Guidelines for review of congenital syphilis case
September 2019

The occurrence of a case of congenital syphilis is a sentinel event reflecting potential missed opportunities for prevention in the public health, antenatal and primary health care systems. Therefore it is important to review each case of congenital syphilis for the purpose of health system improvement and preventing future avoidable cases.

These guidelines were prepared by the WA Syphilis Outbreak Response Group’s Ante- and Post-natal Care Working Group, based on the investigation of a case of congenital syphilis in May 2019 and the feedback received from review participants.

Purpose
- to review the clinical and public health management of a congenital syphilis case
- identify areas for health service improvement
- identify need, if any, to update relevant clinical and public health guidelines
- raise awareness and educate health care staff about syphilis

Activation
The regional public health unit should activate the review process upon receipt of a notification of congenital syphilis. The review should be conducted within six weeks of notification of a confirmed or probable case of congenital syphilis to ensure that the event is still fresh in people’s memory.

Review participants

Review chairperson
This person should be familiar with the clinical and public health management of syphilis and the local context in which the case occurred but not have been involved in managing the case.

Review secretariat
This person should be appointed from one of the essential participants.

Essential participants
1. Primary health care providers involved in antenatal care of the case’s mother or who provide antenatal care in the mother’s usual place of residence.
2. Obstetric care providers involved in the mother’s management.
3. Paediatric care providers involved in the case’s management.
4. Clinical risk management and quality improvement staff in the health service/s responsible for the mother’s antenatal care and mother’s and baby’s care at time of delivery.
5. Public health unit staff involved in contact tracing/partner notification.
6. Heads of units/departments involved in any aspect of the case’s or the case’s mother’s clinical or public health management.
7. Communicable Disease Control Directorate staff involved in disease notification and classification for public health reporting purposes.
8. If the case or case’s mother is Aboriginal or from a culturally and linguistically diverse background, appropriate health practitioners and/or liaison offers.
9. Specialist obstetric, paediatric, midwifery, public health laboratory and other relevant experts not involved in public or clinical management of the case or case’s mother, as appropriate.
**Optional participants**
Observers from other health services, as appropriate, and with agreement of the chairperson and essential participants.

**Medical records**
Medical records for the case and case’s mother should be obtained and made available to review participants. The review chairperson and secretariat will need access to medical records at least 5 working days before the review to summarise the relevant parts of the case’s and the case’s mother’s medical records in a de-identified timeline for oral +/- visual presentation at the review. Other review participants should have access to de-identified copies of these records several days before the review.

**Suggested review agenda**

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<td>2</td>
<td>Welcome, introduce review participants and observers and outline role of participants and observers</td>
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| 4 | State purpose of the review  
  - to review the clinical and public health management of a congenital syphilis case  
  - identify areas for health service improvement  
  - identify need, if any, to update relevant clinical and public health guidelines  
  - raise awareness and educate health care staff about syphilis |
| 5 | Case presentation  
  - summary and timeline |
| 6 | Questions to be asked  
  1. When and at which health services did the mother receive antenatal care?  
  2. If in a declared outbreak region, was the mother offered, and did she have, syphilis testing at booking, 28 weeks, 36 weeks and at delivery and 6 weeks post-partum as recommended in the WA Silver book and National Pregnancy Care Guidelines? If in another region, was routine syphilis testing undertaken at intervals recommended by the local guidelines?  
  3. At what gestation was the mother diagnosed with syphilis and what was the time interval between diagnosis and treatment? (infectious syphilis should be treated as soon as possible and ideally within 2 days as recommended in the CDNA syphilis SoNG)  
  4. What was the time interval between the mother being treated for syphilis and the baby’s delivery? (considered adequate if at least 30 days)  
  5. Was contact tracing/partner notification undertaken in a timely manner? Were named contacts tested and treated for syphilis empirically at the time of presentation within 1 month of being named?  
  6. Following the syphilis diagnosis, was the mother’s ante- and post-natal care and follow-up in relation to repeat syphilis testing in accordance with the CDNA syphilis SoNG and/or local guidelines?  
  7. Has management of the baby been in accordance with current best practice guidelines for managing congenital syphilis? Aspects of management which should be discussed could include, but are not limited to, investigations, treatment and medical referral/transfer. |
8. Were the health service’s infection control guidelines followed during management of the case?
9. What aspects of the mother and baby’s care were managed well?
10. What aspects could be improved?
11. How could this case of congenital syphilis have been prevented?
12. What actions* need to be taken at the local, state and national levels to prevent future cases of congenital syphilis?
13. What actions* need to be taken at the local, state and national levels to ensure best practice management of any future cases of congenital syphilis?
14. Does this case need to be reported as a Severity Assessment Code 1 or 2 incident for further investigation?
15. Any other discussion points/recommendations

| Conclusions and agreed action plan* including documentation of who is responsible for each action and the timeframe for completing each action

* It may be useful to refer to Leveque and Sutherland’s integrated conceptual framework of levers for change in healthcare (see diagram and reference below) when developing an action plan for health service improvement.

**Documentation and confidentiality**
Patient identified information should NOT be recorded in the minutes.
Minutes of the review should be documented and circulated to participants for checking and correction before being finalised and sent to all participants, the Health Service Provider’s CEO, the Director of Communicable Disease Control and, where possible, the Chairperson of the Syphilis Response Group.

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**Integrated conceptual framework of levers for change in healthcare.**

Planned

- Supportive
- Coercive

Formative

- Normative

Mimetic

- Structural

Cognitive

- Competitive

Origin of change

Emergent

- Internal
- Source of motivation
- External

References

