

Royal Hospital for Women (RHW)
NEONATAL BUSINESS RULE
COVER SHEET



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SUMMARY	To provide guidance on obstetric and neonatal interventions during imminent birth of infants born at perivable gestation.
Key Words	Perivable, extremely preterm, neonate, counselling, woman, family

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This Clinical Business Rule (CBR) is developed to guide safe clinical practice at the Royal Hospital for Women (RHW). Individual patient circumstances may mean that practice diverges from this Clinical Business Rule. Using this document outside RHW or its reproduction in whole or part, is subject to acknowledgement that it is the property of RHW and is valid and applicable for use at the time of publication. RHW is not responsible for consequences that may develop from the use of this document outside RHW.

Within this document we will use the term woman, this is not to exclude those who give birth and do not identify as female. It is crucial to use the preferred language and terminology as described and guided by each individual person when providing care.

1 BACKGROUND

Periviability is commonly referred to as borderline viability, grey zone or zone of parental discretion. Periviability is the stage of fetal maturity with a high risk of mortality and long-term morbidity. When birth is anticipated during this period, families and health care teams are faced with complex and ethically challenging decisions. There are many recent reports of improved survival of neonates born at 22-23 weeks gestation in institutions where active treatment is offered. However, gestational age alone should not be the arbitrary limiting factor.

There are many factors that influence neonatal outcomes. An individualised approach is necessary considering known fetal and maternal risk factors as well as parental values and beliefs regarding the best interest of their child. The periviable period is therefore better termed “zone of parental discretion”.

The intent of this CBR is to provide guidelines for staff caring for parents/families with imminent birth during the periviable period regarding decisions on declining or accepting interventions and the management around the time of birth.

2 RESPONSIBILITIES

2.1 Staff

- 2.1.1 Medical - To counsel and support parents, families and neonate(s)
- 2.1.2 Nursing/Midwifery - To support medical teams and parents/families in providing ethically appropriate, individualised and compassionate care

3 PROCEDURE

3.1 Clinical Practice

3.1.1 Birth prior to 22⁺⁰ weeks gestation

- **Imminent birth (neonate is expected to be born prior to 22⁺⁰ weeks):**
 - Do not recommend active neonatal targeted intrapartum interventions
 - Do not recommend neonatal resuscitation
 - Do not recommend maternal transfer to a tertiary maternity/NICU facility
 - Provide comfort care to neonate at the birth hospital

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- **Birth already occurred**
 - Do not recommend neonatal resuscitation
 - Do not transfer neonate to NICU
 - Provide comfort care to neonate and support to families
 - Provide consultation to parents/family obstetric team

3.1.2 Birth between 22⁺⁰ and 22⁺⁶ weeks gestation

- **Imminent birth (neonate is expected to be born between 22⁺⁰ and 22⁺⁶ weeks GA):**
 - Ensure a joint consultation involving obstetric and neonatal intensive care unit (NICU) teams to provide a unified clinical perspective (interdisciplinary review).
 - Provide comprehensive parental counselling with evidence-based information regarding survival rates and the risk of long-term neurodevelopmental disabilities, tailored to the specific clinical picture (e.g., estimated fetal weight, presence of infection, or lung maturity).
 - Engage in a shared decision-making transparent process with parents and family. The decision to pursue transfer/active resuscitation versus comfort care should be a consensus that respects parental values and the best interests of the neonate.
 - Provide the following if active management is decided:
 - Transfer woman to a tertiary perinatal facility if it is safe to do so
 - Antenatal corticosteroids starting from 21⁺⁵ weeks gestational age (GA)
 - Magnesium sulfate for neuroprotection prior to birth
 - Active neonatal resuscitation with delayed cord clamping
- **Birth already occurred at non-tertiary facility**
 - Coordinate interdisciplinary review coordinated by neonatal emergency transfer service (NETS). Ensure a joint consultation involving treating obstetric and neonatal/paediatric teams and NICU team and NETS to reach a unified clinical perspective.
 - Provide comprehensive parental counselling with evidence-based information regarding survival rates and the risk of long-term neurodevelopmental disabilities, tailored to the specific clinical picture (e.g. estimated fetal weight, presence of infection, or lung maturity).
 - Engage in a shared decision-making transparent process with parents and family. The decision to pursue active resuscitation versus comfort care should be a consensus that respects parental values and the best interests of the neonate.
 - Do not recommend neonatal resuscitation
 - Do not recommend neonatal transfer to a tertiary NICU. A neonate born at this gestation at a non-tertiary NICU carries very high chance of death and disability.
 - Provide comfort care to neonate and support to families

3.1.3 Birth between 23⁺⁰ and 23⁺⁶ weeks gestation

- **Imminent birth (neonate is expected to be born between 23⁺⁰ and 23⁺⁶ weeks GA):**
 - Ensure a joint consultation involving obstetric and NICU teams to provide a unified clinical perspective (interdisciplinary review)
 - Provide comprehensive parental counselling with evidence-based information regarding survival rates and the risk of long-term neurodevelopmental disabilities,

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tailored to the specific clinical picture (e.g. small for gestational age, presence of infection, and lung maturity)

- Engage in a shared decision-making transparent process with parents and family. The decision to pursue active resuscitation versus comfort care should be a consensus that respects parental values and the best interests of the neonate.
- Provide the following if active management is decided:
 - Transfer woman to a tertiary perinatal facility if it is safe to do so
 - Antenatal corticosteroids
 - Magnesium sulfate for neuroprotection prior to birth.
 - Active neonatal resuscitation with delayed cord clamping
- **Birth already occurred at non-tertiary facility**
 - Coordinate interdisciplinary review coordinated by NETS. Ensure a joint consultation involving treating obstetric and neonatal/paediatric teams, NICU team and NETS to reach a unified clinical perspective.
 - Provide comprehensive parental counselling with evidence-based information regarding survival rates and the risk of long-term neurodevelopmental disabilities, tailored to the specific clinical picture (e.g. estimated fetal weight, presence of infection, or lung maturity).
 - Engage in a shared decision-making transparent process with parents and family. The decision to pursue active resuscitation versus comfort care should be a consensus that respects parental values and the best interests of the neonate. No neonatal resuscitation is recommended.

3.1.4 Birth between 24⁺⁰ and 24⁺⁶ weeks gestation

- Provide parents/family with consultation:
 - obstetric medical team to counsel parents/family
 - NICU consultant in-charge and fellow to consult/counsel the family advising resuscitation is recommended given the overall survival (around 80%) along with significant reduction in risk of neurodevelopmental impairment and morbidities at this gestational age. This recommendation is however balanced by a clinical assessment of specific risk factors including fetal growth, infection, and lung maturity and guided by expressed wishes and goals of the parents to ensure a shared decision-making process.
- Recommend the following antenatal/intrapartum care:
 - antenatal corticosteroids
 - magnesium sulfate for neuroprotection
 - continuous electronic fetal monitoring in labour
 - discussion around mode of birth according to obstetric risk factors with thorough risk/benefit discussion by obstetric medical team
 - delayed cord clamping if safe to do so
- Encourage maternal transfer to tertiary NICU facility if feasible and woman/family willing to accept the risks of transport
- Provide active resuscitation and subsequent active intervention as per the NICU policy
- Provide consultation and advice if birth already occurred outside a tertiary centre:
 - NICU team/NETS/local treating team to discuss the case and assess the potential outcome for the neonate
 - Emphasise to parents that the outcomes for the neonate is poorer in comparison to planned birth in a tertiary facility. In this setting, clinicians to defer to the values

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and preferences of informed parents on transfer to tertiary care facility for continuation of active intensive care

3.2 Documentation

- eRIC

3.3 Education Notes

- Periviability refers to the stage of fetal development where a newborn baby can potentially survive outside the womb, typically between viability and nonviability.¹
- Periviability is also commonly referred to as borderline viability or zone of parental discretion.
- There are many recent reports of improved survival of infants born at 22-23 weeks gestation in institutions where active treatment is offered. Victoria, Western Australia, Queensland and South Australia published clinical guidance on decision making for births at 22⁺⁰ to 24⁺⁰ weeks gestation.⁶⁻⁹
- Safer Care Victoria published guidance on extreme prematurity in December 2020. The guidance provided parent information sheets to assist clinicians and families in decision making for births at 22-24 weeks gestation.⁸

Extreme prematurity outcomes of Inborn babies, Safer Care Victoria, Dec 2020				
Gestation	Hospital survival	No disability	Mild/moderate disability	Severe disability
22 weeks	20-40%	20%	40%	40%
23 weeks	60%	40%	30% mild; 20% moderate	<10%
24 weeks	70%	50%	20% mild; 10-20% moderate	<10%

- Since the publication of the Victorian guidelines in 2020, there have been more NICU admissions at 22-23 weeks in Victoria, and the data suggest improving hospital outcomes.¹⁰

Survival to discharge of infants admitted to NICU in Victoria, 2021-2024		
Gestation	Number of NICU admissions	Survival (%)
22 weeks	22	12/22 (54.5%)
23 weeks	98	67/98 (68.3%)

- Western Australia data indicate similar outcomes as Victoria.⁷
- When delivery is anticipated during this period, families and health care teams are faced with complex and ethically challenging decisions. The published guidelines from the Industrialised nations generally refer periviable gestation as 22⁺⁰ to 25⁺⁶ weeks gestation.^{1,2} There are many recent reports of improved survival of 22-23 weeks gestation in institutions where active treatment is offered.³⁻⁴
- Gestational age alone should not be the arbitrary limiting factor. There are many factors that influence infant outcomes. Individualised approach is necessary considering known fetal and maternal risk factors as well as parental values and beliefs regarding the best interest of their child.² Periviable period is therefore better termed “zone of parental discretion”.
- A number of institutions have developed local consensus guidelines based on their local practice and outcomes.⁵⁻⁹
- Antenatal counselling is a crucial component of periviable care and counselling. The primary goal of periviable antenatal counselling is to allow parents to make an informed

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decision regarding intervention.⁵ An individualised approach is recommended in decision-making for births at 22-24 weeks taking into account known fetal and maternal risk factors as well as parental beliefs regarding the best interest of their child. Key components to be taken into consideration include assessment of risks, communication of those risks and ongoing support.^{1,2,5-9}

3.4 Abbreviations

MFM	Maternal Fetal Medicine	NICU	Neonatal Intensive Care Unit
ANZNN	Australia New Zealand Neonatal Network	NETS	neonatal emergency transport service

3.5 Related Policies/Procedures

- NSW Health Guideline. Management of Threatened Preterm Labour GL2022_066
- [Magnesium Sulphate Prior to Preterm Birth for Fetal Neuroprotection - MoHGL2022_006](#)
- [Nifedipine for Tocolysis - MoHGL2022_006](#)
- [Transfers – In Utero Transfers at 23-25 Weeks Gestation - MoHGL2022-006](#)

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4 ABORIGINAL HEALTH IMPACT STATEMENT DOCUMENTATION

- Considerations for culturally safe and appropriate care provision have been made in the development of this Business Rule and will be accounted for in its implementation.
- When clinical risks are identified for an Aboriginal and/or Torres Strait Islander woman or family, they may require additional supports. This may include Aboriginal health professionals such as Aboriginal Liaison Officers, health workers or other culturally specific services

5 CULTURAL SUPPORT

- For a Culturally and Linguistically Diverse CALD woman, notify the nominated cross-cultural health worker during Monday to Friday business hours
- If the woman is from a non-English speaking background, call the interpreter service: NSW Ministry of Health Policy Directive PD2017 044-Interpreters Standard Procedures for Working with Health Care Interpreters.

6 NATIONAL STANDARDS

- Standard 1 Clinical Governance
- Standard 2 Partnering with Consumers
- Standard 5 Comprehensive Care
- Standard 8 Recognising and Responding to Acute Deterioration

7 REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
26.11.25	1	S Bolisetty (Medical Co- Director), W Hawke (Director of Obstetrics), A Shand (Director of Maternal-Fetal Medicine Unit), D Challis (Acting Medical Maternity Co-Director)
30.04.2026		Endorsed NCC CBR Committee
18.5.26	1	RHW BRGC

Appendix A – Zone of parental discretion

Zone of parental discretion			
<22 ⁺⁰ weeks	22 ⁺⁰ -22 ⁺⁶ weeks*	23 ⁺⁰ -23 ⁺⁶ weeks*	≥24 ⁺⁰ weeks
Comfort care. No life sustaining interventions	Comfort care recommended but parental views respected	Active management recommended but parental views respected	Active management is recommended unless significant adverse risk factors
*It is a shared decision making between the treating team and the parents. The strength of recommendation may vary depending on family goals and values, and individual risk factors for the baby such as estimated fetal weight <400g, no antenatal steroids and the availability of resources at the time and place of birth.			