Patient Matters Manual for Public Health Organisations

Chapter 17 – Obstetrics

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Note

Where a number appears at the bottom of an amended page [such as 252 (17/09/15) – amendment number, date] an alteration has been made or new section included. Amendment numbers are sequential, the date represents the date the source document was published on the Policy Distribution System (PDS).

Below is a summary of each policy document. To navigate to the complete policy document, click the hyperlink in the Table of Content or under each policy document title.

Public Homebirth Services in NSW

Document number GL2020_022 rescinds PD2006_045.

PURPOSE

This document guides NSW maternity services seeking to establish or sustain a public homebirth service (homebirth services).

KEY PRINCIPLES

NSW Health recognises that the place of birth is a decision for women, their partners and their families, and that some women may choose to birth at home with the care of professionals.

Homebirth services align with NSW Health's commitment to the provision of safe, sustainable, high quality, woman-centred maternity care.

Homebirth services should utilise consultation, escalation, referral and transfer processes in line with local guidelines and referral pathways developed in line with NSW Health Policy Directives/ Guidelines and all relevant legislative requirements.

Women should be advised of the health risks and health benefits of all aspects of maternity care, including those associated with their planned place of birth.

Clinical outcomes in all models of care including the homebirth service should be routinely reviewed to identify quality improvement opportunities irrespective of place of birth.

LOCAL HEALTH DISTRICT RESPONSIBILITIES

Local health districts (districts) should consider the needs of their communities when developing models of care. Those districts seeking to establish and or sustain a homebirth service should ensure the following.

- Consumer and other relevant stakeholder participation and involvement at all stages of implementation and ongoing evaluation of a homebirth service.
- Local guidelines for the provision of a homebirth service follow a robust and comprehensive risk assessment process.
- Strong clinical obstetric and midwifery leadership and commitment to establish, support, and maintain a well-functioning and sustainable homebirth service (see Section 2).
- An appropriately skilled and qualified workforce to provide care across the continuum of pregnancy, birth and postpartum care.
- Systems and processes are established to monitor and evaluate the service including workforce management and clinical service provision.

Management of Threatened Preterm Labour

Document number GL2022_006 rescinds GL2020_009.

GUIDELINE SUMMARY

This Guideline applies to all NSW Health Organisations and/or maternity services where women may present with signs and/or symptoms of threatened preterm labour. The screening for risk factors associated with prevention and the management of preterm birth are outside the scope of this document.

KEY PRINCIPLES

NSW Health organisations are responsible for the implementation of this Guideline within their services / facilities to ensure local protocols or operating procedures are in place and aligned and consistent with this Guideline.

A comprehensive clinical assessment must be reviewed by the most senior obstetric clinician available and is essential to differentiate threatened preterm labour from preterm labour. The clinician must assess maternal and fetal wellbeing and to develop a comprehensive management plan.

Interventions for threatened preterm labour may include the use of corticosteroids, tocolytics, magnesium sulphate and antibiotics.

The use of tocolytic agents is restricted to when there is benefit from delaying preterm birth. There is greater benefit in delaying birth under 34 weeks' gestation.

Care at 23-25+6 weeks should be individualised and will depend on the risk to the woman from continuing the pregnancy and the management approach to care of the fetus after birth.

Women and their families must be provided with information and resources to guide shared decision making.

The Maternal Transfer Decision Making Tool is to be used to determine when an in-utero transfer is required and the subsequent process for effective transfer.

343 (08/07/22)

Reporting of Maternal Deaths to the NSW Clinical Excellence Commission

Document number PD2021_006 rescinds PD2020_043.

POLICY STATEMENT

All NSW Health Services must report all maternal deaths to the Clinical Excellence Commission (CEC) in addition to other existing reporting obligations.

SUMMARY OF POLICY REQUIREMENTS

For all maternal deaths, the Maternity Unit Manager, Nurse Unit Manager, or Patient Safety Manager is to email CEC-PatientSafety@health.nsw.gov.au, with relevant information.

The death is also to be reported by completing the Admitted Patient Death Screening Tool in the CEC Death Review Reporting System.

Unexpected deaths of women who are either pregnant (any stage) or up to 42 days (6 weeks) postpartum are a reportable incident and must be managed and reported as per NSW Health Policy Directive *Incident Management* (PD2020_047).

Hospitals must also have effective systems and procedures in place to report deaths to the Coroner in accordance with the Coroners Act 2009; a Reportable death is defined in NSW Health Policy Directive *Coroners Cases and the Coroners Act 2009* (PD2010_054) .

The health facility will be asked to supply the CEC with the following information via a secure file sharing system:

- a copy of the relevant medical records, including medical certificate of cause of death (if applicable)
- post-mortem report (if applicable)
- any other relevant material requested by the Maternal and Perinatal Mortality Review Committee.

335 (25/02/21)

Stillbirth - Management and Investigation

Document number PD2007_025 rescinds GL2005_013.

This Policy Directive replaces GL2005_013.

This Policy Directive should be read in conjunction with:

- PD2006_006 Deaths- Perinatal – Hospital procedures for review and reporting of perinatal deaths
- PD2005_138 Deaths Register
- PD2005_341 Human Tissue - Use/Retention Including Organ Donation, Post-Mortem Examination and Coronial Mat
- PD2005_406 Consent to Medical Treatment – Patient Information
- PD2007_017 - Deceased Persons In Health Facility Mortuaries & Management of Health Facility Mortuaries
- The Australian Health Ministers Advisory Council The National Code of Ethical Autopsy Practice 2002.

This Policy Directive is based on the *Clinical Practice Guideline for Perinatal Mortality Audit* produced by the Perinatal Society of Australia and New Zealand. The complete guideline can be found at http://www.psanzpnmsig.org/guideline.asp

A stillbirth[1] is the complete expulsion or extraction from the mother of a product of conception of at least 20 weeks gestation or 400grams birth weight that did not, at any time after delivery, breathe or show any evidence of life such as a heartbeat (see Glossary Appendix 1).

In the case of a stillbirth where it is unclear whether the gestational age is less than 20 weeks at the time of delivery the fetus is to be weighed. If the weight is 400 grams or greater the fetus must be registered as a stillbirth.

60 (5/07)

1 NSW Health NSW Mothers and Babies 2005 NSW Public Health Bulletin Volume 18 Number S-1 2007

Document number GL2014_015.

PURPOSE

The purpose of this document is to provide guidance for the clinical management and provision of evidence based information to women with low risk, singleton pregnancies that extend beyond 41^{+0} weeks gestation. It is important to assess each woman individually and base the management plan for pregnancy beyond 41^{+0} weeks on her specific circumstances and preferences.

KEY PRINCIPLES

Effective communication between health care professionals and women is essential. Information should be offered regarding the risks associated with prolonged pregnancies, and the options available. This will help women to make an informed choice, based on her individual preferences and circumstances for either a scheduled induction for a pregnancy beyond 41^{+0} weeks or expectant management.

Women should be informed that most women will go into labour spontaneously by 42^{+0} weeks gestation. The use of early gestational scans to calculate the estimated date of birth can lower the rate of pregnancy beyond 41^{+0} weeks in women. If pregnancy is prolonged, additional fetal surveillance and management plans should be discussed with the woman and clearly documented in the woman's antenatal record.

The information discussed should include:

- The risks and benefits of membrane sweeping during a vaginal examination, as described in Section 2.2.1 of this document
- The risks and benefits of expectant management, as described in Section 2.3.1 of this document
- The need for increased fetal surveillance from 41+0 weeks, as described in Section 2.4 of this document
- The risks and benefits of induction of labour, as described in Section 2.5.1.

USE OF THE GUIDELINE

This guideline will describe clinical management of pregnancies beyond 41^{+0} weeks gestation for otherwise low risk women with singleton pregnancies. The terms postdates, post term and overdue will not be used in this document as these terms are often used interchangeably and can be misleading.

Assisted Reproductive Technology - Ethical Guidelines

Document number GL2006_011 rescinds GL2005_041.

NSW Health endorses the NHMRC Ethical guidelines on the use of assisted reproductive technology in clinical practice and research (2004). These guidelines cover activities associated with assisted reproductive technology in clinical practice and research, and were developed through extensive public, community and professional stakeholder consultation. They are primarily intended for assisted reproduction practitioners, researchers, infertility clinic administrators, HRECs, and state and national government officials. They replace the 1996 NHMRC Ethical guidelines on assisted reproductive technology.

Copies can be obtained through National Mailing and Marketing (02) 6269 1000 or http://www.nhmrc.gov.au/publications/synopses/e56.syn.htm. ISBN Print: 1864962712

(10/08/06)

Genetic Testing

including DNA diagnostic testing, DNA testing for mutation carriers and DNA predictive and presymptomatic testing

Document number PD2007_066 rescinds GL2005_012.

Guidelines for Testing for Genetic Disorders (Circular 97/48) (GL2005_012) has been replaced by two policy directives:

1. Genetic Testing – including DNA Diagnostic Testing, DNA Testing for mutation carriers and DNA Predictive and Presymptomatic Testing
2. Prenatal Testing - including prenatal screening for Down syndrome and other chromosomal abnormalities

This policy sets out NSW Department of Health requirements for testing for genetic disorders and particularly addresses counselling issues and laboratory requirements associated with genetic testing.

Genetic tests and procedures are available for individuals at high risk for certain genetic disorders and birth defects. Testing may benefit individuals and families in a number of ways but it may also create dilemmas which need sensitive management. Counselling is an essential element of genetic testing. Each test has distinct advantages, disadvantages and limitations and should only be used after the individual being tested has given full consideration to these issues. All testing should be carried out with the informed consent of the person being tested. Health professionals and potential test users need to become familiar with the context in which the tests are used.

See also:

- Prenatal testing - including prenatal screening for Down syndrome and other chromosomal abnormalities - PD2007_067
- Guidelines for predictive and diagnostic DNA testing for serious adult onset neurogenetic disorders with predictive implications for other family members and which are likely to reduce normal life expectancy – (PD2005_303) http://www.health.nsw.gov.au/policies/PD/2005/PD2005_303.html

Prenatal Testing/Screening for Down Syndrome & Other Chromosomal Abnormalities including prenatal screening for Down syndrome and other chromosomal abnormalities

Document number PD2007_067 rescinds GL2005_012.

Guidelines for Testing for Genetic Disorders (Circular 97/48) (GL2005_012) has been replaced by two policy directives:

1. Prenatal Testing - including prenatal screening for Down syndrome and other chromosomal abnormalities
2. Genetic Testing – including DNA diagnostic testing, DNA testing for mutation carriers and DNA predictive and presymptomatic testing

This policy directive addresses:

Prenatal screening tests – these tests may identify a baby as being at an increased risk of having a particular problem and include:

- First trimester screening for women presenting between 10 to 14 weeks of pregnancy using a combination of maternal age, ultrasound nuchal translucency measurement (NTS) and serum screening tests (free βhCG and PAPP-A).
- Second trimester screening for women presenting between 15 to 18 weeks of pregnancy, using maternal age, maternal serum screening (free βhCG, AFP and unconjugated estriol).
- Ultrasound

Prenatal diagnostic tests – these tests may be used following an increased risk result on prenatal screening or independently:

- Ultrasound
- Chorionic villus sampling
- Amniocentesis
- Fetal blood sampling

This policy is directed to NSW Health clinical and care providers involved in prenatal care. It provides direction on access to and provision of prenatal screening and diagnostic tests so pregnant women are informed about screening options and are appropriately directed to services.

See also:

Genetic Testing – including DNA diagnostic testing, DNA testing for mutation carriers and DNA predictive and presymptomatic testing PD2007_066

64 (2/08)

Genetic Testing - Guidelines for prioritising genetic tests

Document number GL2007_013.

Introduction

Many genetic tests provided by NSW public hospital laboratories are non-Medical Benefits Schedule items funded through NSW Health. The charging policy for these tests is addressed in Policy Directive PD 2005_335. Further, the Policy Directive requires testing to be assessed and prioritised according to clinical necessity.

The attached guidelines have been developed to assist clinicians/health services to prioritise genetic test requests based on clinical need, equity of access and within available funding levels.

64 (2/08)

DNA Testing - Predictive and Diagnostic for Serious Adult Onset Neurogenetic Disorders – Guidelines

Document number PD2005_303.

Guidelines for predictive and diagnostic DNA testing for serious adult onset neurogenetic disorders with predictive implications for other family members and which are likely to reduce normal life expectancy.

1 INTRODUCTION

This circular replaces circular 2001/87.

Predictive and diagnostic testing using DNA (or sometimes other analytes) is available for a number of adult onset genetic diseases, many of which result in presently incurable illness, dementia and premature death.

Predictive testing refers to testing in an individual who currently does not have symptoms or signs of disease, but who may be at risk due to their family history, and who requests more information about their risk.

Serious adult onset neurogenetic disorders likely to reduce normal life expectancy include Huntington disease, motor neurone disease, spinocerebellar ataxia and pre-senile dementias.

Maternity - Management of Hypertensive Disorders of Pregnancy

Document number PD2011_064 rescinds PD2011_020.

PURPOSE

This policy provides direction to NSW maternity services, Emergency Departments, Ambulance Service of NSW and retrieval services regarding the management of hypertensive disorders of pregnancy. The NSW Maternal and Perinatal Committee and the NSW Maternal and Perinatal Health Priority Taskforce have endorsed *The Guidelines for the Management of Hypertensive Disorders of Pregnancy 2008* issued by the S*ociety of Obstetric Medicine of Australia and New Zealand* and it is now issued as NSW Health policy.

MANDATORY REQUIREMENTS

All NSW Public Health Organisations providing maternity services and/or emergency department services must have clinical practice guidelines and protocols for the management of hypertensive disorders of pregnancy based on this policy directive.

Ambulance Service of NSW and all other retrieval services must also have protocols for the management of hypertensive disorders of pregnancy based on this policy directive.

IMPLEMENTATION

The Chief Executives of Local Health Districts and the Ambulance Service of NSW are ultimately responsible for the implementation of this policy directive within their respective facilities.

136 (13/10/11)

Care Pathway for Women Concerned About Fetal Movements

Document number GL2021_019 rescinds GL2020_017.

GUIDELINE SUMMARY

The Guideline will assist clinicians and women to understand the importance of responding to the woman's concerns about fetal movements in a singleton pregnancy. It aims to improve clinical care and standardise management of concerns about fetal movements, to optimise pregnancy outcomes and reduce maternal anxiety.

KEY PRINCIPLES

This Guideline outlines the clinical principles and key actions that will support evidenceinformed practices and improvement in maternity services.

Fetal movements are a reliable indicator of fetal wellbeing. Maternal perception of decreased fetal movements is associated with adverse pregnancy outcomes.

The woman's concerns about fetal movements override any definition of DFM. These concerns may include decreased frequency of movements, changed quality of movements or absent movements.

This Guideline aligns the Perinatal Society of Australia and New Zealand (PSANZ) *Clinical practice guideline for the care of women with decreased fetal movements for women with a singleton pregnancy from 28 weeks' gestation* (2019), with additional clarification for the NSW context.

The care of a woman concerned about fetal movements from 25 weeks to 28 weeks gestation should use the same care pathway as for a gestation greater than 28 weeks.

Care planning for the fetus less than 25 weeks gestation should be in consultation with a specialist obstetrician or a maternal fetal medicine specialist.

USE OF THE GUIDELINE

The Chief Executives of local health districts are responsible to ensure maternity services have processes in place to:

- Routinely provide verbal and written information to pregnant women about normal fetal movements at each point of contact during the antenatal period. This will include actions to take in the event of concerns about fetal movements.
- Guide management, escalation and transfer of care if necessary, for women reporting concerns about fetal movements, in line with the relevant Policies and Guidelines.

Implement the Perinatal Society of Australia and New Zealand *Clinical practice guideline for the care of women with decreased fetal movements for women with a singleton pregnancy from 28 weeks' gestation* (2019) in the NSW context (see Appendix 1).

Maternity - Rh (D) Immunoglobulin (Anti D)

Document number GL2015_011 rescinds GL2014_017.

PURPOSE

This guideline provides direction to NSW maternity service providers, emergency departments and general practitioners regarding the care of rhesus (Rh) (D) negative women and the use of Rh (D) Immunoglobulin (Anti-D).

Rh (D) Immunoglobulin is used as prophylaxis treatment and or treatment for potential sensitising events for Rh negative women who are pregnant or recently pregnant (up to 10 days post pregnancy cessation).

KEY PRINCIPLES

All pregnant women should be typed for ABO and Rh (D) as early as possible during each pregnancy.

All Rh negative women who are pregnant or recently pregnant (up to 10 days post pregnancy cessation), should be provided with information both verbal and written on their rhesus status and Rh (D) Immunoglobulin.

All Rh negative women who are pregnant or recently pregnant (up to 10 days post pregnancy cessation), should be offered Rh (D) Immunoglobulin prophylactically and or for potential sensitising events.

All Rh negative women should sign the consent/decline to treatment form.

USE OF THE GUIDELINE

The guideline for the use of Rh (D) Immunoglobulin should be used by general practitioners and all staff working in NSW Health Maternity Services or Emergency Departments who are providing care to Rh negative women who are pregnant or recently pregnant (up to 10 days post pregnancy cessation).

- Midwives
- Nurses
- Obstetricians
- Medical Officers
- General Practitioners

Investigation, Review and Reporting of Perinatal Deaths

Document number PD2022_046 rescinds PD2022_026.

POLICY STATEMENT

The NSW Health is committed to review maternal and perinatal morbidity and mortality in the State, through the Perinatal Mortality Review committee (PMRC). The PMRC is a subcommittee of the NSW Maternal and Perinatal Mortality Review Committee (MPMRC), constituted under *Health Administration Act 1982* (NSW).

SUMMARY OF POLICY REQUIREMENTS

All NSW Health Services must report and review all perinatal deaths that meets its definition.

Perinatal deaths are defined as stillbirths (fetal deaths) and deaths of infants within the first 28 days of life (neonatal deaths).

Stillbirths include fetuses weighing at least 400 grams or having a gestational age of 20 weeks. Neonatal deaths comprise all deaths of liveborn babies within 28 days of birth, regardless of gestational age at birth.

Perinatal deaths must be managed and reported as per NSW Health Policy Directive *Incident Management* (PD2020_047) as set out in section 3 Reportable Incident Brief and Appendix D Reportable Incident Definition.

The investigation review and classification of perinatal deaths is based on the Perinatal Society of Australia and New Zealand (PSANZ) *Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death* to support a systematic approach to the provision of care.

Each Maternity service is to have a process in place to undertake clinical reviews and the classification of perinatal deaths. These reviews include analysis through a local perinatal morbidity and mortality committee. The chairperson of the committee is responsible for ensuring timely reporting of death classifications to the Clinical Excellence Commission.

From March 1st, 2022, following a review by the local perinatal mortality review committee, all perinatal mortality reports must be submitted to the Clinical Excellence Commission via local public hospital maternity database systems (eMaternity or CernerMaternity).

Private hospitals may access the Clinical Excellence Commission online form for reporting perinatal deaths.

The Clinical Excellence Commission access the reports quarterly and after the completion of a calendar year. Perinatal deaths for the previous year are to be completed by April 1st, in the following year.

Framework for Termination of Pregnancy in New South Wales

Document number PD2021_018 rescinds PD2021_001.

POLICY STATEMENT

All NSW facilities in which termination of pregnancy services occur are to ensure they have in place protocols that are in accordance with the Abortion Law Reform Act 2019 (the Act).

SUMMARY OF POLICY REQUIREMENTS

The Policy Directive outlines the legal framework of the Act and associated legislation in relation to termination of pregnancy in NSW.

The Act allows a medical practitioner to undertake a termination of pregnancy on a woman who is not more than 22 weeks pregnant provided that (except in emergencies) informed consent has been obtained.

A termination of pregnancy for a woman who is more than 22 weeks pregnant must only be performed by a specialist medical practitioner at a hospital controlled by a local health district, statutory health corporation or approved health facility (ancillary services, tests or other medical procedures, or the administration, prescription or supply of medication, can be carried out in other places).

If termination of pregnancy is not provided within the local health district, statutory health corporation hospital or approved health facility, then local referral pathways must be developed to support the woman, so she has timely access to termination services.

Procedures for registered health practitioners who have a conscientious objection to termination of pregnancy who are asked to perform or assist in a termination of pregnancy or advise about the performance of a termination are provided.

Before performing a termination of pregnancy, it may be disclosed to the medical practitioner that the reason for the request is for the sole purpose of sex selection. If this is the reason for the request, the practitioner **must not** perform the termination, unless not performing the termination will cause significant risk to the woman's health or safety.

When a termination for the sole purpose of sex selection is refused, the medical practitioner must offer additional support and referral to counselling or other relevant services.

Pre procedural considerations are defined and include counselling for a woman seeking a termination of pregnancy, assessment of the request related to pregnancy gestation and the requirement for informed consent. Post procedural considerations include examination and care of the woman and the fetus/baby.

In accordance with section 15 of the Act, termination of pregnancy must be notified to the Ministry of Health within 28 days. Refer to: www.health.nsw.gov.au/women/pregnancyoptions/Pages/for-health-professionals.aspx for further information.

In addition to routine clinical notes concerning the care and treatment of the woman, her gestational age and weight, signs of life following a termination and the specialist medical practitioners involved in the procedure must also be documented.

Prevention of Termination of Pregnancy for the Sole Purpose of Sex Selection

Document number GL2021_008 rescinds GL2021_001.

GUIDELINE SUMMARY

This Guideline has been issued under s14 of the Abortion Law Reform Act 2019 for practitioners who perform termination of pregnancy in NSW and provides guidance for these practitioners when a termination of pregnancy is sought for the sole purpose of sex selection.

Under section 14 of the NSW Abortion Law Reform Act 2019 (the Act), a registered health practitioner performing a termination of pregnancy or assisting in the performance of a termination of pregnancy, must practice in accordance with this Guideline.

Further information can be found in NSW Health Policy Directive: *Framework for Termination of Pregnancy in New South Wales* (PD2021_018)

KEY PRINCIPLES

In NSW, the law on termination of pregnancy is governed by the Act. The Act amended the Crimes Act 1900 to repeal the provisions relating to termination of pregnancy and to abolish the common law offences relating to termination of pregnancy.

The NSW Parliament has opposed the performance of termination of pregnancy for the sole purpose of sex selection.

This Guideline relates to when a termination of pregnancy is sought for the sole purpose of sex selection. This Guideline does not apply to a termination due to the possibility of a sex-linked medical condition in the fetus.

Before performing a termination of pregnancy, it may be disclosed to the medical practitioner that the reason for the request is for the sole purpose of sex selection. If this is the reason for the request, the practitioner **must no**t perform the termination, unless not performing the termination will cause significant risk to the woman's health or safety.

These will often be complex clinical and/or ethical scenarios. In all cases, the woman's physical and psychological wellbeing must be the medical practitioner's priority.

When a medical practitioner is uncertain about the degree of risk to the woman's health and safety arising from the refusal, further advice and support may be sought from either another medical practitioner, a multidisciplinary team, a hospital advisory committee or the local clinical ethics committee. When a termination for the sole purpose of sex selection is refused, the medical practitioner must offer additional support and referral to counselling or other relevant services.

Women can be referred to www.health.nsw.gov.au/pregnancyoptions to find the most up-to-date information about the NSW pregnancy options helpline. The helpline provides unbiased, non-judgmental information on pregnancy options, including continuing a pregnancy, terminating a pregnancy and seeking pregnancy options counselling.

Further resources and guidance for women and health professionals can be found at: www.health.nsw.gov.au/pregnancyoptions

Notification to NSW Ministry of Health

In accordance with section 15 of the Act, all terminations of pregnancy must be notified to the NSW Ministry of Health within 28 days. Information provided to the Ministry must **not** include any particulars that would allow a woman to be identified.

For further information on how to notify the NSW Ministry of Health of a termination of pregnancy, refer to www.health.nsw.gov.au/women/pregnancyoptions/Pages/for-healthprofessionals.aspx

USE OF THE GUIDELINE

This Guideline is intended for use by all termination of pregnancy providers in NSW in line with:

1. NSW Abortion Law Reform Act 2019
2. NSW Health Policy Directive *Framework for Termination of Pregnancy in New South Wales* (PD2021_018)
3. Preventing gender-biased sex selection: An Interagency statement OHCHR, UNFPA, UNICEF, UN Women and WHO

337 (23/06/21)

Maternity - Resuscitation of the Newborn Infant

Document number GL2018_016 rescinds PD2008_027.

PURPOSE This Guideline aims to optimise, facilitate and standardise newborn resuscitation by endorsing the Australian and New Zealand Committee on Resuscitation (ANZCOR) Guidelines - Section 13: Neonatal Guidelines (2016- 17) for use by NSW Health.

KEY PRINCIPLES

This Guideline applies to all clinicians who care for newborn infants in maternity and related environments and to the resuscitation of the newborn immediately following birth and during the birth admission.

USE OF THE GUIDELINE

This Guideline:

- replaces the Policy Directive PD2008_027 Maternity - Clinical Care and Resuscitation of the Newborn Infant
- endorses ANZCOR Guidelines (2016-2017) Section 13 - Neonatal guidelines 13.1-13.10 and the Newborn Life Support algorithm (Attachment 1)
- outlines local health district responsibilities to develop systems to ensure:
    - clinicians are appropriately targeted to complete mandatory and recommended newborn basic life support education, training and proficiency requirements
    - locally determined clinicians complete newborn advanced life support education, training and proficiency requirements, and are in attendance at the birth of newborn infants who are at higher risk of requiring resuscitation at birth
    - standardised newborn resuscitation equipment is available and operational and clinicians are familiar with the equipment
    - local procedures are in place to review resuscitation interventions and outcomes to monitor patient safety and quality of care and improve training and performance.

Postpartum Haemorrhage (PPH)

Document number GL2021_017 rescinds GL2021_010.

GUIDELINE SUMMARY

This Guideline outlines the roles and responsibilities of NSW Health organisations and health practitioners in the prevention, early detection, escalation and management of postpartum haemorrhage (PPH). NSW Health places a high priority on health practitioners working collaboratively with woman and their families, as well as each other, throughout all phases of maternity care.

KEY PRINCIPLES

The key principles that support prevention, early detection, escalation and management of PPH include, identification of women with risk factors and the development of strategies to prevent and/or manage PPH. These strategies include prompt, appropriate clinical and pharmacological management of women experiencing a PPH, and development of a Maternity Massive Transfusion Protocol (MTP) for managing obstetric critical bleeding in local Maternity Services.

USE OF THE GUIDELINE

This Guideline is designed for use by NSW Health staff who are part of the maternity care team. This Guideline should form the basis for:

- Development and implementation of evidenced based local procedures and escalation plans for the prevention, detection, escalation and management of primary PPH that are aligned and consistent with this Guideline
- Provision of culturally safe and responsive maternity care services
- Access to education and training in relation to PPH for clinicians who may be required to care for women before, during and after birth. This may be mandatory or targeted education and training at the discretion of the health entity, based on its assessment of local needs.

Maternity - Timing of Planned or Pre-labour Caesarean Section at Term

Document number GL2016_015 rescinds PD2007_024.

PURPOSE

The purpose of this document is to provide guidance for the timing of planned or prelabour caesarean section at term. Where there are no identified maternal, fetal or obstetric risks, it is advised that a planned or pre-labour caesarean section at term should not routinely take place prior to 39 weeks gestation (39^{+0} weeks).

KEY PRINCIPLES

The risks of maternal and neonatal morbidity incurred by planned caesarean section birth prior to 39^{+0} weeks should be weighed carefully on a case by case basis, against the risks of spontaneous labour occurring prior to the planned procedure.

The risks of maternal and neonatal morbidity include a higher risk of neonatal respiratory distress syndrome, transient tachypnoea of the newborn, mechanical ventilation, transfer and admission to neonatal intensive care units, breastfeeding difficulties, increased maternal blood loss, and longer hospital stay.

Clinical decision-making about the timing of a planned caesarean section at term should follow a discussion with the woman and her family about the risks and benefits of all options for birth, and include information about the risks and benefits of birth after 39^{+0} weeks.

USE OF THE GUIDELINE

The Chief Executives of NSW PHOs are responsible for the implementation of this Guideline within their services / facilities to ensure that local protocols or operating procedures are in place, aligned and consistent with this Guideline. All maternity services staff should be aware of the Guideline and actively participate in its implementation.

290 (26/5/16)

Maternity - Safety and Quality Essentials

Document number PD2023_031 rescinds PD2009_003.

POLICY STATEMENT

NSW Health is committed to the implementation of safe, reliable, and resilient safety systems across all maternity services in NSW.

This Policy Directive outlines a clinical governance framework for maternity services, derived from the NSW Health Safety Systems Model and aligned with the National Safety and Quality Health Service (NSQHS) Standards.

SUMMARY OF POLICY REQUIREMENTS

Embedding Safety Strategically

All local health district (District) maternity services are to implement governance structures that promote safety and quality. Districts require managerial and clinical leadership positions that are responsible for operational and strategic aspects of maternity services. Regular monitoring, evaluation and reporting of the key deliverables assigned to maternity leadership positions are essential.

Collaborative agreements are required to enable shared leadership across the Tiered Perinatal Networks (TPN).

Consumers are to be supported and encouraged to be actively involved in maternity service activities.

Accountable Leadership and Culture

Accountable leadership plays a crucial role in driving improvements in safety and quality and extends beyond the sole responsibility of maternity leaders. Districts are required to:

- Ensure all staff are informed and aware of the importance of safety and quality, and their individual roles and responsibilities in safety improvement.
- Ensure safety and quality behaviour and capability is included in performance review discussions for all maternity staff.
- Implement the Clinical Excellence Commission Safety Culture Framework, undertake regular safety culture measurements, and utilise the *Aboriginal Cultural Engagement Self-Assessment tool* to ensure delivery of culturally safe and accessible maternity services for Aboriginal women and women having an Aboriginal baby (sections 3.1 *Patient Safety Culture* and 3.2 *Organisational Safety Culture*).
- Districts are required to ensure allocation of resources that support staff self-care and emotional and psychological support (section 3 *Accountable Leadership and Culture*).

Safety Governance

Districts are required to:

- Complete the *Governance and Accountability in NSW Health Maternity Services – Self-Assessment Tool* annually and associated monitoring and reporting (section 4 *Safety Governance*).

- Implement a clearly defined and documented governance structure (section 4.1 *Maternity Safety Governance Structure*).
- Establish multidisciplinary Maternity Safety and Quality Committees with clearly defined and articulated reporting lines.

Safety Intelligence

Districts are required to:

- Ensure the development, implementation and utilisation of a maternity safety and quality surveillance strategy and have dedicated data and analytics support and resources for maternity services (section 5.2 *Data Surveillance Strategy*).
- Ensure near real time data is accessible to clinicians to support women to make informed decisions through the continuum of their pregnancy, birth, and the postnatal period.

Safety and Improvement Capability

Ensuring safety and quality improvement capability requires Districts to have clear executive sponsorship, and a collective governance commitment across maternity services.

Districts are to ensure that the healthcare safety and quality capabilities are included in position descriptions for all maternity leadership positions, recruitment selection criteria, professional career development goals and to guide safety and quality capability development of other clinicians.

It is recommended that all District and facility maternity leaders complete the Safety and Quality Essentials Pathway.

Safety Improvement

Embedding safety and quality improvement as business as usual is pivotal to improving the safety and quality of maternity services.

Districts are required to implement a number of processes to achieve this including identifying quality improvement opportunities and having clear quality improvement goals, ensuring regular auditing processes, implementing morbidity and mortality review meetings, and disseminating outcomes and lessons learnt from these processes (section 7 *Safety Improvement*).

Maternity - Management of Early Pregnancy Complications

Document number PD2012_022 rescinds PD2009_058.

PURPOSE

This is a policy for maternity services with respect to the management of early pregnancy complications in Early Pregnancy Assessment Services (EPAS). It also acts as a guide as to what is deemed suitable for ambulatory management.

This policy provides information related to the diagnosis and clinical management of women with early pregnancy loss, defined as a loss within the first 12 completed weeks of pregnancy. It mainly addresses the management of spontaneous miscarriage, but is also relevant to women affected by ectopic pregnancy and gestational trophoblastic disease, although specific guidelines for these conditions should be examined separately.

This policy recognises the importance and value of a dedicated outpatient EPAS within hospitals, as the EPAS has been shown to provide clinical benefits.

It is recognised that EPAS may care for women between 12 to 20 weeks gestation. However, the clinical and psychological needs of such women are often different compared to those with early pregnancy complications. Consideration needs to be given to a lower threshold for admission to hospital to ensure that such clinical and psychological needs can be met. The carers in environments to which such women are admitted need to be cognisant of the particular clinical and psychological needs of these women.

MANDATORY REQUIREMENTS

The place of the different diagnostic modalities must be clearly defined within service-specific algorithms (Appendix B), and the full range of therapeutic options (expectant and surgical) must be available to women who miscarry whenever possible. Apart from certain specific clinical circumstances, women should be able to choose their preferred method of management.

All maternity services must provide or be networked to a dedicated outpatient Early Pregnancy Assessment Service (section 2).

IMPLEMENTATION

Chief Executives or delegated officers are to ensure a written local protocol is in place and implemented as described in this policy.

Health professionals in all relevant health care settings must be familiar with the various diagnostic tools necessary to help delineate viable from non-viable pregnancy and ectopic from intrauterine pregnancy.

Maternity services and Emergency Departments must ensure that there are appropriate local policies and algorithms for each therapeutic intervention with clearly outlined pathways for each of the options available.

All health professionals must be aware of the psychological sequelae associated with pregnancy loss and must provide support, follow-up and access to formal counselling when necessary (section 5).

Maternal & Child Health Primary Health Care Policy

Document number PD2010_017.

(A component of the NSW Health / *Families NSW* Supporting Families Early Package)

PURPOSE

This policy is to ensure a consistent statewide approach to the provision of primary health care and health home visiting to parents expecting or caring for a new baby is implemented throughout NSW.

The policy identifies a primary health model of care for the provision of universal assessment, coordinated care, and home visiting, by NSW Health's maternity and community health services, for all parents expecting or caring for a new baby.

MANDATORY REQUIREMENTS

All Area Health Services (AHS) are to ensure that:

- a comprehensive assessment process, consistent with the SAFE START model, is implemented in both maternity and early childhood health services (Reference: Policy Section 3)
- risk factors and vulnerabilities are determined using a team-management approach to case discussion and care planning (Reference: Policy Section 3)
- the continuity-of-care model is implemented in accordance with this policy (Reference: Policy Section 3)
- effective communication systems from maternity services to early childhood health services are established (Reference: Policy Section 3)
- Universal Health Home Visiting (UHHV) is implemented and that every family in NSW is offered a home visit by a child and family health nurse within two weeks of the baby's birth (Reference: Policy Section 4)
- Sustained Health Home Visiting (SHHV) is implemented in accordance with this policy (Reference: Policy Section 4) *NB: SHHV is not provided in all AHS and is not mandatory*

IMPLEMENTATION

Chief Executives are to ensure this policy is implemented in accordance with the Implementation Requirements (Reference: Policy Section 5) and personnel, resources and the assignment of responsibly is adequate to effectively implement the policy.

AHS are to provide to NSW Department of Health data as requested on UHHV and SHHV (from those AHS funded to implement SHHV).

This policy must be read in conjunction with the following documents that comprise the **NSW Supporting Families Early Package**.

- PD2010_016 SAFE START Strategic Policy available at: http://www.health.nsw.gov.au/policies/pd/2010/PD2010_016.html
- GL 2010_004 SAFE START Guidelines: Improving mental health outcomes for parents and infants available at: http://www.health.nsw.gov.au/policies/gl/2010/GL2010_004.html

Maternity - National Midwifery Guidelines for Consultation and Referral

Document number PD2020_008 rescinds PD2010_022.

POLICY STATEMENT

This is a Policy Directive for maternity services with respect to appropriate consultation and referral by midwives.

This Policy establishes the requirement that all midwives providing midwifery care utilise the *Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral*©[2]. The ACM Guidelines provide an evidenced-based framework to support midwives in their clinical decision making across all practice areas and facilitate appropriate consultation and referral to peer midwives, medical and allied health staff during pregnancy, birth and the postnatal period.

It is recognised that safe maternity care is reliant on robust systems and processes. This includes careful risk assessment with pathways for escalation to an appropriately role delineated service.

SUMMARY OF POLICY REQUIREMENTS

Local Health Districts:

- Must ensure that all midwives who are providing maternity care refer to and use the *Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral*©.
- Must ensure the availability of the *ACM National Midwifery Guidelines for Consultation and Referral*© to all midwives within their maternity services.
- Provide ongoing education on the use of the *ACM National Midwifery Guidelines for Consultation and Referral*©.
- Are to include an audit of the usage of the *ACM National Midwifery Guidelines for Consultation and Referral*© in their quality framework.

Maternity services must be aware of their designated higher level maternity service for consultation and/or referral and transfer. Equally, higher designated maternity services must be aware of their obligations and responsibilities for lower level maternity services.

Chief Executives or delegated officers are to ensure a written local protocol is in place within maternity services and is implemented as described in this Policy.

Health professionals in all relevant health care settings must be familiar with and use the ACM National Midwifery Guidelines for Consultation and Referral©.

Maternity services must ensure that the ACM National Midwifery Guidelines for Consultation and Referral© are available to all midwives in all areas of maternity care.

These areas include but are not limited to:

- Antenatal Clinics, both medical and midwifery
- Antenatal inpatient units
- Postnatal inpatient units
- Day Assessment Units

2 Australian College of Midwives, National Midwifery Guidelines for Consultation and Referral, 2014, 3rd Edition, Issue 2.

- Delivery Suites/Birthing Centres
- Community Midwifery Programs
- Midwifery Continuity of Care Programs
- Privately Practicing Endorsed Midwives with access rights.

Instructions for accessing the ACM National Midwifery Guidelines for Consultation and Referral© can be found at the Australian College of Midwives website.

Local Health Districts should have in place a local implementation plan for education in the use of the *ACM National Midwifery Guidelines for Consultation and Referral©*

The ACM National Midwifery Guidelines for Consultation and Referral are appropriate for use by other clinicians when providing maternity care.

328 (11/30/20)

Maternity - Fetal heart rate monitoring

Document number GL2018_025 rescinds GL2016_001.

PURPOSE

This Guideline provides guidance for fetal heart rate (FHR) monitoring using intermittent auscultation (IA), antenatal and intrapartum electronic fetal heart rate monitoring (EFM), and fetal blood scalp sampling (FBS) to monitor fetal wellbeing.

KEY PRINCIPLES

This Guideline applies to all NSW Public Health Organisations (PHOs) providing maternity services where fetal welfare assessment is conducted. The Guideline:

- clarifies the indicators for FHR assessment, monitoring and FBS
- defines the terms used to describe FHR features used by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), and the International Federation of Gynaecologists and Obstetricians (FIGO)
- clarifies the features of the preterm FHR response compared to the term fetus
- introduces new assessment tools (algorithms and documentation labels) for the interpretation of antenatal and intrapartum FHR features
- facilitates standardisation of clinical management, consultation and escalation of abnormal FHR features in line with Policy Directive PD2013_049 Recognition and Management of Patients who are Clinically Deteriorating and the GL2016_018 NSW Maternity and Neonatal Service Capability Framework.

USE OF THE GUIDELINE

The Chief Executives are responsible for:

- the implementation of this Guideline in NSW PHO maternity services
- the development of local protocols, pathways and Clinical Emergency Response Systems (CERS) to facilitate consultation and escalation of concern where abnormal FHR features are identified
- monitoring patient safety and quality outcomes related to fetal monitoring, particularly for women with identified risks
- processes are in place to ensure that all relevant maternity services staff (this includes permanent, casual staff, agency and locum staff) receive appropriate education.

Connecting, listening and responding: A Blueprint for Action – Maternity Care in NSW

Document number IB2023_006 rescinds PD2010_045.

PURPOSE

This Information Bulletin is to notify the NSW Health system of the release of *Connecting, Listening and Responding: A Blueprint for Action – Maternity Care in NSW* (the Blueprint).

KEY INFORMATION

The Blueprint is guided by the *Woman-centred care: Strategic directions for Australian maternity services* and aligns with the NSW Health Policy Directive First 2000 Days Framework (PD2019_008). It has been developed in consultation with local health districts, NSW Health pillars, consumers and key stakeholders.

The Blueprint aims to strengthen maternity care services to ensure they are collaborative, equitable and woman-centred, while acknowledging and striving to address the contemporary organisational challenges for maternity care in NSW.

The Blueprint's vision is that '*all women in NSW receive respectful, evidence-based and equitable maternity care that improves experiences and health and wellbeing outcomes*'.

The Blueprint is supported by 10 goals:

1. Women receive maternity care that is socially and culturally respectful
2. Women's views actively inform improvements to maternity care
3. Women have enough information before conception to optimise their health, pregnancy experience and outcomes
4. Women are connected to information and care early in pregnancy
5. Antenatal care reflects the individual preferences and needs of women, babies and families
6. Women are offered different care options, are actively involved in decision-making about their care and their choices are respected
7. Women with additional needs during pregnancy are connected to appropriate services
8. Women are informed of the possible outcomes of all aspects of care during labour and birth
9. Women receive safe, high quality, evidence-based care that is appropriate to their individual needs and expectations
10. Women are connected to the care and support they need after the birth.

The NSW Ministry of Health will work with key stakeholders to develop an implementation plan for the Blueprint. The implementation plan will set out the short, medium and long-term priorities and further guide decisions on actions required to strengthen implementation.

Key actions

All local health districts and speciality health networks are to:

- promote and utilise the Blueprint for ongoing system reform and service redesign to strengthen maternity care across NSW including preconception, antenatal, labour, birth, postnatal care and transition to care in the community.

- promote the use of the Blueprint to inform direction and local actions to ensure all women in NSW receive respectful, evidence-based and equitable maternity care that improves experiences and health and wellbeing outcomes.
- provide input to the NSW Health implementation plan and to support local implementation of the goals, objectives and actions documented in the Blueprint.

Further information

For further information, contact the Health and Social Policy Branch, NSW Ministry of Health at MOH-HSPB@health.nsw.gov.au.

346 (01/03/23)

Maternity - Oxytocin for the Induction of Labour at or Beyond Term

Document number PD2011_075.

PURPOSE

This Policy Directive was developed to ensure safe and uniform clinical practice in relation to the use of oxytocin (Syntocinon®) for the induction of labour at or beyond term in maternity hospitals throughout NSW. It applies to induction of labour at or beyond term with a live baby. It is acknowledged that fetal death in utero at any stage of pregnancy may require induction of labour with similar or alternative agents acting upon the uterus not mentioned in the policy directive.

This policy directive provides direction to NSW maternity services regarding safe and uniform practice in relation to the induction of labour. It follows an audit of NSW maternity services undertaken in 2008 that demonstrated a wide variation in clinical practice. This policy directive should help inform maternity services in the development and implementation of local clinical practice guidelines and protocols.

MANDATORY REQUIREMENTS

All NSW Public Health Organisations providing maternity services must have clinical practice guidelines and protocols for the use of oxytocin for the induction of labour at or beyond term. Such clinical practice guidelines and protocols must reflect a Local Health District wide, standardised, evidence based policy for the induction of labour. The Local Health District policy must have statements that reflect the appropriateness of the procedure for the role level of maternity services.

All appropriately role delineated NSW public hospitals providing maternity services must have clinical practice guidelines for the induction of labour at term. Such guidelines must include a clear local plan of action for all clinicians to follow with appropriate early involvement of senior consultants in obstetrics in the event of uterine hyperstimulation (tachysystole), unsuccessful induction of labour, cord prolapse, uterine rupture and maternal collapse.

Health services and hospitals should comply with the educational program components as outlined in IB2008_002 *Fetal Welfare, Obstetric Emergency, Neonatal Resuscitation Training* (FONT). In particular, fetal welfare and maternity emergencies education days must include cord prolapse and maternal collapse/resuscitation in the program content. All clinicians working in maternity units are expected to complete the various components of the FONT program.

This policy directive must be read in conjunction with:

PD2009_003 Maternity - Clinical Risk Management Program

PD2010_040 Maternity - Fetal Heart rate Monitoring

PD2010_045 Maternity - Towards normal Birth in NSW

IMPLEMENTATION

The Chief Executives of Local Health Districts are ultimately responsible for the implementation of this policy directive within their respective facilities.

Maternity - Supporting Women in their Next Birth After Caesarean Section (NBAC)

Document number GL2014_004.

PURPOSE

The *Guideline: Maternity - Supporting Women in their Next Birth After Caesarean Section (NBAC)* provides direction to the NSW maternity services staff to provide consistent, evidencebased information to women. This information will support pregnant women in their decision making about their next birth after caesarean section.

This Guideline should be read in conjunction with PD2010_045 *Maternity - Towards Normal Birth in NSW*, which aims to increase the vaginal birth rate in NSW.

KEY PRINCIPLES

This Guideline applies to all NSW Public Health Organisations (PHOs) providing maternity services. It guides all NSW PHOs to support women in their decision making around their NBAC which includes ensuring that:

- Women are provided with access to vaginal birth after caesarean section (VBAC) services
- Women are provided with consistent evidence-based information regarding NBAC
- Clinicians have access to consistent evidence-based information in order to support women to make informed choices about birth after a previous caesarean section.

IMPLEMENTATION

The Chief Executives of NSW PHOs are responsible for the implementation of this Guideline within their services/facilities to ensure that local VBAC protocols or operating procedures are in place, aligned and consistent with the Guideline.

All maternity services staff should be aware of the Guideline and actively participate in its implementation to support pregnant women who have had a previous caesarean section in their decision making around their NBAC.

(14/03/14)

Maternity - Indications for Placental Histological Examination

Document number GL2014_006.

PURPOSE

This guideline describes indications for placental histological examination for births occurring in NSW Public Health Organisations as well as recommendations for storage, transport and submission of placentas for pathological review.

This document is intended to support clinical practice. The information provided in this document has been guided by the *Clinical Practice Guideline for Perinatal Mortality* produced by the Perinatal Society of Australia and New Zealand (PSANZ).

KEY PRINCIPLES

Within NSW, all placentas should be grossly examined at the time of birth. Specialist medical practitioners and midwives present at the time of delivery who have knowledge of placental anatomy and pathology as well as an understanding of the abnormalities and variations that affect the placenta may carry out the examination.

As the vast majority of pregnancies, newborns and placentas are normal, formal pathological examination of all placentas is neither required nor feasible for many institutions. Therefore, only a subset of placentas requires submission for histological examination. Formal histological examination of the placenta may provide valuable explanation for pregnancies affected by medical complications, pregnancy loss or neonatal death, as well as information relevant to the management of the infant and/or subsequent pregnancies.

USE OF THE GUIDELINE

This guideline should be brought to the attention of staff involved in the delivery of maternity and neonatal care including maternity services units, neonatal intensive care units and general and specialist pathology departments.

The decision regarding the indications for referral of placenta for histological examination should be agreed at a local level by obstetricians, neonatologists, midwives and other relevant maternity services staff. Further advice can be found in Appendix 1 of the Guideline – A Guide to Indications for Placental Histological Examination. Submission of placentas following other pregnancy complications or adverse outcomes that are not listed in the Guide at Appendix 1, may depend on local resources and availability of pathology services.

212 (15/05/14)

Maternity-Pregnancy and Birthing Care for Women Affected by Female Genital Mutilation / Cutting

Document number GL2014_016.

PURPOSE

The purpose of this document is to assist health care professionals within NSW Public Health Organisations to provide sensitive and culturally appropriate, evidence-based antenatal, intrapartum and postnatal care for women and their families affected by Female Genital Mutilation/Cutting (FGM/C). It is an expectation that clinical care provided to women with FGM/C will be provided in accordance with these guidelines.

KEY PRINCIPLES

Women with FGM/C are significantly more likely than those without FGM/C to have adverse obstetric outcomes. As more women from these countries settle in Australia, clinicians working within maternity services will increasingly need to become familiar with the skills required to optimise the health of women affected by FGM/C during pregnancy and childbirth.

USE OF THE GUIDELINE

Tiered Maternity Networks (Section 1.5.1)

Delivering best practice care will require a coordinated approach within NSW public hospitals for women affected by FGM/C, including support, counselling and related surgery.

Consultation and referral pathways should also be in place to facilitate the woman's movement between services within her tiered maternity network, to enable her to access skilled care. Local Health Districts (LHDs) should ensure that local guidelines for referral and transfer remain current and are in line with State policy.

Maternity Units in LHDs with a high population of women from countries that practice FGM/C (section 1.5.2)

These facilities should consider establishing an experienced designated team specialising in FGM/C issues, potentially comprising the following staff:

- Midwife
- Doctor
- Nurses, including women's health nurse, child and family health nurse
- Mental Health workers.

The designated team members should:

- Have a sound knowledge of FGM/C and understand the cultural and social complexities around the practice of FGM/C and its health effects through established contact with the NSW Education Program on FGM (WSLHD)
- Undertake regular clinical education / training on FGM/C. More information can be obtained through the NSW Education Program on FGM (WSLHD)
- Act in an advisory capacity or a referral point for maternity units that see fewer affected women.

Maternity Units in LHDs with a low population of women from countries that practice FGM/C

Although all LHDs should be familiar with guidance provided in this guideline it may not be practical for facilities to establish or maintain substantial local expertise. This may be due to factors such as low incidence of FGM/C, staff turnover and difficulty in accessing clinical education / training on FGM/C. In such instances, it will be necessary for these hospitals to establish and maintain links with hospitals that have staff with the required expertise in their tiered maternity network or source the nearest facility that offers FGM/C expertise. These arrangements will be best determined locally. Advice on appropriate contacts and clinical education/training can be sourced from the NSW Education Program on FGM.

224 (25/09/14)

Guidelines for the Management of Substance Use During Pregnancy Birth and the Postnatal Period

Document number GL2014_022 rescinds IB2024_042.

PURPOSE

These clinical guidelines are intended to support a range of health care workers who care for pregnant and breastfeeding women with substance use issues, and their infants and families.

KEY PRINCIPLES

The guidelines emphasise the importance of establishing a sound therapeutic relationship with the woman based on respect and non-judgmental attitudes, of engaging the woman into adequate antenatal care through this relationship, and of maintaining continuity of care and of carers throughout the pregnancy and postnatal period.

The guidelines recommend that pregnant women with significant problematic substance use will benefit from an appropriate referral for specialist drug and alcohol assessment (in addition to midwifery and obstetric care), appointment of a consistent and continuous case manager and care team who use effective communication systems, and specific treatments for their substance use, which may include counselling, pharmacotherapies and relapse prevention strategies.

USE OF THE GUIDELINE

These guidelines are intended for use by all health care practitioners in NSW working with pregnant women who are using substances during pregnancy, and the postnatal period. Substances refers to both licit purposes, such as those prescribed for pain relief, substance use treatment or other issues, and illicit purposes, which can include prescribed substances used for purposes other than that prescribed, and illicit substances.

Substances discussed in these guidelines include the licit substances of alcohol and tobacco; illicit substances of opioids, amphetamine-type stimulants (ATS), cocaine, cannabis and inhalants; and prescription medication which can be used licitly or illicitly. Other topics covered include breastfeeding, vertical transmission of blood-borne viruses, obstetric implications, pain management during labour, psychosocial issues, the management of Neonatal Abstinence Syndrome and early childhood development. This NSW revision of the guidelines has chapters specifically addressing the needs of women who are incarcerated or at risk of incarceration, women who live in rural and/or remote locations, and Aboriginal women. New legislation pertaining to child protection in NSW is also covered in detail.

231 (18/12/14)

Neonatal and Infant Hepatitis B Prevention and Vaccination Program Policy Directive

Document number PD2023_032 rescinds PD2017_036.

POLICY STATEMENT

NSW Health is committed to reducing the risk of hepatitis B transmission to neonates born in NSW. This Policy Directive focuses on the screening of all pregnant women for hepatitis B disease, appropriate referral to a specialist hepatology service/ specialist hepatologist as required, and the follow-up and management of all infants born to hepatitis B surface antigen (HBsAg) positive women.

SUMMARY OF POLICY REQUIREMENTS

This Policy Directive must be read in conjunction with the current edition of *The Australian Immunisation Handbook*.

The Policy Directive aims to ensure consistent implementation of the NSW Neonatal and Infant Hepatitis B Prevention and Vaccination Program in all local health districts; and applies to NSW ante- and post-natal services, maternity hospitals, and public health units within the local health district.

All maternity facilities must offer hepatitis B surface antigen (HBsAg) screening and referral where appropriate to all pregnant women. HBsAg positive pregnant women with a high viral load (>200,000 or 5.3 $\log_{10}$ IU/mL) are recommended to be referred to a hepatology service/ specialist hepatologist.for management and follow up. HBsAg positive pregnant women with a low viral load (≤200,000 or 5.3 $\log_{10}$ IU/mL) can be managed by either their general practitioner or hepatology service.

All maternity facilities are required to offer Hepatitis B immunoglobulin (HBIG) to all neonates born to HBsAg positive mothers within 12-hours of birth. In addition, all neonates regardless of mothers HBsAg status must be offered the hepatitis B vaccine within 7-days of birth.

For reporting requirements, all maternity facilities are required to enter hepatitis B data onto eMaternity or Cerner as appropriate and report regularly to their Local Health District

The Neonatal Hepatitis B Hospital Coordinator must forward a copy of the Neonatal and Infant Hepatitis B Follow Up Letter to the LHD Neonatal and Infant Hepatitis B Lead and the mother's nominated doctor, if known to assist with following up babies born to a HBsAg positive mother.

In addition, the Neonatal Hepatitis B Hospital Coordinator must complete the Maternity Unit Record Form for every infant born to a HBsAg positive mother. The completed form must be sent to the LHD Neonatal and Infant Hepatitis B Lead to ensure all reporting and monitoring responsibilities are met.

The LHD Neonatal and Infant Hepatitis B Lead is required to send a copy of the *Neonatal and Infant Hepatitis B Follow Up Letter to General Practitioners* and the *Maternity Unit Record Form* to the local PHU Immunisation Coordinator for monitoring and follow up of vaccination course completion.

All neonates born to HBsAg positive mothers outside of NSW Health facilities should be notified to the local public health unit to assist with monitoring the completion of their primary hepatitis B vaccination course.

Following collection of the data, the local health district is responsible for reporting program performance and follow-up all neonates born to HBsAg positive mothers who are overdue for vaccination.

Maternity - External Cephalic Version

Document number GL2017_007 rescinds GL2016_024.

PURPOSE

This Guideline describes the procedure for external cephalic version (ECV) and clinical care required when a woman presents at or near term with a singleton breech presentation.

KEY PRINCIPLES

ECV should be an option for women who have a baby that is in a breech presentation and meet criteria for the procedure to be undertaken safely.

USE OF THE GUIDELINE

This Guideline recommends consistent, evidence-based information regarding the option of ECV be provided to the woman by experienced clinicians.

ECV should be offered as noted in GL2016_018 NSW Maternity and Neonatal Service Capability Framework. Each Tiered Maternity Network in NSW should have consultation, referral and transfer processes in place to ensure all women are provided with the option of ECV in the presence of a term singleton breech presentation. The woman's management plan should be documented in her medical record.

310 (04/05/17)

Maternity - Supporting Women Planning a Vaginal Breech Birth

Document number GL2017_008.

PURPOSE

This Guideline provides guidance to Local Health Districts (LHDs) to establish a planned vaginal breech birth service in order to ensure all women have access to this birth option. Alternatively, LHDs are encouraged to ensure that a consultation and referral process is in place for access to vaginal breech birth within their Tiered Maternity and Neonatal Network.

KEY PRINCIPLES

Local and international guidelines support the provision of vaginal breech birth in selected circumstances. For women with a singleton breech presentation at term, research has demonstrated that in maternity units with policies and guidelines to direct clinical care, there is no significant excess additional risk associated with planned vaginal birth compared with planned caesarean section.

USE OF THE GUIDELINE

Access to a supportive vaginal breech birth service within NSW is limited. It is an obligation of NSW Health to provide women with birthing options that offer appropriate safety controls and processes within a tiered network of maternity services. Consultation, referral and transfer processes should be in place to ensure all women are provided with the option of vaginal breech birth.

To ensure the best outcomes for mothers and babies, vaginal breech birth should be managed in services with expertise in this birth option, including support for informed decision making. Information should be provided on the benefits and risks, both for current and future pregnancies, of planned caesarean section versus planned vaginal birth for breech presentation at term.

Visiting Endorsed Midwife Practice

Document number PD2023_036 rescinds PD2022_018.

POLICY STATEMENT

NSW Health is committed to facilitating women's options for maternity care. NSW Health also supports public hospitals to enable admitting and practice rights for Visiting Endorsed Midwives (VEMs), in accordance with Commonwealth maternity reforms.

SUMMARY OF POLICY REQUIREMENTS

This Policy Directive provides options for endorsed midwives to apply for an Access Agreement with an NSW Public Health Organisation (PHO). These options include in the capacity as a VEM who provides private midwifery services in NSW Health facilities in an individual capacity, or as a VEM who is separately employed by a midwifery practice or Health Care Service.

Planned births at home that require escalation or transfer of care to a public maternity facility is not included in the scope of this Policy Directive.

An Access Agreement outlines the terms and conditions under which a PHO agrees to grant a VEM the right of access to NSW Health facilities operated by that organisation.

A collaborative arrangement must be agreed and in place between the VEM and either a NSW Health maternity service, or an Obstetric Specified Medical Practitioner who also has rights of practice at the same service.

PHOs must establish Verification Committees to assess applications for Access Agreements from VEMs, and applications from midwifery practices or Health Care Services that employ a VEM requesting an Access Agreement. Verification Committees make recommendations to the Chief Executive (or their delegate) of the PHO to approve or decline applications. Verification Committees are also responsible for credentialing and determining the scope of practice of VEMs.

Verification Committees verify, cite and authenticate relevant documents supplied by a VEM to validate their professional qualifications and experience, and also validate the endorsement of VEMs for use of scheduled medicines. Verification Committees also consider and approve amendments to Collaborative Arrangements. Verification Committees review the right of access of the VEM, midwifery practice or Health Care Service at one year from the commencement date of the Access Agreement, and then each 12-month period thereafter (a new application for an Access Agreement is required every five years).

Nausea and Vomiting in Pregnancy and Hyperemesis Gravidarum

Document number GL2022_009.

GUIDELINE SUMMARY

Nausea and vomiting in pregnancy and hyperemesis gravidarum can cause significant emotional, psychological, physical and financial distress for women and their families.

This Guideline provides evidenced-based guidance to support consistency of practice, decision-making and care coordination for the diagnosis and management of nausea and vomiting in pregnancy and hyperemesis gravidarum.

This Guideline applies to NSW Health and non-NSW Health clinicians (such as general practitioners) who provide care to pregnant women.

KEY PRINCIPLES

This Guideline reflects evidence based best clinical practice and expert consensus opinion to standardise the diagnosis and management of nausea and vomiting in pregnancy and hyperemesis gravidarum.

The Guideline provides recommendations for the care of priority populations including the care of Aboriginal and/or Torres Strait Islander families, culturally and linguistically diverse families and care of LGBTIQ+ people.

Comprehensive assessment, including the Pregnancy Unique Quantification of Emesis (PUQE-24) scoring index, will assist with defining the severity of illness and to guide care pathways which promote community and ambulatory care settings.

Holistic and multidisciplinary care must consider the woman's social and emotional wellbeing. Individual care plans are to be developed in partnership with the woman and must include advice on how to adjust treatment if symptoms improve, fluctuate or deteriorate, and how to access care if required.

Continuity of care models, including access to specialist care, must be developed to support women accessing care closer to home. This may include community or ambulatory care for women with mild to moderate severity; Hospital in the Home for women with more severe symptoms; and virtual care as appropriate.

Transfer of care between maternity services and community-based services is to be coordinated, ensuring that women receive consistent information, assessment, management, treatment, and continuity of care.

Pre-conception support, counselling and early or pre-emptive treatment, including an early pregnancy booking, is to be offered to women who have experienced hyperemesis gravidarum in a previous pregnancy.

Local Health Districts and Specialty Health Networks must ensure:

- implementation of this Guideline
- relevant staff receive education and training based on this Guideline
- local protocols or operating procedures are in place and consistent with this Guideline
- monitoring of practice.

Reducing the effects of smoking and vaping on pregnancy and newborn outcomes

Document number PD2022_050.

POLICY STATEMENT

NSW Health services and clinical staff are committed to provide evidence-based and highquality smoking and vaping cessation support to women before, during and after pregnancy.

Smoking during pregnancy is the most significant preventable cause of complications for pregnant women and their children, and is associated with preterm birth, low birth weight, babies who are small-for-gestational-age and perinatal death.

SUMMARY OF POLICY REQUIREMENTS

All clinicians working in Maternity and Newborn, Child and Family Health, Perinatal Infant Mental Health Services (PIMHS), Aboriginal Maternal and Infant Health Services (AMIHS), Building Strong Foundations for Aboriginal Children, Families and Communities (BSF), Oral Health Services, Primary Care and Aboriginal Community Controlled Health Services (ACCHSs), and other relevant services are to be appropriately skilled in the management of smoking and vaping in pregnancy.

Carbon monoxide (CO) monitoring is to be offered to all women before asking about smoking status:

- at first pregnancy visit and at the 28 weeks gestation visit.
- at every health visit for women who are known to smoke, or who have recently quit (i.e., in the last 12 months).

The carbon monoxide measurement is to be used as a tool to engage in discussion on smoking status, avoiding second-hand smoke, and to motivate quitting. The expired carbon monoxide reading is to be recorded in the woman's health care record.

Clinicians are to use a sensitive and empathetic approach when discussing smoking and vaping with pregnant women. The 'Ask, Advise, Help' smoking and vaping cessation brief intervention model must be used at every health visit.

Clinicians are to ask and record the smoking and vaping status of all pregnant women and that of their partner and/or household members at all health visits. Clinicians are to advise on the short and long term benefits of quitting and effective ways to quit, and offer culturally appropriate support (help) and resources to assist their attempts to quit.

Clinicians are to provide all Aboriginal women with care that is safe, respectful and trauma informed. A comprehensive, holistic approach must be taken when addressing smoking and/or vaping. This includes the physical, spiritual, cultural, emotional, and social wellbeing of women. This is especially important for Aboriginal women and women having an Aboriginal baby.

Clinicians are to offer consultation with an Aboriginal health worker that the woman is comfortable with, or referral to a culturally safe service, such as Aboriginal Quitline (accessed by calling Quitline and asking to speak to an Aboriginal Advisor).

Support and interventions to quit smoking and vaping are to be self-determined and adopt a strengths-based approach to ensure women and their families feel supported in their progress to quit. A strengths-based approach acknowledges the strengths of Aboriginal people, their families, and their communities, including connection to culture, resilience, and a holistic view of health, and moves away from deficit discourse.

People who smoke or vape may have complex needs associated with their nicotine/tobacco use, including psychosocial issues, trauma, mental health conditions, and drug and alcohol related health issues. Clinicians are to provide smoking and vaping cessation support that is safe, respectful and trauma informed.

Clinical staff are to document carbon monoxide readings, smoking and vaping status, support offered, and outcomes of discussions in the woman's health care record to ensure continuity of care and appropriate follow-up.

344 (14/10/22)

Care of women with suspected or confirmed Fetal Growth Restriction

Document number GL2023_004.

GUIDELINE SUMMARY

Fetal growth restriction is a common complication in pregnancy that is associated with adverse perinatal and neurodevelopmental outcomes including stillbirth, neonatal mortality and short- and long-term morbidity. This Guideline provides evidence-based guidance to support maternity services in the care planning for pregnant women with suspected or confirmed fetal growth restriction, ensuring women and their families are fully informed of risks, potential outcomes and their options of care.

This Guideline applies to all NSW Health maternity services.

KEY PRINCIPLES

This Guideline reflects evidence based clinical practice for the screening, management, and escalation of Fetal Growth Restriction (FGR) during pregnancy. Women with confirmed FGR require as a minimum, a multidisciplinary collaborative care plan in line with the Tiered Perinatal Networks.

Throughout all pregnancy and perinatal care, women and their families must be fully informed of risks, potential outcomes and their options of care. Women and their support person(s) are always included in care planning and decision making, and consent for healthcare treatment must be established.

Throughout the antenatal period, all women must be assessed for risk factors associated FGR in line with the *NSW Fetal Safety Risk Assessment Pathway* and an appropriate care plan developed in collaboration with the woman.

FGR is associated with adverse perinatal outcome including stillbirth. Aboriginal and Torres Strait Islander women experience higher rates of stillbirth. Risk factor identification is vital to support perinatal risk reduction and reduce adverse outcomes for Aboriginal and Torres Strait Islander women.

Serial plotting of symphysis fundal height (SFH) measurements on the NSW Health *International Symphysis-Fundal Height Standards* chart are to be conducted as part of routine antenatal care starting from 24 to 28 weeks gestation, to monitor for potential FGR.

Women who are unsuitable for symphysis fundal height measurements or have FGR risk factors as per the *NSW Fetal Safety Risk Assessment Pathway* will require growth ultrasound assessments.

Where FGR is identified, consultation and referral for specialist obstetric care must be offered and arranged as appropriate.

In the presence of FGR, decisions for planning birth should include consideration of the gestational age and be balanced against the benefits of ongoing pregnancy, in collaboration with the woman.

Optimal care planning includes ensuring the availability of multidisciplinary team members including the neonatal team, to support stabilisation and potential admission of the baby to a neonatal unit.

For future pregnancies, women with a history of FGR require as a minimum, multidisciplinary collaborative care planning involving midwifery and medical consultation.

All women should be provided the opportunity to debrief with clinicians about their pregnancy and birth experience and appropriate follow up support be made available. This should include psychosocial support where indicated with appropriate wellbeing support made available.

346 (24/02/23)

Domestic Violence Routine Screening

Document number PD2023_009.

POLICY STATEMENT

NSW Health is committed to early identification of domestic violence and promoting awareness of the health impacts of violence. Domestic violence routine screening is mandatory for all women and girls accessing maternity and child and family services, and women 16 years and over accessing mental health and alcohol and other drug services.

Other appropriate NSW Health services, following NSW Ministry of Health approval, can implement domestic violence routine screening with all women 16 years and over in line with this Policy Directive.

SUMMARY OF POLICY REQUIREMENTS

Domestic violence routine screening is conducted through five phases: delivering the domestic violence routine screening preamble; asking the screening questions; taking appropriate actions in response to the woman's answers; explaining and offering the domestic violence Z-card; and documenting screening and outcomes in medical records.

Health workers are to take account of clients' broader social context and be responsive to clients' needs, including by addressing additional barriers that women from priority populations may face.

All clinical staff and Aboriginal Health Workers who conduct screening must complete the four-hour mandatory face-to-face Domestic Violence Routine Screening Training. In participating health services, staff must complete the training before conducting screening.

Screening must occur with all eligible women, except in the following circumstances: others are present; the woman is not well enough to answer the screening questions; or the woman has made a recent disclosure of domestic violence.

Where domestic violence is identified prior to screening health workers are to respond in line with the requirements of this Policy and related NSW Health policies.

Domestic violence routine screening must be conducted at face-to-face appointments in a safe and private space, not via telehealth. Where privacy cannot be assured, domestic violence routine screening is not to proceed. Where health services are delivering services through a mix of face-to-face and telehealth, health services must prioritise domestic violence routine screening at face-to-face appointments.

If domestic violence routine screening cannot be conducted when initially scheduled, attempts must be made at subsequent appointments or on subsequent occasions of service until the domestic violence routine screening is completed.

Health workers must read out the preamble on the Domestic Violence Routine Screening form before asking the screening questions and then ask the screening questions, in full and as instructed, on the Domestic Violence Routine Screening form.

Responses to disclosures of domestic violence must include risk assessment and safety planning. All women who disclose domestic violence are to be offered a referral to a counsellor, social worker, or other appropriate trained psychosocial worker within NSW Health or relevant specialist services.

Health workers must also address the safety, health, and wellbeing needs of children and young people. Workers are to respond to suspected risk of significant harm and take action that promotes the safety of both adult and child victims of domestic violence. This includes identifying

responses to assist women to continue to care for their children in a safer environment where possible.

Where a woman or where children are identified as being at serious threat, workers must prioritise action to reduce the threat.

All women must be offered a Z-card, and have its contents explained, regardless of the outcome of the domestic violence routine screening.

Where a woman discloses other forms of violence and abuse, including family violence, health workers will respond in line with this Policy's procedures and other relevant NSW Health policies.

Responses to screening questions and subsequent actions must be documented in the woman's medical record, including if they do not disclose violence. This includes completing the Domestic Violence Routine Screening form. Domestic Violence Routine Screening forms must be completed in the electronic medical record where available.

Local Health Districts and Specialty Health Networks are to support health workers to deliver domestic violence routine screening by:

- Ensuring that Domestic Violence Routine Screening Training is provided to clinical staff and Aboriginal Health Workers whose role involves delivery of domestic violence routine screening.
- Identifying appropriate staff to complete the Domestic Violence Routine Screening Facilitator Training so that they can deliver the Domestic Violence Routine Screening Training within their Local Health District or Specialty Health Network.
- Ensuring workers who conduct screening and respond to disclosures have access to support. This includes promoting awareness of and access to domestic and family violence leave provisions, and other supports for workers who may themselves be experiencing domestic and family violence.
- Promoting screening practices that are accessible, safe and respectful to all women, including women from priority populations.
- Establishing and maintaining consultation and referral pathways from screening services to specialist violence, abuse and neglect practitioners and services both within and beyond NSW Health.
- Monitoring and reporting on the implementation of domestic violence routine screening and training as required.

347 (03/04/23)