Australian College
of Midwives

National Midwifery Guidelines for Consultation and Referral

Australian College of Midwives • 3rd Edition Issue 2

3rd Edition

Revised Edition: May 2013

Issue 2: December 2014

ISBN: 0-9751674-0-5

DISCLAIMER

These Guidelines provide information to assist midwives to integrate evidence with experience (clinical judgment) in providing midwifery care; and to assist midwives in their discussions with women regarding the suitability of different maternity care options. The Guidelines are not intended as a guide to the most appropriate place for birth.

The Guidelines are not designed to be prescriptive. They should not be interpreted and/or used as a substitute for an individual midwife's decision-making and judgment in situations where care has been negotiated within the context of informed decision-making by a woman.

These Guidelines are endorsed by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

Cover design & layout by Jacqueline Abela

Table of Contents

Foreword

It is with much pleasure that the College publishes Issue 2 of this 3rd Edition of the National Midwifery Guidelines for Consultation and Referral.

The guidelines are now used across the country by midwives and health services in the private and public sector, recognising their valuable role in safe maternity care. The first Edition was published in early 2004 in response to a need for midwives to have clearer advice about consultation and referral indications.

They are endorsed by many state and territory ministries of health and guide the care of thousands of women. We are very pleased that this Issue is endorsed by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists to demonstrate our commitment to respectful collaboration with our medical colleagues.

These guidelines have a long history and many people have contributed to their development over more than a decade. We hope this latest issue assists midwives across the country to provide high quality maternity care for all women and babies.

- Caroline Homer, President Australian College of Midwives

Acknowledgements

The Australian College of Midwives (ACM) thanks the organisations and individuals who have given their time and expertise to contribute to the development of this 3rd edition of the National Midwifery Guidelines for Consultation and Referral (Guidelines).

The release of this edition would not have been possible without the considered input provided by the Working Group and the Branches of the ACM. Members of the Working Group contributed as individual volunteers, not as representatives of their employers. The commitment and diligence of maternity consumers is highly regarded and appreciated.

This revision was funded by a small grant from the ACM in 2012 for a project midwife - Dr Donna Hartz, Research Fellow, University of Sydney and Royal Hospital for Women, Sydney. The ACM is particularly grateful to Professor Sally Tracy for her dedication and diligence in leading this review.

Steering Group	
Professor Hannah Dahlen	Professor of Midwifery, University of Western Sydney, Sydney NSW
Natasha Donnolley	Consumer member NSW
Professor Caroline Homer	Professor of Midwifery, University of Technology, Sydney NSW
Ann Kinnear	Executive Officer, ACM
Professor Sue Kruske	National President, ACM, Professor of Midwifery, Queensland Centre for Mothers and Babies, University of Queensland QLD
Professor Susan McDonald	Professor of Midwifery, La Trobe University and the Mercy Hospital for Women VIC
Professor Sally Tracy (Chair)	Professor of Midwifery, University of Sydney and Royal Hospital for Women NSW
Working Group	
Sonya Beutel	Midwife in Private Practice & Midwifery Lecturer, Griffith University QLD
Ann Catchlove	Consumer member VIC
Kym Davey	Midwife Leader, Royal Hospital for Women Melbourne VIC
Amanda Forti	Research Midwife, Mater Mother's Brisbane QLD
Associate Professor Pauline Glover	Associate Professor of Midwifery, Flinders University SA
Leonie Hewitt	Caseload Midwife, Ryde Midwifery Group Practice, Sydney NSW
Lyndall Mollart	CMC Antenatal Services, Central Coast Local Health District, Gosford NSW
Tamzin Mondy	Caseload Midwife, Gold Coast Hospital QLD

Kerry Peart	Coordinator Midwifery Group Practice, Barwon Health, Geelong VIC
Project Midwife	
Dr Donna Hartz	Post Doc Research Fellow, University of Sydney NSW
Contributors	
Professor Maralyn Foureur	Professor of Midwifery, University of Technology, Sydney NSW
Marie Heath	Eligible Midwife in Private Practice NSW/ACT
Bec Jenkinson	Consumer QLD
Michelle Meares	Consumer NSW
Amy Monk	Research midwife (EMU project) and caseload midwife, University of Sydney NSW
Kylie Sheffield	Consumer ACT
Bruce Teakle	Consumer QLD
Liz Wilkes	Eligible Midwife in Private Practice QLD
Medical Reviewers	
Associate Professor Andrew Bisits	Associate Professor and Director, Obstetrics, Royal Hospital for Women, Sydney NSW
Dr Sarah Clements	Consultant Obstetrician, Royal Hospital for Women, Randwick NSW
Professor Gus Dekker	Professor of Obstetrics and Gynaecology, University of Adelaide Clinical Director Women's and Children's Division Lyell McEwin Hospital SA

Dr Janet Hornbuckle	Specialist in Maternal Fetal Medicine, King Edward Memorial Hospital, Perth WA
Dr Paul Howat	Director of Women's Health, Cairns Base Hospital, Cairns QLD
Dr David Knight	Deputy Clinical Director, Obstetrics and Gynaecology, The Canberra Hospital, Canberra ACT
Associate Professor Michael C Nicholl	Associate Professor and Clinical Director Division Women's Children's & Family Health, NSRHS & Maternal Neonatal & Women's Health Network NSLHD / CCLHD, NSW
Professor Jeremy Oats	Chair Victorian Consultative Council on Obstetric and Paediatric Mortality and Morbidity Medical Co-Director Northern Territory Integrated Maternity Service Professorial Fellow, Melbourne School of Population and Global Health, University of Melbourne VIC
Dr Kirsten Small	Obstetrician and Gynaecologist, Nambour QLD
Associate Professor Anne Sneddon	Associate Professor and Clinical Director of Obstetrics and Gynaecology Gold Coast Hospital & Health Services QLD
Dr Mark Tracy	Director, Newborn Intensive Care, Westmead NSW
Professor Alec Welsh	Professor in Maternal Fetal Medicine, UNSW and Royal Hospital for Women , Sydney NSW

Issue 2 reviewers	
Professor Sue Kruske	President, ACM
Dr Donna Hartz	ACM
Professor Sally Tracy	ACM
Ann Kinnear	CEO, ACM
Professor Michael Permezel	President, RANZCOG
Associate Professor Steve Robson	Vice-President, RANZCOG
Dr Vijay Roach	Vice-President, RANZCOG
Professor Sue Walker	Councillor, RANZCOG

1

About these Guidelines

The Guidelines were first issued by the ACM in 2004. The Guidelines were based on similar guidelines in use in other OECD countries[1,2,3] and on a thorough review of contemporary evidence-based practice in maternity care.

When the ACM first published these Guidelines, there was very little guidance available for midwives and doctors who wanted an evidence-based framework for collaboration in the care of individual women.

Specifically, there was no single, nationally consistent and evidence-based tool to assist midwives to make decisions about when to discuss care and/or consult with other midwives or to refer a woman's care to a suitably qualified health practitioner.

This represented a significant barrier to the successful establishment of midwifery services, in which midwives are the primary care givers, offering women continuity of midwifery

---

[1] The Obstetric Working Group of the National Health Insurance Board of the Netherlands. (1998). Obstetrical Manual. Final Report of The Obstetric Working Group of the National Health Insurance Board of the Netherlands.

[2] New Zealand (NZ) Ministry of Health. (2002). Maternity Services. Notice Pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000.

[3] NZ Ministry of Health. (2012). Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines). Wellington: Ministry of Health.

care in collaboration with other healthcare providers. These Guidelines were first developed to address this gap and the revised editions continue to meet the same need.

The 2004 release of the Guidelines was well-received. The Guidelines are now in use in most maternity services across Australia. The adoption of this 3rd Edition of the Guidelines by all institutions and midwives who offer pregnant women midwifery care will help to ensure maternity services provide high quality, safe and collaborative care to women and their babies.

1.1 Who are these Guidelines for?

Midwives working throughout Australia, in all models of care, use these Guidelines to inform their clinical decision-making. The Guidelines are designed to be relevant in all midwifery practice situations.

This edition of the Guidelines reflects the scope of practice of all midwives practising in the Australian environment to offer pregnant women the highest standard of safe and collaborative maternity care.

In November 2010, the Commonwealth Government made some changes to the Medicare Benefits Schedule (MBS) and

Pharmaceutical Benefits Scheme (PBS), which introduced rebates for women who receive care from a 'Medicare eligible midwife'. This means that a midwife endorsed by the Nursing and Midwifery Board of Australia (NMBA) to prescribe scheduled medicines can prescribe medications on the PBS approved for prescription by a midwife and order diagnostic and screening tests. The NMBA provides a formulary[4] of medications that midwives endorsed to prescribe scheduled medicines are approved to prescribe with additional medications not on the PBS.

To recognise the scope of practice of the Medicare eligible midwife or midwives endorsed to prescribe scheduled medicines and ensure that these guidelines reflect this, a new A* level of consultation has been introduced.

For further detailed information on Medicare eligible midwives or midwives endorsed to prescribe scheduled medicines see www.midwives.org.au or www.nursingmidwiferyboard.gov.au

4 http://www.nursingmidwiferyboard.gov.au/documents/default.aspx?record=WD11%2F5857&dbid=AP&chksum=ZuEvRx%2FJc7mITLI0eAnzsQ%3D%3D

1.2 Evaluation and the policy context

The Guidelines were evaluated in a randomised, controlled trial of midwifery care at the Royal Hospital for Women, Sydney and the Mater Mother's Hospital, Brisbane[5] (in press). A paper published in 2012 outlined their value in collaborative models of maternity care.[6]

In the policy context, the Guidelines are consistent with the scope of practice of midwives practising in the Australian environment as referenced by the Australian Nursing and Midwifery Accreditation Council and the Nursing and Midwifery Board of Australia.[7,8]

The Australian Government's National Maternity Services Plan identifies the Guidelines in the Standards of Care initiative which

[5]A Randomised Controlled trial of Caseload midwifery care: the (M@NGO) trial (In press). Australian New Zealand Clinical Trials Registry N ACTRN12609000349246 http://www.anzctr.org.au/trial_view.aspx?ID=83469

[6]Beasley S, Ford N, Tracy SK, Welsh AW. (2012). Collaboration in Maternity Care is achievable and practical. *Australian and New Zealand Journal of Obstetrics and Gynaecology* DOI: 10.1111/ajo.12003

[7]Nursing and Midwifery Board of Australia. (2007). National framework for the development of decision-making tools for nursing and midwifery practice

[8]Nursing and Midwifery Board of Australia. (2008). Code of Professional Conduct for Midwives in Australia

is designed to improve maternity service provision and service delivery.[9]

The Guidelines complement the proposed National Maternity Services Capability Framework in the National Maternity Services Plan, and were endorsed in NSW;[10] QLD,[11] Victoria,[12] and South Australia,[13] and acknowledged in WA.[14] They are also referenced in the National Consensus Framework for Rural Maternity Services.[15]

[9]Commonwealth Branch Department of Health and Ageing. (2011). National Maternity Services Plan Commonwealth of Australia

[10] NSW Health. (2010). PD2010_022 Maternity – National Midwifery Guidelines for Consultation and Referral

[11] QLD Health. (2008). Clinical Governance for Midwifery Models of Care

[12] Department of Human Services. (2004). Rural birthing services: Planning Framework

[13] Women's and Children's Hospital South Australia. (2012). Midwifery Group Practice http://www.wch.sa.gov.au/services/az/divisions/wab/mid_gp/index.html

[14] WA Department of Health. (2012). State-wide Policy for publicly funded Home Births including guidance for consumers, health professionals and health services

[15]http://www.midwives.org.au/lib/pdf/documents/National%20Concensus%20Framework.pdf

1.3 About the review process

In the first edition of the Guidelines, the ACM committed to reviewing and updating the document regularly to ensure the Guidelines remain evidence-based, comprehensive and usable.

In 2012, the ACM established a Steering Group and appointed a Working Group to undertake this most recent review of the Guidelines. Comprising midwives and consumers, the Working Group met several times between December 2012 and March 2013 to review submissions and to reach consensus on changes to the Guidelines. The Group's aim was to ensure that the Guidelines are clear, reflect contemporary research evidence, and remain relevant to the provision of maternity care in Australia.

The Working Group considered submissions from a wide range of experts—including midwives, doctors, health service managers, regulators, employers and consumers.

In developing the 3rd edition of the Guidelines, the Working Group:

- Consulted with interested members of the ACM and consumers

- Considered the findings of a September 2012 survey of all maternity services across Australia
- Conducted a survey of midwives and doctors through the ACM, ACRRM,[16] RANZOG[17] and RACGP[18] (as members of the Joint Committee on Maternity Services) in January 2013
- Reviewed the research findings from an evaluation of the Guidelines under randomised, controlled trial conditions[19] and an observational study.[20]
- Considered the contributions and comments from the medical reviewers on the final draft of the 3rd edition.

In 2014, RANZCOG and ACM agreed additional/revised indications that are included in Issue 2.

The ACM Board of Directors has endorsed these Guidelines.

---

[16]Australian College of Remote and Rural Medicine

[17] Royal Australian and New Zealand College of Obstetricians and Gynaecologists

[18] Royal Australian College of General Practitioners

[19]A Randomised Controlled trial of Caseload midwifery care: the (M@NGO) trial (In press). Australian New Zealand Clinical Trials Registry NACTRN12609000349246 http://www.anzctr.org.au/trial_view.aspx?ID=83469

[20]Beasley S, Ford N, Tracy SK, Welsh AW. (2012). Collaboration in Maternity Care is achievable and practical. *Australian and New Zealand Journal of Obstetrics and Gynaecology* DOI: 10.1111/ajo.12003

2

DEFINITIONS

Within these Guidelines, certain terms have specific meanings.

Collaboration refers to all members of the health care team working in partnership with consumers and each other to provide the highest standard of, and access to, health care. Collaborative relationships depend on mutual respect. Successful collaboration depends on communication, consultation and joint decision-making within a risk management framework, to enable appropriate referral and to ensure effective, efficient and safe health care.[21]

Commencement of care refers to the first contact with a woman in the antenatal period may be when she attends primary care to confirm the pregnancy. Women will either start antenatal care at that point or be referred to a maternity care provider or service (e.g. the local hospital, midwife, obstetrician, GP or Aboriginal Health Service). Women intending to give birth in hospital will attend a booking visit. This may be their first visit at the hospital if they are receiving care through this service or later in pregnancy if they are receiving care through a private provider. The first antenatal visit should be longer than most

[21]Nursing and Midwifery Board of Australia. (2007). National framework for the development of decision-making tools for nursing and midwifery practice p18

later visits because of the large volume of information exchange needed in early pregnancy. [22]

Consultation is the seeking of professional advice from a qualified, competent source and making decisions about shared responsibilities for care provision. It is dependent on the existence of collaborative relationships, and open communication, with others in the multidisciplinary health care team.[23]

Referral is the transfer of primary health care responsibility to another qualified health service provider/health professional. However, the midwife referring the consumer for care by another professional or service may need to continue to provide their professional services collaboratively in this period.[24]

---

[22] Australian Health Ministers' Advisory Council. (2012). Clinical Practice Guidelines: Antenatal Care – Module 1. Australian Government Department of Health and Ageing, Canberra

[23]Nursing and Midwifery Board of Australia. (2007). National framework for the development of decision-making tools for nursing and midwifery practice p19

[24] Nursing and Midwifery Board of Australia. (2007). National framework for the development of decision-making tools for nursing and midwifery practice p22

Primary maternity care is where the responsibility for maternity care rests with the primary level maternity care provider (in this case, the midwife).[25] The safety and effectiveness of primary maternity care is underpinned by a collaborative services framework for care providers that ensures appropriate assessment, timely referral and access to secondary and/or tertiary services.[26]

Secondary maternity care is where the responsibility for maternity care rests with the medical practitioner (such as a general practitioner with an obstetric qualification, specialist obstetrician, or the medical staff on duty in the referral hospital) working in collaboration with a midwife or midwives who continue to provide midwifery care.

Tertiary maternity care is when responsibility for maternity care rests with a healthcare provider in a specialised maternity hospital. This provider usually works with a team which may include an obstetrician, neonatologist, midwife or other specialised services.

---

[25] National Health and Medical Research Council. (2010). National Guidance on Collaborative Maternity Care

[26] Australian Health Ministers' Advisory Council. (2008). Primary maternity services in Australia- a framework for implementation

3

INTRODUCTION

As primary carers, midwives hold responsibility for making decisions about whether a woman in their care may need medical attention during pregnancy, labour, birth or the postnatal period (6 weeks after the baby is born).

The aim of these Guidelines is to provide an evidence-based, structured, decision-making framework for midwives caring for women at the commencement of care, during the antenatal period; during labour and birth; and in the postnatal period.

The Guidelines are designed to facilitate consultation, referral and integration of care between midwives, medical practitioners and other health professionals, giving confidence to providers, women and their families.

3.1 Core assumptions for midwifery care

These Guidelines are based on a set of core assumptions for midwifery care that are informed by international standards and best practice in maternity care.

1. Pregnancy, birth and the postnatal period are normal physiological processes.

2. Maternity care must be based on an awareness and/or assessment of the physical, emotional, social, cultural and spiritual aspects of wellbeing for both the woman and her infant/s. This is aided by a comprehensive assessment at the commencement of care.

3. The achievement of collaboration and co-operation between the professional groups involved in maternity care is of major importance for optimal care[27.] This involves recognition of the particular expertise found within the various groups of healthcare providers.

4. The woman and the midwife work together during the whole maternity experience, building a relationship of mutual trust, sharing information to facilitate informed decision-making, and recognising the active role that each plays in the woman's maternity care.

[27]Optimal means the best possible processes of care and outcomes for women and their babies, given their individual set of circumstances. See: Cragin, L., Powell Kennedy, H. (2006). Linking obstetric and midwifery practice with optimal outcomes. *Nursing.* 35(6) 779-785

5. Where a woman has selected a midwife for her care, any referral to secondary or tertiary level maternity care is carried out by the midwife (primary level caregiver). The midwife should provide a referral letter explicitly stating the reasons for the referral.

6. Midwifery care may continue even when a secondary or tertiary level health care provider is necessary (that is, the midwife continues to provide midwifery care to the woman). Good communication between care providers is essential for safe and effective maternity care.

7. In an emergency, clinical responsibility is immediately transferred to the most appropriate practitioner available. The clinical roles and responsibilities of the attending practitioners are dictated by the needs of the mother and baby and the skills and ability of the practitioners available.

8. Following consultation or referral, it is expected that the midwife will receive return communication. However, it is the midwife's responsibility to request confirmation from the health practitioner of the ongoing care plan, including the agreed roles of the midwife and the health practitioner.

3.2 Guiding principles

3.2.1 Use of the Guidelines

1. As primary caregivers, midwives are responsible for their professional decision-making. These Guidelines are for the use of a midwife in making decisions.[28]
2. Midwives respect the conditions under which information about the woman and her infant(s) may or may not be shared with others[29]
3. If problems occur during pregnancy, birth or the postnatal period, the midwife may decide to consult with her peers in the first instance; or consult directly with a secondary or tertiary level health care provider and refer when appropriate.
4. The midwife discusses the care of a woman, consults or refers primary care responsibility in accordance with the Guidelines.

[28]Nursing and Midwifery Board of Australia. (2007). National framework for the development of d*ecision-making tools for nursing and midwifery practice*
[29]Nursing and Midwifery Board of Australia. (2008). Code of Ethics for Midwives in Australia

5. The level of consultation and/or referral that may be required will be influenced by the midwife's endorsement to prescribe scheduled medicines.
6. The secondary or tertiary level health care provider may assume ongoing clinical responsibility, and the role of the midwife will be agreed between the specialist, the midwife and the woman. This transfer of clinical responsibility will include a discussion about the timing of transfer back to the midwife once the condition(s) permit.
7. The severity of the woman's condition will influence these decisions.

3.2.2 Informed choice

1. Before commencement of care, the midwife should outline to the woman the scope and boundaries of midwifery care.[30,31] This will include an explanation of how these Guidelines work.

[30] Nursing and Midwifery Board of Australia.(2010). A midwife's guide to professional boundaries
[31] Nursing and Midwifery Board of Australia. (2010). National competency standards for the midwife

2. Midwifery care must be provided in accordance with the principle of informed choice. The midwife must provide the woman with sufficient information to inform the woman's consent to any procedure and must give the woman the opportunity to consider the advice being offered. The woman is free to accept or reject any procedure or advice.
3. When a woman exercises a choice that is contrary to professional advice or the Guidelines, the midwife should carefully document the woman's concerns and decision and the advice and information that the midwife provided. Refer to Appendices A and B and the ACM position statement about caring for women who make choices outside professional advice.

3.3 Structure of the Guidelines

To assist midwives to provide the best quality and most effective care possible, the Guidelines provide indicators to allow midwives to quickly identify situations requiring risk assessment and referral decisions.

The Guidelines are organised into four sections:

- Indications at commencement of care
- Indications developed or discovered during pregnancy
- Indications during labour and birth
- Indications during the postnatal period

Each section contains reference tables that list specific conditions or circumstances that a woman or her baby may present with. The tables provide a recommended response to the presentation, to assist the midwife in making a decision about appropriate care.

4

The Three Levels of Consultation and Referral

When a variance from normal is identified during a woman's care, it is recommended the midwife undertake one or more of three steps:

A or A*. Discuss the situation with a colleague (midwife), and/or with a medical practitioner, and/or another health care provider. A* is the category for midwives endorsed to prescribe scheduled medicines and order diagnostic and screening tests;

and/or

B. Consult with a medical practitioner or other health care provider; and/or

C. Refer a woman or her infant to a medical practitioner for Secondary or Tertiary care.

Where there are variations in the severity of a condition there may be more than one level recommended e.g. B/C; A/B/C.

4.1 A/A*: Discuss

4.1.1 It is the midwife's responsibility to initiate a discussion with (or provide information to) another midwife or health care provider, in order to plan and provide optimal care.

4.1.2 Following this discussion, the midwife may recommend to the woman (or a baby's parents) that consultation with another health care provider or medical practitioner take place because her pregnancy, labour, birth, postnatal period, or the baby may be affected by the condition or situation. Such a discussion does not transfer the responsibility for care. It is important that all parties are made aware of any recommended changes to care arrangements after the discussion.

4.1.3 Any exchange of information or advice must be clearly documented.

4.2 B: CONSULT

4.2.1 It is the midwife's responsibility to initiate a consultation and to clearly communicate to the medical practitioner or other health care provider that she and/or the woman is seeking a consultation.

4.2.2 A consultation can include:

- A 'face to face' assessment of the indication with the woman by the medical practitioner or other health care provider. This can also be done utilising telehealth technologies. This outcome should be clearly communicated to the midwife and the woman. Documentation should be in a concrete form. This may be the woman's hand held record, an electronic record, by letter or email documentation. The midwife should also be included in any other consultation documentation required (e.g. cardiology).
- The midwife seeking advice directly from the medical practitioner or other health care provider on behalf of the woman (only in circumstances where the woman herself cannot attend). This

consultation may occur in person, by telephone or using telehealth facilities. The midwife should document this request for advice as well as the advice she/he receives so that the matter can be discussed with the woman.

4.2.3 When a consultation occurs, the decision regarding ongoing clinical roles and responsibilities must involve a discussion between the medical practitioner or health care provider, the midwife and the woman. The woman may choose to consent to or decline the consultation. Seeking a consultation does not transfer responsibility for care. If the medical practitioner or health care provider recommends a change to the responsibility of care, this must be clearly communicated to the midwife and the woman involved.

4.2.4 The midwife or medical practitioner will not automatically assume responsibility for ongoing maternity care. Responsibility will depend on the clinical situation and the wishes and needs of the individual woman. After consultation with a

medical practitioner, it should be clearly established whether maternity care and responsibility:

a) Continues with the midwife (primary care), or

b) Is referred to the medical practitioner (secondary or tertiary care).

4.2.5 Areas of discussion and involvement must be agreed upon and clearly documented.

4.3 C: REFER

4.3.1 When maternity care is referred (either permanently or temporarily) from the midwife to a medical practitioner, that medical practitioner, in consultation with the woman and midwife, assumes all responsibility for maternity care (secondary or tertiary). The woman must provide informed consent prior to a transfer. The obstetrician (or other medical specialist) will assume ongoing clinical responsibility and the role of the midwife will be agreed between the specialist, the midwife and the woman. This will include a discussion about the appropriate timing

of a transfer of clinical responsibility back to the midwife when the condition(s) permit.

4.3.2 When maternity care is referred to a medical practitioner, the midwife may continue to provide midwifery care within the midwife's scope of practice, in collaboration with the medical practitioner.

4.3.3 Areas of discussion, responsibility and involvement should be agreed upon and clearly documented and communicated to the woman.

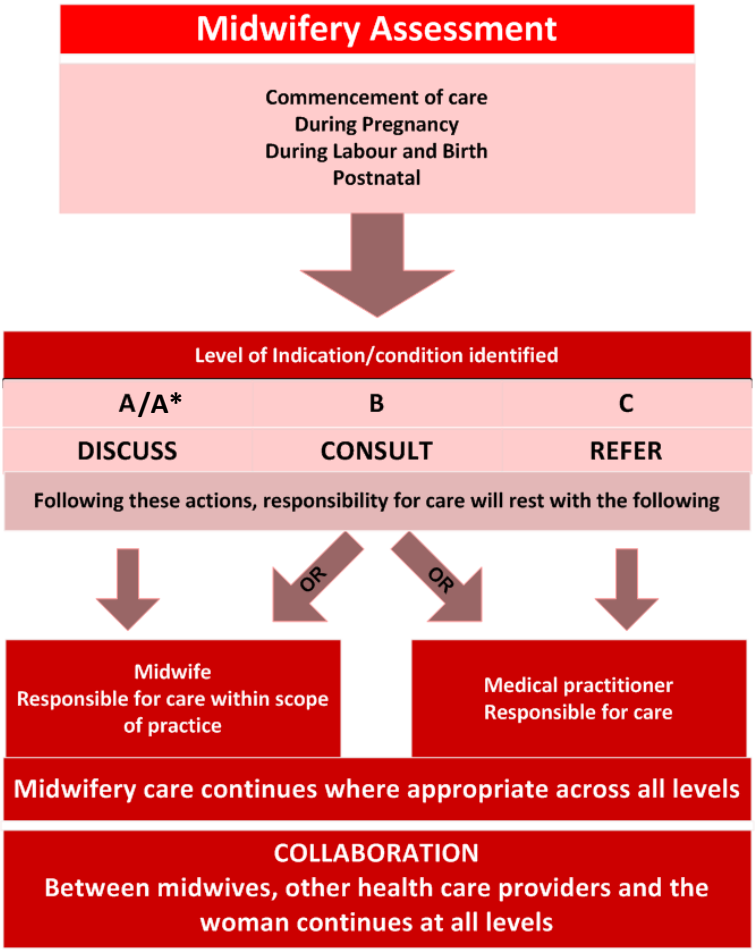
Regardless of the nature or level of discussion, consultation or referral, communication between providers about changes to management plans should include the woman involved, and should be clearly documented and communicated to all people involved.

Table 4.1 Summary of Codes used for the health care providers

Code	Description	Care provider with primary responsibility
A/A*	DISCUSS A discussion will be initiated with another health care provider to plan care.	Midwife and/or medical practitioner or other health care provider.
B	CONSULT Evaluation involving both primary and secondary care needs. The individual situation of the woman will be evaluated and agreements will be made about the responsibility for maternity care.	Midwife and/or medical practitioner or other health care provider
C	REFER This is a situation requiring medical care at a secondary or tertiary level for as long as the situation exists. The request for referral will be made in writing. Alterations in care will be communicated in writing to the midwife.	Medical practitioner (for secondary or tertiary care). Where appropriate the midwife continues to provide midwifery care.

5

How to use these Guidelines


Midwifery Assessment
Commencement of care
During Pregnancy
During Labour and Birth
Postnatal
Level of Indication/condition identified
A/A*
B
C
DISCUSS
CONSULT
REFER
Following these actions, responsibility for care will rest with the following
OR
OR
Midwife
Responsible for care within scope of practice
Medical practitioner
Responsible for care
Midwifery care continues where appropriate across all levels
COLLABORATION
Between midwives, other health care providers and the woman continues at all levels

6

Indications at Commencement of Care

The following are specific indications for discussion, consultation and/or referral of care when discussing a woman's needs during a first visit at the commencement of care.

[For an explanation of the codes A 'Discussion', B 'Consultation' and C 'Referral of Care' see Part 4 of these Guidelines.]

6.1 Medical conditions

6.1.1	**Anaesthetic difficulties**	
	Malignant hyperthermia or neuromuscular disease or family history	**C**
	Previous failure or complication (e.g. difficult intubation, failed epidural)	**B**
6.1.2	**Connective tissue autoimmune disease**	
	Periarteritis nodosa	**C**
	Scleroderma, rheumatoid arthritis, Sjörgen's syndrome	**C**
	SLE • Active OR major organ involvement OR hypertension OR on medication OR positive Ro/La OR coexisting anti-phospholipid syndrome OR ITP	**C**

	• Inactive, no renal involvement, no hypertension, or only skin/joint problems	**B**
	Other autoimmune disease	**B**
6.1.3	**Body Mass Index**	
	BMI <18 and >35	**B**
	BMI >40	**C**
6.1.4	**Cardiovascular disease**	
	Arrhythmia/palpitations; murmurs: recurrent, persistent or associated with other symptoms	**C**
	Cardiac valve disease	
	Cardiac valve replacement	
	Cardiomyopathy	
	Congenital cardiac disease	
	Hypertension	
	Ischaemic heart disease	
	Pulmonary hypertension	
	Other cardiac disease	**B**
6.1.5	**Drug dependence or misuse**	
	Use of alcohol and other drugs	**B**

	Medicine use the effect of drugs on the pregnant woman and the unborn child, lactation and/or neonate. Information is available from Mothersafe: 1800 647 848	**B**
6.1.6	**Endocrine**	
	Addison's Disease, Cushing's Disease or other endocrine disorder requiring treatment	**C**
	Diabetes mellitus	
	• Gestational diabetes in previous pregnancy (recommend early GTT)	**A**
	• Pre-existing Type I and Type II diabetes	**C**
	Hypothyroidism	
	• stable treated hypothyroidism	**B**
	• new diagnosis	**B**
	Hyperthyroidism	**B**
	Other Thyroid disease	**B**
6.1.7	**Gastro-intestinal**	
	Hepatitis B with positive serology (HBsAg+)	**C**
	Hepatitis C	**B**
	Inflammatory Bowel Disease This includes ulcerative colitis and Crohn's disease.	**B**
	Other GIT disease	**B**

6.1.8	**Genetic – any condition**	**B**
6.1.9	**Haematological**	
	Anaemia at commencement of care irrespective of how treated or whether it responds to treatment: Anaemia defined as Hb < 90g/L	**B**
	Coagulation disorders	**C**
	Women declining blood products **Note:** midwives should use Appendix B if women decline referral	**C**
	Haemoglobinopathies	**B/C**
	Haemolytic anaemia	**C**
	Other antibodies detected	**B/C**
	Rhesus antibodies	**C**
	Rhesus Negative requiring Anti D	**A*/B**
	Thalassaemia	**C**
	Thrombocytopenia <150 (x10^9/L)	**C**
	Thrombo-embolic process of importance is the underlying pathology and the presence of a positive family medical history	**C**
	Thrombophilia • Anti-phospholipid antibodies and hereditary thrombophilia other than MTHFR mutation (heterozygous)	**C**

	• MTHFR mutation (heterozygous) • No previous obstetric complications or maternal thrombosis • On warfarin, previous obstetric complications or maternal thrombosis	**B** **C** **C**
6.1.10	**Infectious diseases**	
	Cytomegalovirus	**C**
	Chlamydia	**A*/B**
	Previous GBS positive neonate	**B**
	Genital Herpes • Primary infection • Recurrent infection	 **B** **A*/B**
	Gonorrhoea	**B**
	History of pre pregnancy Cytomegalovirus, Rubella, Parvovirus, Toxoplasmosis, Varicella	**A**
	Human Papilloma Virus (HPV)	**A/B**
	HIV-infection	**C**
	Listeriosis	**B**
	Parasitic infection	**A/B**
	Parvo virus infection	**C**
	Rubella	**C**

	Syphilis	
	• Positive serology and treated	**C**
	• Positive serology and not yet treated	**C**
	Trichomoniasis	**A*/B**
	Toxoplasmosis	**C**
	Tuberculosis	
	• Active	**C**
	• Past History & Treated	**B/C**
	Varicella/Zoster virus infection	**C**
	Other infection with which no familiarity	**B**
6.1.11	**Maternal Age (under 16 and older than 40 years)**	**B**
6.1.12	**Neurological**	
	AV malformations	**C**
	Bells Palsy	**A**
	Epilepsy with medication or seizure in the last 12 months	**B/C**

	Epilepsy without medication or in the past without treatment and no seizures in the last 12 months	**B**
	Multiple sclerosis	**B**
	Muscular dystrophy or Myotonic Dystrophy	**C**
	Myasthenia gravis	**C**
	Spinal cord lesion (paraplegia or quadriplegia)	**C**
	Subarachnoid haemorrhage, aneurysms	**C**
	Other neurological conditions	**B**
6.1.13	**Organ Transplants**	**C**
6.1.14	**Perinatal Mental Health Problems – History of**	
	Care during pregnancy and birth will depend on the severity and extent of the mental health status.	
	EPDS >12	**B**
	EPDS - positive response to Q10 self harm	**B**
	Psychiatric condition requiring medication	**B**
	Puerperal Psychosis	**C**
6.1.15	**Renal function disorders**	
	Disorder in renal function, with or without dialysis	**C**
	Glomerulonephritis	**C**

	Pyelitis	**B**
	Previous kidney surgery with potential to impair kidney function during pregnancy i.e. removal of a kidney etc	**C**
	Urinary Tract Infection/s	
	• Current	**A/B**
	• Past history of recurrent	**A/B**
	Other Renal	**B**
6.1.16	**Respiratory Disease**	
	Asthma Mild	**B**
	Asthma Moderate (i.e. oral steroids in the last year and maintenance therapy)	**B**
	H1N1 (Current)	**C**
	Severe lung function disorder	**C**
	Sarcoidosis (can exacerbate during pregnancy)	**C**
6.1.17	**Skeletal Problems**	
	These include conditions that may cause severe pain during labour **History of developmental skeletal disorders**	**B**
	Osteogenesis Imperfecta	**B/C**
	Scheuermann's disease	**B/C**

	Scoliosis (with or without rods)	**B/C**
	Spondylolisthesis	**B/C**
6.1.18	**System/connective tissue diseases**	
	Marfan's syndrome, Raynaud's disease and other systemic and rare disorders (See also 6.1.2 & 6.1.9)	**C**
6.1.19	**Dermatological disease requiring systemic therapy**	**B**
6.1.20	**Malignancy** - Any history or current	**C**

6.2 Pre-existing gynaecological disorders

6.2.1	Cervical Abnormalities	
	Abnormal PAP smear results requiring follow-up during pregnancy	B
	Cervical amputation	C
	Cervical surgery including cone biopsy, laser excision or LLETZ biopsy	B
	Cervical surgery with subsequent term vaginal birth	A/B
	Cervical surgery without subsequent term vaginal birth	B
6.2.2	Female Genital Mutilation (FGM)	B
6.2.3	Fibroids	B
6.2.4	Infertility treatment	B
6.2.5	Intra Uterine Contraceptive Device (IUCD) in situ	B
6.2.6	Pelvic deformities (trauma, symphysis rupture, rachitis)	B
6.2.7	Pelvic floor reconstruction	
	Colpo- suspension following prolapse, fistula and/or previous rupture.	C
6.2.8	Uterine Abnormalities	
	Myomectomy /hysterotomy	C
	Bicornuate uterus/unicornuate uterus or other congenital reproductive tract anomaly (this includes vaginal septum)	C

6.3 Previous maternity history

6.3.1	**ABO-incompatibility**	**B**
6.3.2	**Active blood incompatibility** • Anti-Red Cell antibodies (including but not exclusively Rh, Kell, Duffy, Kidd) • Anti-Platelet antibodies (Neonatal alloimmune thrombocytopenia-NAIT)	**C**
6.3.3	**Autoimmune thrombocytopaenia**	**C**
6.3.4	**Classical Caesarean section operation**	**C**
6.3.5	**Cervical weakness** (and/or cervical suturing procedure)	**C**
6.3.6	**Cholestasis**	**B**
6.3.7	**Congenital and/or hereditary disorder of a previous child**	**B**
6.3.8	**Forceps or vacuum extraction**	**A/B**
6.3.9	**Grand multiparity** – defined as parity ≥5	**B**
6.3.10	**Hypertension**	
	Eclampsia/ Severe preeclampsia (including HELLP)	**C**
	Gestational Hypertension	**B**
	Pre-eclampsia	**B**
6.3.11	**IUGR < 10 percentile**	**B**
6.3.12	**Macrosomia > 4.5kg**	**B**

6.3.13	**Neonatal Asphyxia** (defined as an APGAR score of <7 at 5 minutes)	**B**
6.3.14	**Perinatal death**	**B**
6.3.15	**Placenta**	
	Abruption	**B**
	Accreta	**C**
	Manual Removal	**B**
6.3.16	**Postpartum depression**	**A/B/C**
6.3.17	**Postpartum haemorrhage >500 ml requiring additional treatment/transfusion**	**B/C**
6.3.18	**Pre-term birth (<37 weeks) in a previous pregnancy**	**B**
6.3.19	~~**Previous HELLP syndrome**~~ **Moved to 6.3.10**	
6.3.20	**Previous neonate GBS infection**	**B**
6.3.21	**Previous serious psychological disturbance**	**B**
6.3.22	**Recurrent miscarriage** (3 or more first trimester)	**B**
6.3.23	**Rhesus Isoimmunisation**	**C**
6.3.24	**Shoulder Dystocia**	**B**
6.3.25	**Symphysis pubis dysfunction**	**A**
6.3.26	**Termination of pregnancy (TOP): >3**	**B**

6.3.27	**Trophoblastic disease**: Hydatidiform mole or vesicular mole, within last 12 months	**C**
6.3.28	**Third or fourth degree perineal laceration**	
	Functional recovery	**B/C**
6.3.29	**Vulval/perineal haematoma requiring surgical treatment**	**A/B**
6.3.30	**Other significant obstetric event**	**A/B/ C**
6.3.31	**Pelvic floor dysfunction**	
	Dyspareunia Faecal incontinence Urinary incontinence Proplapse	**B/C**
6.3.32	**Previous mid-trimester loss**	**B/C**

6.4 Other indications

6.4.1	**Current or previous child protection concerns**	**B**

7

Indications Developed/ Discovered During Pregnancy

The following are specific indications identified during pregnancy for discussion, consultation and/or referral of care.

7.1 Clinical indications during pregnancy

7.1.1	**Adoption - intended**	**B**
7.1.2	**Cervical weakness** (Cervical dilation prior to 37 weeks and/or cervical-procedure)	**C**
7.1.3	**Cervix cytology abnormalities**	**B/C**
7.1.4	**Ectopic pregnancy**	**C**
7.1.5	**Endocrine**	
	Diabetes mellitus	
	• Gestational diabetes diet controlled	**B**
	• Gestational diabetes requiring insulin	**C**
	Thyroid disease	
	• Subclinical hypothyroidism	**B**
	• Hypothyroidism	**B**
	• Hyperthyroidism	**B**
	Addison's Disease, Cushing's Disease or other endocrine disorder requiring treatment	**C**
7.1.6	**Fetal anomaly**	**B/C**

7.1.7	Fetal death in utero	C
7.1.8	Fetal Size/date discrepancy:	
	Polyhydramnios/Oligohydramnios	B
	Small for dates or large for dates	
7.1.9	Fibroids	B
7.1.10	Gastro-intestinal and Hepatobiliary	
	Cholecystitis or Biliary Colic	B
	Cholestasis	B/C
	Hepatitis B or C positive serology (HBsAg+)	B
	Acute Hepatitis (any cause) or jaundice	B
	Inflammatory Bowel Disease including ulcerative colitis and Crohn's disease	B
	Other Acute Gastrointestinal or Hepatobiliary presentation	B
7.1.11	Haematological	
	Anaemia Hb < 90 g/l	B
	Blood group incompatibility	C
	Coagulation disorders	B
	Mean corpuscular volume (MCV) < 80	B
	Rhesus negative requiring Anti D	A/B

	Thrombosis or Thrombophilia (other than MTHFR mutation)	**C**
	Thrombocytopenia < 150 x 10^9 /L	**C**
7.1.12	**Hernia Nuclei Pulposi (slipped disc)**	**B**
7.1.13	**High head at term**	**B**
7.1.14	**Hyperemesis Gravidarum**	**B**
7.1.15	**Hypertension**	**B/C**
	Any type with Proteinuria (≥2+ or >0.3g/24hrs)	**C**
	Chronic Hypertension is present in the preconception period or the first half of pregnancy. It may be essential where there is no apparent cause or secondary where the hypertension is associated with renal, renovascular, endocrine disorder or aortic coarctation. Diastolic pressure should be recorded as Point V Korotkoff (K5) (i.e. the point of disappearance of sounds)	**C**
	Eclampsia	**B**
	Gestational Hypertension: any hypertension after 20 weeks gestation	**C**

	Pre-eclampsia: BP of ≥140/90 and/or relative rise of > 30/15mmHg from BP at commencement of care	**C**
	and any of proteinuria > 0.3g/24 hours; or protein/creatinine ratio ≥ 30mg/mmol or 2+ protein on dipstick testing • Platelets < 150 x 10/9/l • Abnormal renal or liver function Imminent eclampsia	
7.1.16	**Infectious diseases**	
	Chlamydia	**A*/B**
	Cytomegalovirus	**C**
	Genital Herpes • Late in pregnancy – active lesions • Primary Infection • Recurrent (Consider antivirals to begin at 36 weeks)	 **C** **B/C** **A* /B**
	Gonorrhoea	**B**
	HIV-infection	**C**

	Human Papilloma Virus (HPV)	**A/B**
	Listeriosis	**B**
	Parvo virus infection	**C**
	Rubella	**B**
	Syphilis	**C**
	Toxoplasmosis	**B**
	Tuberculosis • Active • Past History & Treated	 **C** **B/C**
	Varicella /Zoster virus infection	**C**
7.1.17	**Malpresentation/non cephalic presentation at full term**	**C**
	Breech presentation (refer for ECV at 35 weeks)	**C**
7.1.18	**Multiple pregnancy**	**C**
7.1.19	**No prior prenatal care (at full term)**	**B**
7.1.20	**Perinatal mental health issues**	
	EDPS >12 OR positive response to Q10 self harm	**B/C**
	Mental health issue requiring medication	**B/C**
7.1.21	**Placental indications**	
	Placental abruption	**C**

	Placenta accreta	C
	Placenta praevia confirmed	
	Vasa Praevia	
7.1.22	**Post-term pregnancy** (≥ 42 completed weeks or 294 days)	**C**
	Post-dates pregnancy Gestational age ≥ 41 completed weeks or 287 days	**B**
7.1.23	**Preterm labour (threatened or actual) and birth**	**C**
7.1.24	**Preterm rupture of membranes**	**B/C**
7.1.25	**Reduced fetal movement in third trimester**	**B**
7.1.26	**Renal function disorders**	
	Haematuria or Proteinuria (≥ 2+)	**B**
	Urinary tract infections	**A/B**
	Pyelitis	**C**
7.1.27	**Respiratory Disease**	
7.1.28	**Asthma**	**A*/B**
7.1.29	**Surgery during pregnancy**	**C**
7.1.30	**Symphysis pubis dysfunction** (pelvic instability)	**A**
7.1.31	**Uncertain duration of pregnancy by amenorrhoea >20 weeks**	**B**

7.1.32	**Vaginal Blood loss**	
	Recurring loss prior to 12 weeks	**A/B**
	At or after 12 weeks	**B**
7.1.33	Potentially significant clinical presentations during pregnancy: e.g. Acute abdominal pain, palpitations, neurological symptoms, intractable headaches	B

7.2 Other indications during pregnancy

7.2.1	**Current or previous child protection concerns**	**B**

8

Indications During Labour and Birth

The following are specific indications for discussions, consultation and/or referral of care in response to conditions or abnormalities that are **identified during labour and birth**.

8.1 Clinical indications during labour and birth

8.1.1	**Breech presentation**	**C**
8.1.2	**Fetal death during labour**	**C**
8.1.3	**GBS positive**	**A**
8.1.4	**Genital Herpes active in late pregnancy or at onset of labour**	**C**
8.1.5	**Haemorrhage**	
	Intrapartum Haemorrhage	
	• Asymptomatic and/or <50 ml	**A**
	• Symptomatic and/or >50 ml	**C**
	Postpartum Haemorrhage	
	• Asymptomatic and/or <500 ml	**A**
	• Symptomatic and/or >500 ml	**C**
8.1.6	**Hypertension**	
	Eclampsia	**C**
	Gestational	

	Pre-eclampsia	
8.1.7	**Maternal Collapse/Shock**	**C**
8.1.8	**Meconium stained liquor**	**B**
8.1.9	**Multiple pregnancy**	**C**
8.1.10	**Non-vertex presentation**	**C**
8.1.11	**Pathological CTG**	**C**
8.1.12	**Placental abruption and/or praevia (suspected or confirmed)**	**C**
8.1.13	**Pre-labour preterm rupture of membranes (PPROM) before 37 weeks**	**C**
8.1.14	**Rupture of membranes**	
	Rupture of membranes at term (not in labour) > 24 hrs	**B**
	Rupture of membranes at term > 18 hrs	**A*/B**
8.1.15	**Preterm labour < 37 weeks**	**C**
8.1.16	**Prolapsed cord or cord presentation**	**C**

8.1.17	**Prolonged labour**	
	Active 1st stage of labour commences at 4cm dilatation	
	Prolonged Active 1st stage labour **Nulliparae**: ≤ 0.5cm /hr **Multiparae**: 1cm/hr Take into consideration descent & rotation of fetal head, and changes in strength, duration and frequency of contractions. Consider ease or difficulty of access and/or transfer to referral services, e.g. location.	**B/C**
	Prolonged 2nd stage labour **Nulliparae**: • ≥ 2 hours without descent **Multiparae:** • With an epidural: ≥ 2 hours including ≥1 hour of expulsive effort without descent • Without an epidural: ≥1 hour without descent Consider ease or difficulty of access and/or transfer to referral services, e.g. location.	**B/C**
8.1.18	**Regional Anaesthetic (epidural, spinal)**	**C**

8.1.19	**Retained placenta**	**C**
8.1.20	**Shoulder dystocia**	**C**
8.1.21	**Suspicious fetal heart rate pattern**	**B**
8.1.22	**Third or fourth degree perineal tear**	**C**
8.1.23	**Unengaged head in active labour in primipara**	**C**
8.1.24	**Uterine inversion**	**C**
8.1.25	**Uterine rupture**	**C**
8.1.26	**Vasa praevia**	**C**
8.1.27	**Vital signs** Persistent deviation from normal: tachycardia, decreased urine output, hypertension, hypotension Temperature 38 degrees or more on 2 consecutive readings at least an hour apart	**B/C** **C**
8.1.28	**Oxytocin Infusion for any indication**	**C**
8.1.29	**Hb < 9 g/l in labour**	**C**

9

Indications During the Postpartum Period

The following are specific indications for discussion, consultation and/or referral of care in response to conditions or abnormalities that are **identified in the mother or baby in the early weeks after the birth**.

9.1 Clinical indications: postpartum (maternal)

9.1.1	Persistent hypertension	C
9.1.2	Postpartum eclampsia	C
9.1.3	Postpartum Haemorrhage	
	Asymptomatic and/or < 500 ml	A
	Symptomatic and/or >500 ml	C
9.1.4	Serious psychological disturbance	B
9.1.5	Significant social isolation and lack of social support	B
9.1.6	Suspected maternal infection	A*/B
9.1.7	Temperature over 38°C on more than one occasion	B
9.1.8	Thrombophlebitis or thromboembolism	C
9.1.9	Uterine prolapse	C

Indications During the Postpartum Period

9.1.10	Acute urinary retention	B
9.1.11	Anorectal incontinence	C
9.1.12	Vulval or paravaginal haematoma	C

9.2 Clinical indications: postpartum (infant)

9.2.1	Abnormal cry	B
9.2.2	Abnormal findings on physical examination	B
9.2.3	Abnormal heart rate	B
9.2.4	Apgar less than 7 at 5 minutes	C
9.2.5	Birth injury/trauma requiring investigation	
	Excessive bruising, abrasions, unusual pigmentation and/or lesions	B/C
	Excessive moulding and cephalhaematoma	
9.2.6	Birth weight less than 2500 g	B
9.2.7	**Congenital abnormalities,** for example: cleft lip or palate, congenital dislocation of hip, ambiguous genitalia	C
9.2.8	Dehydration (clinical) suspected or observed	B

Indications During the Postpartum Period

9.2.9	**Failure to pass urine or meconium within 24 hours of birth**	**A/B**
9.2.10	**Failure to pass urine or meconium within 36 hours of birth**	**B**
9.2.11	**Failure to thrive**	
	Weight loss in the first week more than 10% of body weight	**B**
	Failure to regain birth weight in two weeks	**B**
9.2.12	**Feeding problems**	**A/B/C**
9.2.13	**Infection of umbilical stump site**	**B**
9.2.14	**Jaundice in first 24 hours**	**B**
9.2.15	**Jaundice after 24 hours** suspected pathological	**B**
9.2.16	**Major congenital anomaly**	**C**
9.2.17	**Persistent abnormal respiratory rate and/or pattern**	**B**
9.2.18	**Persistent cyanosis or pallor**	**B**
9.2.19	**Preterm< 37 weeks gestational age**	**B/C**
9.2.20	**Seizure activity, observed or suspected**	**C**
9.2.21	**Temperature instability**	**C**

Indications During the Postpartum Period

9.2.22	Temperature less than 36° C, unresponsive to therapy	B
9.2.23	Temperature more than 37.4° C, axillary, unresponsive to non-pharmacological therapy	C
9.2.24	Two vessels in umbilical cord	B
9.2.25	Vomiting: projectile, excessive, bloody, uncharacteristic for newborn	C

9.3 Other indications postpartum

9.3.1	Current or previous child protection concerns	B

10

CONTACT

The ACM will update and republish these Guidelines at appropriate intervals. You are welcome to send feedback and comments on these Guidelines to:

Post

Australian College of Midwives

PO Box 965

Civic Square ACT 2608

Australia

Email

ceo@midwives.org.au

11

BIBLIOGRAPHY

Albers LL, Sedler KD, Bedrick EJ, Teaf D, Peralta P. (2006).Factors related to genital tract trauma in normal spontaneous vaginal births, *Birth*. 33(2):94-100.

Australian Health Ministers' Advisory Council. (2012). *Clinical Practice Guidelines: Antenatal Care – Module 1*. Australian Government Department of Health and Ageing: Canberra, Australia. Available: http://www.health.gov.au/antenatal

Australasian Diabetes in Pregnancy Society. (2005). Position statement: The Australasian diabetes in pregnancy society consensus guidelines for the management of patients with of type 1 and type 2 diabetes in relation to pregnancy. Australasian Diabetes in Pregnancy Society: Sydney, Australia. Available: http://www.adips.org/downloads/adips_pregdm_guidelines.pdf

Beckmann MM, Garrett AJ. (2006). Antenatal perineal massage for reducing perineal trauma. *Cochrane Database of Systematic Reviews* 2006, Issue 1. Art. No.: CD005123. DOI: 10.1002/14651858.CD005123.pub2

Buckley S. (2007). *Gentle Birth, Gentle Mothering.* Available: http://www.sarahjbuckley.com

Catalano PM. (2007). Management of obesity in pregnancy, *ObstetGynecol*. 109(2 Pt 1): 419-33.

Chaillet N, Dumont A. (2007). Evidence-Based Strategies for Reducing Caesarean Section Rates: A Meta-Analysis, *Birth*. 34 (1): 53-64

Cox JL, Holden JM, Sagovsky R. (1987). *The Edinburgh Postnatal Depression Scale (EPDS).* Available: http://www.blackdoginstitute.org.au/docs/CliniciansdownloadableEdinburgh.pdf

Crowther CA, Harding JE. (2007). Repeat doses of prenatal corticosteroids for women at risk of pre-term birth for

preventing neonatal respiratory disease. *Cochrane Database of Systematic Reviews* 2007, Issue 2. CD003935-CD003935.

Dahlen HG, Homer CS, Cooke M, Upton AM, Nunn R, Brodrick B. (2007).Perineal outcomes and maternal comfort related to the application of perineal warm packs in the second stage of labour: a randomised controlled trial, *Birth*. 34(4): 282-90.

Gamble JA, Creedy DK, Moyle W, Webster J, McAllister M, Dickson P. (2007).Effectiveness of a counselling intervention after a traumatic childbirth: a randomized controlled trial, *Birth* 32(1): 11-19

Hodnett ED, Gates S, Hofmeyr GJ, Sakala C. (2007). Continuous support for women during childbirth, *Cochrane Database of Systematic Reviews*2007, Issue 2. Art. No.: CD003766. DOI: 10.1002/14651858.CD003766.pub2

Homer C, Brodie P, Leap N. (2008). *Midwifery Continuity of Care: A Practical Guide*. Elsevier: Sydney, Australia.

Kjærgaard H, Olsen J, Ottesen B, Nyberg P and Dykes AK Obstetric risk indicators for labour dystocia in nulliparous women: A multi-centre cohort study. BMC Pregnancy and Childbirth 2008, **8**:45

Kettle C, Hills RK, Ismail KMK. (2007). Continuous versus interrupted sutures for repair of episiotomy or second degree tears. *Cochrane Database of Systematic Reviews* 2007, Issue 3. Art. No.: CD000947. DOI:10.1002/14651858.CD000947.pub2

Lopez Bernal A. (2007). Overview. Pre-term labour, *BMC Pregnancy and Childbirth*. 7 (Suppl 1):S2

Luke B, Brown MB. (2007). Elevated risks of pregnancy complications and adverse outcomes with increasing maternal age, *HumReprod*. 22(5):1264-72

National Health and Medical Research Council (2010) *National Guidance on Collaborative Maternity Care*. Canberra: National Health and Medical Research Council

National Health and Medical Research Council (2012) Infant Feeding Guidelines. Canberra: National Health and Medical Research Council.

National Institute for Health and Clinical Excellence (NICE) 2007 National Collaborating Centre for Women's and Children's Health. *Quick Reference Guide, CG55 Intrapartum care of healthy women and their babies during childbirth*. NICE, London. Online: http://guidance.nice.org.uk/CG55/QuickRefGuide/pdf/English

National Institute of Clinical Excellence (NICE). (2008). *Antenatal care: Routine care for the healthy pregnant woman.* National Institute for Clinical Excellence: London, England. Available: http://guidance.nice.org.uk/CG62/Guidance/pdf/English

NICE. (2011). *Caesarean Section; NICE Clinical Guideline 132*. NICE: London, England. Available: http://guidance.nice.org.uk/CG132

NICE. (2012). *GC55 Intrapartum care: Care of healthy women and their babies during childbirth*. NICE: London, England. Available: http://www.nice.org.uk/guidance/CG55/NICEGuidance

Nursing and Midwifery Board of Australia. (2007). *A national framework for the development of decision-making tools for nursing and midwifery practice*. Available: http://www.nursingmidwiferyboard.gov.au

Nursing and Midwifery Board of Australia. (2008). Code of Ethics for Midwives in Australia Available: http://www.nursingmidwiferyboard.gov.au

Nursing and Midwifery Board of Australia. (2008). Code of Professional Conduct for Midwives in Australia Available: http://www.nursingmidwiferyboard.gov.au

Nursing and Midwifery Board of Australia. (2010). *National competency standards for the midwife*. Nursing and Midwifery

Board of Australia: Melbourne, Australia. Available: http://www.nursingmidwiferyboard.gov.au

Ovelese Y, Scorza WE, Mastrlia R, Smulian JC. (2007). Postpartum hemorrhage, *ObstetGynecolClin North Am.* 34(3):421-41,

Pairman S, Tracy SK, Thorogood C, Pincombe J. *Midwifery: Preparation for Practice, 2nd edition*. Elsevier: Sydney, Australia.

RANZCOG (2012). Maternal Suitability for Models of Care, and Indications for Referral Within (C-Obs 30). http://www.ranzcog.edu.au/college-statements-guidelines.html

RANZCOG July 2013a Management of Hepatitis B in Pregnancy C-Obs 50 http://www.ranzcog.edu.au/college-statements-guidelines.html

RANZCOG July 2013b Management of Hepatitis c in Pregnancy C-Obs 51 http://www.ranzcog.edu.au/college-statements-guidelines.html

Reid SM, Middleton P, Cossich MC, Crowther CA, Bain E. Interventions for clinical and subclinical hypothyroidism pre-pregnancy and during pregnancy. *Cochrane Database of Systematic Reviews 2013, Issue 5.* Art. No.: CD007752. DOI: 10.1002/14651858.CD007752.pub3

Simhan HN, Caritis SN. (2007). Prevention of preterm delivery, *N Engl J Med*.7 (357):477-487.

Smith R. (2007). Parturition, *N Engl J Med* 356: 271-283.

Suebert DE, Huang WM, Wasserman-Hoff R. (2007). Medical legal issues in the prevention of prematurity, *ClinPerinatol*. 34(2):309-18.

Tracy SK, Sullivan ES, Tracy MB. (2007). Admission of term infants to neonatal intensive care: A population based study, *Birth*. 34(4):301-307.

Van Der Ham DP, Nijhuis JG, Mol BW, van Beek JJ, Opmeer BC et al. (2007).Induction of labour versus expectant management in women with preterm prelabour rupture of membranes between 34 and 37 weeks (the PPROMEXIL-trial), *BMC Pregnancy Childbirth*. 6(7):11.

Villar J, Carroli G, Zavaleta N, Donner A. (2007). Maternal and neonatal individual risks and benefits associated with caesarean delivery: multicentre prospective study, *BMJ*. 335(7628):1025.

World Health Organisation. (2013). *WHO BMI classification*. Available: http://apps.who.int/bmi/index.jsp?introPage=intro_3.html

Resources:

Australian Health Ministers' Advisory Council. (2012). *Clinical Practice Guidelines: Antenatal Care – Module 1*. Australian Government Department of Health and Ageing: Canberra, Australia. Available: http://www.health.gov.au/antenatal

Association for Improvement in Maternity Services (AIMS): http://www.aims.org.uk

Australian Commission on Safety and Quality in Health Care: www.safetyandquality.gov.au

Australian Nursing and Midwifery Accreditation Council: http://www.anmac.org.au/accreditation-standards

Beyond Blue: http://www.beyondblue.org.au

Black Dog Institute: http://www.blackdoginstitute.org.au

Breastfeeding: http://www.mothersdirect.com.au

Mothersafe: 1800 647 848 (Australia)

Midwives Information and Resource Service (MIDIRS): http://www.midirs.org

Nursing and Midwifery Board of Australia:
http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx

Royal College of Midwives Guidelines:
http://www.rcm.org.uk/college/policy-practice/evidence-based-guidelines

12

APPENDIX A: WHEN A WOMAN CHOOSES CARE OUTSIDE THE ACM NATIONAL MIDWIFERY GUIDELINES FOR CONSULTATION AND REFERRAL[32]

[32] This document was informed by the College of Midwives of Ontario 'When A Client Chooses Care Outside Midwifery Standards of Practice' January 1994, Revised September 22, 2004.

The ACM respects and supports a woman's legal right to make decisions regarding her care following a discussion of the risks and benefits of any aspect of care, including procedures.

This document can assist midwives to continue to provide midwifery care when a woman chooses a course of action against advice or outside the Guidelines. It should be read in conjunction with the ACM position statement about caring for women who make choices outside professional advice.

Background

The ethical and legal principles that underpin health care and health law both emphasise the importance of respecting the autonomy and rights of individuals to weigh risks and benefits according to their personal needs and values and make independent decisions.

A woman in the care of midwives may, at times, choose not to accept a care pathway as recommended in the Guidelines. It is also possible that a woman receiving midwifery care may either choose care that the midwife has determined is beyond her ability to safely manage within her scope of practice, or decline care that the midwife considers essential for the provision of safe care.

Midwives are responsible for:

- clearly describing the scope of their practice and any limitations
- providing advice and care that is consistent with the Guidelines

- providing information about the risks and benefits of any aspect of care being provided and any alternative approaches
- providing information that is sourced from evidence-based and/or peer-supported sources of evidence
- providing care that is consistent with the national professional standards for midwives.[33] [34] [35] [36]

In the first instance

When a woman chooses care outside the recommendations provided in the Guidelines, the midwife must attempt to discuss with the woman (and with any hospital staff through identified channels where applicable) the risks and benefits of the woman's decision. It is important to explore available options and possible resolutions, within midwifery professional standards, to address the woman's needs.

If this does not resolve the issues to the satisfaction of both the woman and midwife, the following approach is recommended.

[33]Nursing and Midwifery Board of Australia. (2010). National competency standards for the midwife

[34]Nursing and Midwifery Board of Australia. (2008). Code of Ethics for Midwives in Australia

[35]Nursing and Midwifery Board of Australia. (2008). Code of Professional Conduct for Midwives in Australia

[36]Nursing and Midwifery Board of Australia. (2007). National framework for the development of decision-making tools for nursing and midwifery practice

If the matter remains unresolved

If a midwife advises a woman that a certain course of action should be followed in order to comply with midwifery standards of practice, and the woman declines to follow that advice, the midwife should:

1. **Advise** the woman about the recommended guideline and the reasoning and evidence behind the guideline, ensuring that risks are neither understated nor overstated.
2. **Support** the woman to access relevant, high quality, unbiased evidence-based information.
3. **Consult** with:
    a. another midwife, and/or
    b. a medical practitioner.

Consultation should include discussion of the appropriate next steps if the woman continues to choose care outside the recommended guideline. It should also identify the safest and most ethical course of action given these circumstances, i.e. continuation of care (which may or may not be subject to mutually agreed conditions and/or restrictions) or the discontinuation of care.

The midwife may also recommend to the woman that she consult with other professionals to help inform her decision-making.

4. **Share the advice** of the consultation with the woman and ask the woman to share any advice she has received.

5. **Document** the advice, process and outcomes of the decision, and record relevant details. The ACM recommends using the 'record of understanding' provided in Appendix B.
6. **Provide** a reasonable amount of time for the woman to consider the information and advice given to her, before discussing and documenting the woman's informed decision.

If, after completing steps 1 to 6 above, a satisfactory resolution has still not been reached (for either the woman or the midwife) the midwife may decide whether to continue care (including care that is subject to any mutually agreed conditions and/or restrictions) or to discontinue care.

Continuing or discontinuing care when a woman chooses a course of action outside the guidelines

The decision to continue or discontinue care when a woman has chosen a course of action outside midwifery standards of practice is a serious one.

The midwife's decision must be informed by her:

- ethical judgment
- scope of practice
- the ability to justify her decision-making to a reasonable body of peers
- the midwife's support networks.

The midwife's own wellbeing should also be a consideration.

The impact on the woman should also be considered. Midwives should express clearly that, if the woman continues care with the midwife in any form, the midwife's continued care does not mean she or he endorses the woman's decision to choose a pathway of care that carries increased risk of harm to either the woman or her baby.

Similarly, the midwife must ensure the decision to discontinue care is not used coercively, but that it adequately conveys the gravity of the midwife's concern.

The midwife should notify his or her insurer, if appropriate, of any changes in circumstances.

If care continues

If the midwife decides to continue care, the midwife must:

a. Continue to inform the woman about changes in indications health and wellbeing for her and/or her baby(s).
b. Continue to make recommendations for safe care consistent with the Guidelines and any relevant broader evidence base.
c. Engage other caregivers who may have become involved in providing advice or care (e.g. obstetricians, general practitioners, hospital based midwives and/or other midwives).

d. Plan for the management of an emergency, including those that may be outside the midwife's scope of practice or competence.
e. Document all discussions and decisions.

If care is discontinued

If the midwife decides to discontinue care, the midwife must:

a. As soon as possible, clearly communicate his or her inability to continue to provide care to the woman, and the reasons why.
b. Follow this discussion with written advice to the woman confirming that midwifery care is being discontinued. A specific date should be given for the cessation of care. The date should give the woman a reasonable length of time to find another caregiver. A "reasonable" length of time will vary according to location and circumstance. If the woman is unable to arrange alternative care, the midwife should make a reasonable attempt to find a registered maternity care provider who is willing to see the woman and provide care.
c. Send a written referral (see Appendix C) to the registered maternity care provider identified in (b) above, confirming the date on which the midwife will discontinue midwifery care of the woman. In the event that no registered maternity care provider has been identified, seek the woman's consent to send a written referral to the nearest appropriate public maternity service.

d. Retain a copy of the correspondence stipulated in (b) and (c) above including proof of receipt. The midwife should also document in the woman's maternity care record the attempts the midwife has made to find an alternative registered maternity care provider.
e. Provide the woman with a copy of her maternity care record and the referral letter.

When an emergency or issues arise in labour

If issues arise during labour or in urgent circumstances, the midwife is obliged to attend the woman.

Where a woman has refused emergency transport or transfer of care during active labour, the midwife must remain in attendance as the primary care provider. He or she may be called upon to deal with an urgent situation, or one that is not within the midwife's standards, scope or abilities to perform.

In the case of responding to an emergency outside the midwife's scope of practice or competence, the midwife should:

1. If outside of the hospital setting:
    a. Call an ambulance to facilitate the most timely transfer of care should the woman decide to change her decision.
    b. With the woman's consent, notify the hospital receiving the transfer.
2. If in a hospital setting, inform the midwife in charge and/or call a medical practitioner.

3. Continue to inform the woman about any changes in indications of her or her baby's health and wellbeing.
4. Call the second midwife to attend. The second midwife should maintain his or her own contemporaneous notes documenting the care being provided, discussions and decisions.
5. Provide care to the best of his or her ability.
6. Access appropriate resources and/or personnel to provide any needed care.

Continue to document all care provided, as well as discussions and decisions (documentation should include the date and time along with the name and status of all persons involved).

13

APPENDIX B: RECORD OF UNDERSTANDING[37]

[37]This form will be updated from time to time. Fo r a copy of the most recent version of this form and the accompanying explanatory notes, go to www.midwives.org.au

It is recommended that this form is completed when a woman chooses care outside these Guidelines or against the advice of her midwife.

There are three parts in the Record of Understanding:

Between (woman)	
And (midwife)	
On (date)	
At (address)	

PART 1: Record of advice/discussions

To be completed by the woman	To be completed by primary midwife
What option(s) are you considering?	What is your advice in relation to the option(s)?
What, if any, information, evidence or concerns have you considered in exercising the option(s)?	What information or evidence have you provided to the woman to support her decision making in relation to the option(s)?
What questions/concerns do you have?	
What is your understanding of the answers you have	With whom have you discussed the woman's care?

<table>
<tr><td rowspan="4">received to your questions or concerns?</td><td colspan="4"></td></tr>
<tr><td></td><td>Name</td><td>Date</td><td>Method</td></tr>
<tr><td>Midwife</td><td></td><td></td><td></td></tr>
<tr><td>Medical Practitioner</td><td></td><td></td><td></td></tr>
<tr><td>Did you discuss your maternity care option(s) with your midwife and/or other care providers? Why/why not?

What is your understanding of those discussions?</td><td colspan="4">Summarise those discussions, including:
the safest and most ethical course under these circumstances
discussion of appropriate next steps if the woman continues to choose care outside the guideline</td></tr>
<tr><td>What questions do you have about your midwife’s recommendations to you?</td><td colspan="4">Following your discussions, what, if any, alternate care plan have you recommended to the woman?</td></tr>
<tr><td></td><td colspan="4">When was the woman advised of your recommendation?
___/___/____</td></tr>
<tr><td></td><td colspan="4">On what date have you agreed to further discuss the woman’s decision about your recommendation?
___/___/____</td></tr>
</table>

PART 2: Management Plan

This plan is to be completed where agreement on an alternate care plan has been reached.

Date ___/___/____

In this section, outline the agreement you have reached with the woman about her ongoing care. Specify each care provider's role.			
[Tick all that apply] ❍ Midwife lead carer Name:	❍ Medical Practitioner/s Name:	❍ Other (please specify) Name:	
Date	**Name**	**Signature**	**Role**
___/___/____			❍ Woman
___/___/____			❍ Midwife
___/___/____			❍ Medical practitioner
___/___/____			❍ Other [state type]

This management plan should be reviewed regularly or whenever there is a change of circumstances. The maternity care record should reflect all decisions relating to this plan.

PART 3: Declaration

This declaration is to be completed if no agreement has been reached on an alternative care plan (Complete EITHER 3.1 or 3.2).

3.1: DECLARATION FOR THE CONTINUATION OF CARE WHERE THE MIDWIFE HAS ELECTED TO CONTINUE CARE OR CONTINUE CARE SUBJECT TO CERTAIN CONDITIONS.

This declaration is to be completed by the woman and the midwife

As primary midwife, I have decided to continue to provide midwifery care.

❍ Reasons for decision to continue midwifery care
❍ Conditions/restrictions imposed on continued care
❍ Conditions upon which midwife may revisit the decision to continue care
Declaration by the woman: I, _____, have read and understood the contents of Parts 1, 2 and 3.1 in this Record of Understanding. I have had the opportunity to ask questions and discuss possible alternatives. I am satisfied that my questions have been answered. I acknowledge that my midwife has concerns that we have not been able to resolve and I agree to continued care by the midwife on the terms stipulated above. I understand that I am free to change my mind at any time and I will notify my midwife in that event at the earliest opportunity. _____ (Signed by woman) ___/___/___ _____ (Signed by midwife) ___/___/___

3.2: DECLARATION FOR DISCONTINUATION OF CARE WHERE THE MIDWIFE HAS ELECTED TO DISCONTINUE CARE.

This declaration is to be completed by the midwife where agreement on an alternative care plan has not been reached.

NOTE: In the course of labour or in urgent situations, the midwife is obliged to attend the woman[38].

As primary midwife, I have decided to discontinue providing midwifery care.

❍ Reasons for decision to discontinue providing midwifery care	
❍ I have completed the following steps:	
Date	Action
	Discussion with the woman informing her of discontinuation of care.
	Letter sent to the woman confirming discontinuation of care (attach copy and proof of receipt).
	Agreed date for woman to have alternative care arrangements in place.
	Sought consent from the woman to provide a referral letter to the nearest public maternity service (if applicable).

[38] The ACM has been guided by established legal principles and the ethical guidelines of other maternity care providers, namely the AMA and RANZCOG, for the purposes of ascertaining appropriate conduct between practitioner and client in the event of an emergency or onset of labour, even where a termination of relationship is imminent or being contemplated.

	Referral letter sent to public maternity service (if applicable).
	Woman provided with a copy of her maternity care record and letter of referral.
I have made the following reasonable efforts to find a registered maternity care provider who is willing to see the woman and provide care (if not applicable, insert N/A):	
Signed _____ (midwife) Dated: ___/___/___	

14

APPENDIX C: MAKING A REFERRAL

It is strongly recommended that midwives provide a referral letter either in the clinical record or separately by letter when making a referral. It is expected that healthcare providers in the secondary or tertiary services will communicate directly with the midwife in writing about their findings including the provision of information about any alternation in the plan of care. This is an accepted convention of communication across all levels of health care.

A referral letter should contain demographic details and all relevant clinical information that is appropriate, as well as the midwife's contact information. The midwife should indicate whether she/he will provide ongoing midwifery care.

SAMPLE referral letter

Date
Obstetric Clinic/Hospital Address

Dear Consultant

Re: Woman's name ("Jennifer Jones") DOB: __/__ /__ l ID #
Address/Phone number.

Thank you for seeing "Jennifer Jones" who is now coming up to ## weeks pregnant. She requires review because of her previous caesarean section. Her history is as follows:
Date: ## weeks. ## onset of labour, # hours duration, ## wt ###g boy
Date: ## 40 weeks. IOL for pre-eclampsia. Unsuccessful IOL after three days, caesarean section performed. 3575g boy.
Both of these pregnancies were assisted conceptions.
This time Jennifer spontaneously conceived and her due date is xx/xx/xx. She is keen to pursue VBAC for this birth, but was told at a consultation very early in this pregnancy that she should have elective LSCS at 38 weeks.

[Include any further relevant information.]

We look forward to discussing this with you at the clinic appointment. Jennifer's pregnancy has been straightforward this time, notably her blood pressure has remained stable and normal, and she has had no proteinuria or oedema. She is currently taking some iron to boost her stores. This baby is growing well and movements are reassuring.

I have included a copy of her blood and US scan results for you.

Kind regards

Midwife's signature
Midwife's name, Midwife's registration number
Contact details.[39]

[39] This sample letter is based on a similar example in
Pairman S, Tracy SK, Thorogood C, Pincombe J. (2010). Midwifery: Preparation for Practice. Adapted from Suzanne Miller chapter p 354

Australian College of Midwives

Midwifery Practice Review
For Midwives

Our vision is:

"To be the leading organisation shaping Australian maternity care, and to ensure the best possible maternity outcomes for all Australian women."

Contact us: 1300 360 480
Email: mpr@midwives.org.au
Visit our website at:
www.midwives.org.au

The Australian College of Midwives is the peak professional body for midwives in Australia.

MidPLUS

The Australian College of Midwives Continuing Professional Development Program

- For midwives by midwives
- Supporting ongoing learning
- Contemporary and flexible
- Enhancing professional confidence and competence

www.midwives.org.au