SESLHD PROCEDURE COVER SHEET

Health
South Eastern Sydney
Local Health District

NAME OF DOCUMENT	Patient with Acute Condition for Escalation (PACE): Management of the Deteriorating NEONATAL Inpatient in Maternity Services and Nurseries
TYPE OF DOCUMENT	Procedure
DOCUMENT NUMBER	SESLHDPR/340
DATE OF PUBLICATION	July 2018
RISK RATING	High
LEVEL OF EVIDENCE	National Safety and Quality Health Service Standards, 3, 6 and 9 NSW Ministry of Health Policy Directive 'Recognition & Management of Patients who are Clinically Deteriorating' PD2013_049
REVIEW DATE	July 2020
FORMER REFERENCE(S)	N/A
EXECUTIVE CLINICAL SPONSORS	Kim Brookes SESLHD Director Clinical Governance
AUTHOR	Suzanne Schacht - Clinical Stream Manager Critical Care, Cardiac and Respiratory (SESLHD) Felicity McLaren - PACE Coordinator (RHW)
POSITION RESPONSIBLE FOR THE DOCUMENT	Manager, Women's and Children's Clinical Stream, SESLHD
KEY TERMS	Neonatal clinical deterioration, Special Care Nursery Pace Tier 1, Pace Tier 2, clinical emergency response
SUMMARY	This document outlines the PACE escalation procedure for Neonatal Inpatients, specifically: • Operational components of the PACE system including Neonatal Calling Criteria for initiating a PACE call • District and hospital responsibilities and accountabilities in relation to the PACE system.

Feedback about this document can be sent to seslhd-executiveservices@health.nsw.gov.au

Patient with Acute Condition for Escalation (PACE): Management of the Deteriorating Inpatient NEONATES

SESLHDPR/340

1. POLICY STATEMENT

Early recognition of the deteriorating neonate and providing a prompt and appropriate response are essential components of safe quality patient care.

Staff in SESLHD facilities will utilise a standardised clinical emergency response system to facilitate early recognition and response to neonates with signs of clinical deterioration. The clinical emergency response system used in SESLHD is known as PACE (Patient with Acute Condition for Escalation).

This procedure shall be read in conjunction with NSW Ministry of Health Policy - PD2013_049 Recognition and Management of Patients who are Clinically Deteriorating

The procedure also complies with National Safety and Quality Health Service Standards:

- Standard 3 - Partnering with Consumers
- Standard 6 - Clinical Handover
- Standard 9 - Recognising and Responding to Clinical Deterioration in Acute Health Care.

For adult and maternity patients refer to SESLHDPR/283 Patient with Acute Condition for Escalation (PACE): Management of the Deteriorating ADULT & MATERNITY Inpatient

For paediatric patients refer to SESLHDPR/284 Clinical Emergency Response System (CERS): Management of the Deteriorating PAEDIATRIC Inpatient

Neonatal PACE is operational in the following clinical areas:

	Post Natal Wards	Special Care Nursery	Birthing Unit/ Delivery Suite	Recovery/Theatres
RHW	Yes	No	Code Blue	Yes
SGH	Yes	Yes	Yes	Yes
TSH	Yes	Yes	Yes	Yes

2. BACKGROUND

PACE is the rapid response system activated if the observations or condition of a neonate meets criteria listed on the NSW Standard Newborn Observation Chart (SNOC). PACE aims to identify and reverse early signs of deterioration, through early management and treatment. The success of the system relies on the following:

- Observations monitored at a sufficient frequency to detect deterioration or procedural complications
- Recognition of early signs of deterioration by a staff member
- Activation of the PACE system if observations meet calling criteria or other clinical condition of concern
- Timely medical response and management by a senior member of the primary care team
- Built in escalation to specialised emergency care should the neonate continue to deteriorate or if the neonate's condition is life threatening.

2.1 Definitions / Abbreviations:

- **AMO:** Attending Medical Officer
- **BTF:** Between the Flags
- **CERS:** Clinical Emergency Response System
- **DETECT: D**etecting deterioration **E**valuation, **T**reatment, **E**scalation and **C**ommunicating in **T**eams. A mandatory education program based on e-learning and a practical scenario based session designed to improve clinical assessment skills, recognition and management of patients who are clinically deteriorating
- **DETECT Junior:** A similar e-learning and practical scenario based session as DETECT, which is mandatory for all staff who care for paediatric patients
- **FONT:** Fetal welfare assessment, Obstetric emergencies and Neonatal resuscitation Training for all midwives and obstetric medical staff
- **GCS:** Glasgow Coma Scale
- **ISBAR: I**ntroduction / **S**ituation / **B**ackground / **A**ssessment / **R**ecommendations
- **Observation Monitoring Plan:** A plan outlining the minimum observations and assessments that are required, including observation frequency
- **PACE:** Patient with Acute Condition for Escalation
- **REACH:** Stands for Recognise / Engage / Ask / Call / Help is on its way. REACH is the process a parent or family member can use to independently make an escalation call if they have clinical concern about their baby. REACH is being rolled out across NSW
- **SNOC:** Standard Newborn Observation Chart is used for newborns admitted to the Special Care Nursery or Birthing Services
- **SCN:** Special Care Nursery
- **RED ZONE Criteria:** Mandatory calling criteria that requires Neonatal PACE activation
- **YELLOW ZONE Criteria:** Discretionary calling criteria that requires the nurse / midwife in conjunction with the nurse / midwife in charge to decide whether a PACE call is activated.

	Activate	**Response**
YELLOW ZONE Criteria	Consult Nurse / Midwife in charge and decide whether a Neonatal PACE Tier 1 call is required	NICU Team / Paediatric Team review within 30 minutes
RED ZONE Criteria	Activate a Neonatal PACE Tier 2 call	NICU Team / Paediatric Team review within 5 minutes

3. NSW HEALTH STANDARD NEWBORN OBSERVATION CHART (SNOC)

- All newborns must have a set of observation and a Newborn Risk assessment performed and documented prior to discharge from the birthing environment (or operating theatre) on the Standard Newborn Observation chart (SNOC)
- If perinatal risk factors are identified including use of maternal opioid therapy in labour, and/or an observation is abnormal, observations should continue to be recorded on the SNOC every 15 minutes for the first hour, then at intervals

determined by the condition of the newborn or identification of risk factors for at least four hours after birth

- All newborns / neonates in special care nurseries and maternity services must have any observations attended recorded on the SNOC.

4. RESPONSIBILITIES

4.1 Primary Care Team (PCT) will:

- Attend PACE Orientation and complete online DETECT e-learning, as well as a practical session through DETECT
- Prescribe the frequency of observations on the NSW Health Standard Newborn Observation Chart (SNOC) for neonates with identified risk factors
- **Altering Calling Criteria:** Calling criteria may only be altered in consultation with the AMO. All alterations to calling criteria must be reviewed by the AMO within 48 hours or earlier if clinically indicated. Alterations to calling criteria and the due review date / time are documented on the front page of the SNOC
- Notify the neonate's family as soon as practical following a PACE call or code blue / cardiac arrest call.

4.2 Neonatal / Paediatric Registrar will:

- Review all Neonatal PACE Tier 1 calls (i.e. calls activated due to yellow zone breaches) as soon as possible but within 30 minutes. If unable to attend, a locally agreed deputy can attend
- Attend to all Neonatal PACE Tier 2 calls (i.e. calls activated due to red zone breaches) within five minutes
- Attend immediately to all Neonatal Code Blue / Cardiac Arrest calls
- Document a management and review plan in the health care record following any Neonatal PACE call
- Notify the Attending Medical Officer (AMO) of the neonate's condition following every Neonatal PACE call or Neonatal Cardiac Arrest / Code Blue call
- Complete the Notification Audit Form.

4.3 Nurses / Midwives will:

- Attend PACE Orientation and DETECT Junior or equivalent as required
- Attend neonatal basic life support (BLS) at orientation and attend annual neonatal BLS refreshers. Complete the Newborn BLS and ALS eLearning on my Health Learning
- Midwives are exempt from attending DETECT practical (as the principles have been incorporated into mandatory Fetal welfare Obstetric emergency Neonatal resuscitation Training (FONT)
- Monitor vital signs at a frequency that is appropriate to the clinical condition or treatment being administered
- Check whether the neonate has an altered calling criteria (i.e. signed by the AMO and current i.e. within the 48 hour review period)
- If observations or clinical condition meet the YELLOW ZONE criteria, consult promptly with the nurse / midwife in charge to determine whether a PACE call is required
- If observations meet the RED ZONE criteria, the nurse / midwife must immediately activate the PACE system

- Ensure that parents have received information regarding **REACH** including how to make a REACH call
- If a parent or family member raises clinical concern for the patient, the nurse / midwife must review the patient and assess whether the patient is deteriorating. If the patient is deteriorating a PACE call must be made. If the patient is not deteriorating the nurse / midwife must provide the patient or family / carer with a rationale
- If the patient or family remain concerned or not satisfied with the rationale provided the nurse / midwife must activate a PACE call
- Following a PACE call ensure the NUM / MUM or team leader is aware a PACE call has been activated
- Initiate treatment within scope of clinical practice including a repeat set of observations. Monitor for signs of deterioration. Prepare to handover to the responder using ISBAR principles and SESLHDPR/303 Clinical Handover: Implementation of ISBAR Framework and Key Standard Principles
- Contemporaneously document the episode in the health care record
- Complete the PACE Activation sticker (including observations at time of call) and place in the progress notes (only applicable in units / wards using paper based charting)
- Complete the activator section of the Notification Audit form and place in the PACE collection folder
- If Code Blue / Cardiac Arrest or prolonged resuscitation occur document on the Neonatal Resuscitation Chart.

NB: Facilities in SESLHD will start to implement use of an electronic Rapid Response form that will replace the PACE Activation sticker and the PACE Notification data form

4.4 Nursing/Midwifery Unit Manager (NUM / MUM) will:

- Review with the bedside nurse / midwife any neonate with observations charted in the YELLOW ZONE of the SNOC to determine if PACE activation is required
- Review observation charts on a regular basis to ensure that vital signs are monitored and recorded completely, at a frequency sufficient to detect clinical deterioration and that calling criteria are escalated as per the PACE procedure
- To ensure continuous quality improvement, remedial action and follow up with staff should occur, if deficits are identified
- The NUM / MUM or shift team leader of the ward / unit is responsible for the provision of sufficient equipment to ensure nursing workflow is not delayed due to faulty or missing equipment i.e. thermometers, oxygen saturation monitors and probes.

4.5 Allied Health Professions will:

- Attend PACE Orientation, DETECT
- Immediately notify the nurse / midwife if a neonates' clinical condition deteriorates. The nurse / midwife will activate the appropriate response.

NEONATAL CALLING CRITERIA

NEONATAL Criteria	YELLOW ZONE Criteria	RED ZONE Criteria
Respiratory Rate	25 – 30 or 60 – 80	≤ 25 or ≥ 80
Respiratory Distress *	Moderate	Severe
Oxygen Saturation	90 - 95%	<90%
Heart Rate	70 – 90 or 160 – 190	≤ 70 or ≥ 190
Capillary Refill	≥ 3 Seconds	-
Systolic Blood Pressure	40 – 60 or 90 – 100 mmHg	≤ 40 or ≥ 100 mmHg
Neurological	Only responds to Voice or Touch	Only responds to Pain or Unresponsive
Pain Score	≥ 4	-
Temperature	34.5 – 36 or 38 – 39.5º	≤ 34.5 or ≥ 39.5º
Colour	Jaundiced	Pallor or Cyanosed
Blood Glucose Level	1.7 – 2.5 or >10 mmol/ * Initiate local procedures for hypoglycaemia immediately.	≤ 1.7 mmol/L
Clinical Concern	Clinical Concern by Family or Staff	Serious Clinical Concern by Family or Staff

***For further information on the assessment of Respiratory Distress see SNOC Section 3**
**** For further information on Pain Score see page 11**

Additional YELLOW ZONE Criteria	• Increasing oxygen requirement • Poor peripheral circulation • Greater than expected fluid loss • Altered mental state • New, increasing or uncontrolled pain • Clinical Concern by any staff or family member.
Additional RED ZONE Criteria	• Respiratory Arrest • Cardiac Arrest or Circulatory Collapse • New onset of Stridor • Significant bleeding • Sudden decrease in level of consciousness of ≥2 points on GCS • New or prolonged seizure activity • Three (3) or more simultaneous YELLOW ZONE observations • Serious Clinical Concern by any staff or family member.

5. PROCEDURE

5.1 ACTIVATION OF THE PACE SYSTEM – NEONATAL PATIENT

Summary of Terminology used to activate PACE or Code Blue / Cardiac Arrest				
Facility		**If Neonate's observations meet YELLOW *ZONE and* a PACE is Required DIAL 2222 and request the Speciality as per the clinical area and facility**	**If Neonate's observations meet RED ZONE criteria DIAL 2222 and request as per the clinical area and facility**	**If Neonate's condition is immediately Life Threatening DIAL 2222 and request as per the clinical area and facility**
RHW	Post Natal ward	Neonatal PACE Tier 1	Neonatal PACE Tier 2	Neonatal Code Blue
	Delivery Suite	Neonatal Code Blue	Neonatal Code Blue	Neonatal Code Blue
	Recovery	Neonatal PACE Tier 1	Neonatal PACE Tier 2	Neonatal Code Blue
SGH	Post Natal ward and Special Care Nursery	Neonatal PACE Tier 1	Neonatal PACE Tier 2	Neonatal Cardiac Arrest
	Delivery Suite / Birth Centre	Neonatal Tier 1	Neonatal Tier 2	Neonatal Cardiac Arrest
	Recovery / Theatre	Neonatal PACE Tier 1	Neonatal PACE Tier 2	Neonatal Cardiac Arrest
TSH	Post Natal and SCN	Neonatal PACE Tier 1	Neonatal PACE Tier 2	Neonatal Cardiac Arrest
	Birthing Suite, Recovery OT	N/A*	Neonatal PACE Tier 2	Neonatal Cardiac Arrest
	Emergency or Ward		Code Blue Neonatal ED	Code Blue Neonatal ED

Delivery Suite has an established system for escalation to the neonatal team. (NB: SNOC may only have been initiated hence unable to assess trends).

5.2 Neonatal BLUE ZONE Criteria

If a neonate's observations are charted in the BLUE ZONE of the NSW Standard Neonatal Observation Chart (SNOC):

Initiate appropriate clinical care and increase the frequency of observations.

Activate a PACE Call at any time if concerned for the neonates clinical condition
To determine if escalation is required consider:

- Where abnormal observations reflect deterioration
- What is usual for the neonate or if there are altered calling criteria
- Whether there is an adverse trend in observations.

5.3 Neonate YELLOW ZONE Criteria

If a neonate's observations are charted in the YELLOW ZONE or meet ADDITIONAL YELLOW ZONE CRITERIA on the SNOC:

- Initiate appropriate clinical care and repeat the observations as indicated by the neonate's clinical condition
- Consult promptly with the nurse / midwife in charge to assess whether a Neonatal PACE is required
- If PACE activation is required, activate a PACE call (refer above) and prepare to handover to the responder using ISBAR principles.

If a Neonatal PACE is required the clinician MUST immediately activate PACE:

- Dial the facility emergency number (**2222**)
- State Neonatal PACE Tier 1 ward and bed / room number, consultant (if allocated).

The PACE Responder will review as soon as possible but within 30 minutes.

If escalation is not required:

- Increase observation frequency as indicated by the neonate's condition.

NB: If the neonate's condition becomes immediately life threatening, deteriorates further or is not reviewed within 30 minutes or if deterioration is not reversed within one (1) hour the clinician MUST activate a Neonatal PACE Tier 2 call.

5.4 Neonate RED ZONE Criteria

If a neonate's observations are charted in the RED ZONE or meet ADDITIONAL RED ZONE CRITERIA you MUST immediately activate a Neonatal PACE Tier 2

- Dial the emergency number **(2222)**
- State Neonatal PACE Tier 2, ward and bed / room number, consultant (if allocated)
- Instigate treatment within scope of clinical practice.

Neonatal RED ZONE – Preferred Facility Escalation Term		
RHW	Post Natal ward	Neonatal PACE Tier 2
	Delivery Suite	Neonatal Code Blue
SGH	Post Natal ward	Neonatal PACE Tier 2
	Special Care Nursery	Neonatal PACE Tier 2
	Delivery suite / Birth Centre	Neonatal PACE Tier 2
TSH	Post Natal	Neonatal PACE Tier 2
	Special Care Nursery	Neonatal PACE Tier 2
	Birthing Suite	Neonatal PACE Tier 2
	Recovery	Neonatal PACE Tier 2
	Emergency	Code Blue Neonatal

The Tier 2 Responder will review within five (5) minutes.

NEONATAL CARDIAC ARREST / CODE BLUE
If a neonate's condition is IMMEDIATELY LIFE THREATENING or YOU ARE SERIOUSLY CONCERNED immediately activate a Neonatal CARDIAC ARREST / CODE BLUE

- Dial the emergency number **(2222)**
- State Neonatal Cardiac arrest / Code Blue ward and bed number
- Instigate treatment within scope of clinical practice including basic life support (BLS).

The Neonatal Cardiac Arrest / Code Blue team will review immediately.

5.5 REVIEWING to a Neonatal PACE Call

The neonatal / paediatric registrar must review **within five (5) minutes for all Neonatal PACE Tier 2 calls and immediately for Code Blue / Cardiac Arrest calls.**

The neonatal / paediatric registrar or locally agreed deputy must attend as soon as possible but **within 30 minutes for a Neonatal PACE tier 1**.

- The responder must conduct an urgent systematic review of the neonate's condition and commence appropriate management
- **If the neonate deteriorates further during the review or if the neonate's condition becomes immediately life threatening escalate to a Neonatal Code Blue / Cardiac Arrest call by dialling the facility emergency number (2222)**
- The Registrar is responsible for informing the AMO of all Neonatal PACE calls and Neonatal Code Blue / Cardiac Arrest calls as soon as possible
- The next of kin should be notified if the neonate has a Neonatal PACE or Code Blue / Cardiac Arrest activation as soon as possible.

NEONATE ESCALATION BEYOND FACILTIY AND TRANSFER PROCESSES FOR LEVEL 3 AND 4 UNITS

For all neonatal patients who are clinically unstable, deteriorating or for whom there is a high level of clinical concern medical or nursing staff must urgently contact the clinical support or on-call paediatrician to discuss the patient's ongoing care.

This escalation to the consultant is necessary to:

- Review stabilisation+/- resuscitation requirements for the patient
- Have a telephone consultation with RHW consultant neonatologist
- Assess the requirement for NETS transfer to tertiary neonatal service.

6. ALTERING CALLING CRITERIA

RED ZONE calling criteria are late signs of deterioration. Any alterations to calling criteria section should be undertaken with great caution and only in consultation with the AMO.

Calling criteria are altered by completing the Alteration to Calling Criteria, located on the front page of the SNOC. Alterations to calling criteria must be formally reviewed by the AMO within 24 hours. The review due date / time must be documented and signed on the front page of the SNOC.

Any alteration to calling criteria must have a clinical rationale documented in the medical record.

At all times staff should use their clinical judgment and re-evaluate the criteria alteration order and/or escalate care if there is a change in the patient's clinical condition.

7. MONITORING AND INCREASING FREQUENCY OF OBSERVATIONS

7.1 **The Nurse / Midwife** is accountable for the safety of the neonate under his/her care. This includes monitoring the neonate's vital signs in accordance with their clinical condition and treatment.

Core Vital Signs: for a neonate include: respiratory rate, respiratory distress assessment, heart rate, level of consciousness, skin colour and temperature.

- All neonates should have core vital signs recorded on the SNOC at birth
- Oxygen saturation measurement should be recorded between four (4) and 24 hours of age and prior to discharge as a routine screen for cardiac anomalies.

7.2 **Frequency of Observations** for Neonates with perinatal risk factors should be attended and recorded according to local guidelines or per the frequency charted on the front page of the SNOC.

Local Clinical Business Rules / LOPs will dictate the need and frequency of additional observation recordings. Additional recordings include but are not limited to; blood pressure, oxygen saturation, blood glucose levels and pain score.

7.3 Increasing Frequency of Observations will be dependent upon:

- Mothers Diagnosis
- Neonates Diagnosis
- Clinical Condition, treatment and deterioration
- Vital signs change or trend away from normal limits
- Vital signs are charted in the BLUE, YELLOW or RED zone of the SNOC or meet ADDITIONAL YELLOW or RED ZONE criteria
- Following a general anaesthetic or conscious sedation of the mother prior to birth.

NB: This list is not exhaustive. Nurses / midwives should use their own clinical judgement if concerned.

Clinical Situation	Frequency	Action
If vital signs change and are in the BLUE Zone	Repeat vital signs	• Monitor and reassess.
YELLOW Zone criteria or ADDITIONAL YELLOW Zone criteria	Repeat vital signs within 30 minutes and continue to monitor	• Assess with nursing / midwifery team leader and determine whether a Neonatal PACE Tier 1 call is required • Initiate clinical management within scope of practice.
RED Zone Criteria or ADDITIONAL RED Zone criteria	Immediately repeat vital signs and continue to monitor	• Activate a Neonatal PACE Tier 2 call • Inform nursing / midwifery team leader.

8. ACCURACY OF VITAL SIGNS MEASUREMENT

The reliability of the vital sign is dependent on proper technique and well maintained equipment.

- **Respiratory Rate:** should be assessed for at least 60 seconds
- **Oxygen Saturation:** the probe should be placed optimally on a limb which is warm and well perfused
- **Heart Rate:** should be measured via listening to apex beat. The heart rate should be counted for at least 15 seconds and if irregular over a full minute
- **Blood Pressure:** should be measured when clinical condition warrants or as per protocol
- **Palpate Femoral Pulses:** if cardiac abnormalities, sepsis or bleeds are suspected

- **Pain Score:** pain score assessment will be used as per local procedures and in the unit specified in the local procedure
- **Neurological Assessment:** A neonate who is irritable, hypotonic / floppy or flaccid should be escalated for a clinical review. (SNOC refers to alert, voice, pain, unresponsive (AVPU) and not the numerical Glasgow Coma Scale (GCS) which is referred to in the escalation boxes. Neither assessment scales are appropriate to judge in the neonatal period).

9. DOCUMENTATION

- NSW Standard Newborn Observation Chart
- Newborn Resuscitation chart
- PACE Label / Sticker only for units using paper based documentation
- PACE / BTF Notification Form.

10. EDUCATION RESOURCES

- Monitoring Paediatric Vital Signs Powerpoint

11. AUDIT

District and Facility Clinical Emergency Response Systems (CERS) Committees will:

- Monitor and review key performance indicators, incidents involving the deteriorating neonate and system management issues
- Data will be collected on every PACE and code blue / cardiac activation
- The results of data analysis should be reported to clinical units, facilities and District quality committees
- Monthly audits include identification of system failures (i.e. system failures in relation to Neonatal Code Blue / Cardiac Arrest team activations)
- Observation chart audit.

12. REFERENCES

- Australian Commission on Safety & Quality in Health Care (2011); A guide to support implementation of the National Consensus Statement: Essential elements for recognising and responding to clinical deterioration. Sydney, ACSQHC.
- Harrison, G., Jacques, T., McLaws, M., & Kilborn, G. (2006). Signs of Critical Conditions and Emergency Responses (SOCCER): A Model for Predicting Adverse Events in the Inpatient Setting. . *Resuscitation 69*, 175-183.
- Harrison, G., Jacques, T., Kilborn, G., & McLaws, M. (2005). The Prevalence of Recordings of Signs of Critical Conditions and Emergency Responses in Hospital Wards - the SOCCER Study. *Resuscitation 65*, 149-157.
- Harrison, G., Jacques, T., McLaws, M., & Kilborn, G. (2006). Combinations of Early Signs of Critical Illness Predict In-Hospital Death - the SOCCER Study (Signs of Critical Conditions and Emergency Responses). *Resuscitation 71*, 327-334.
- Harrison, G., & Jacques, T. (2006). *Summary of GMCT Guidelines for in-Hospital Clinical Emergency Response Systems for Medical Emergencies*.
- RPAH PD 2010_04 Patient Observation (Vital Signs) Policy – Adult
- National Safety and Quality Health Service Standard No. 6 ‘Clinical Handover’

- National Safety and Quality Health Service Standard No. 9 'Recognising and Responding to Clinical Deterioration in Acute Health Care'
- SESLHD Procedure 'Clinical Handover: Implementation of ISBAR Framework and Key Standard Principles' SESLHDPR/303
- NSW Ministry of Health Policy Directive 'Recognition & Management of Patients who are Clinically Deteriorating' PD2013_049

15. REVISION AND APPROVAL

Date	Revision No.	Author and Approval
Jan 2014	0	Suzanne Schacht District PACE & Intensive Care Manager & District Women's and Children's Clinical Stream
Feb 2014	1	Felicity McLaren, RHW PACE CNC.
Mar 2014	2	Felicity McLaren, RHW PACE CNC.
Mar 2014	3	Dee Sinclair CMC Clinical Maternity Risk Management
Mar 2014	3.5	Revised and re-formatted by District Policy Officer.
Mar 2014	4	Dee Sinclair CMC Clinical Maternity Risk Management & Felicity McLaren, RHW PACE CNC.
April 2014	5	Dee Sinclair CMC Clinical Maternity Risk Management & Felicity McLaren, RHW PACE CNC. Felicity McLaren, RHW PACE CNC
April 2014	6	Dee Sinclair CMC Clinical Maternity Risk Management
April 2014	7	Dee Sinclair CMC Clinical Maternity Risk Management, Felicity McLaren, RHW PACE CNC. Pauline Best Nurse Educator Paediatrics.
May 2014	8	Dee Sinclair CMC Clinical Maternity Risk Management, Felicity McLaren, RHW PACE CNC. Pauline Best Nurse Educator Paediatrics.
May 2014	9	Dee Sinclair CMC Clinical Maternity Risk Management, Felicity McLaren, RHW PACE CNC. Pauline Best Nurse Educator Paediatrics.
May 2014	9.5	District Policy Officer amended 'Policy Statement' section, added references to the relevant National Safety and Quality Health Service Standards and re-formatted procedure.
Jun 2014	9.5	Submitted to CQC for approval.
Jun 2014	9.5	Approved by CQC.
May 2018	10	Draft for Comment
June 2018	10	Processed by Executive Services prior to submission to SESLHD Clinical and Quality Council – Major review.
July 2018	10	Endorsed by SESLHD Clinical and Quality Council