision of care		
Criterion 1: Assessment and care planning 12.1 Ensuring assessment is comprehensive and based upon current professional standards and evidence based practice	12.1.1 Guidelines are available and accessible by staff to assess physical, spiritual, cultural, physiological and social health promotion needs	☑ Assessment and care appropriate to the cohort of patients is identified in the guideline ☑ The guideline is based on the best available evidence

References

1. Kingston M, French P, Higgins S, McQuillan O, Sukthankar A, Stott C, et al. UK national guidelines on the management of syphilis 2015. Int J STD AIDS 2016;27(6):421-46.
2. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. [Internet]. 2012 [cited 2016 March 09]. Available from: http://www.safetyandquality.gov.au.