DISCLAIMER

These guidelines are intended to provide information enabling the midwife to integrate evidence with experience (clinical judgment) in providing midwifery care; and to assist midwives in their discussions with women. The guidelines are not designed to be prescriptive.

The Guidelines should in no way be interpreted and/or be 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 the individual woman.
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Appendix A:  When a Woman Chooses Care Outside these recommended Guidelines
Guidelines Development

Consultation

This is the second edition of the National Midwifery Guidelines for Consultation and Referral published by the Australian College of Midwives. The 2004 edition of these Guidelines has been revised and updated on behalf of the Australian College of Midwives by a multidisciplinary Expert Working Group.

The Guidelines were revised following national consultation with organisations and individuals from a wide range of stakeholder professions, organisations and consumers. In March 2007, interested parties across Australia were formally invited to submit comments and any recommendations for amendment, together with supporting evidence, regarding the 2004 edition of the Guidelines. Calls for submissions were also distributed in the ACM’s national news magazine, on the ACM’s website and in e-bulletins. Interested organisations were also invited to nominate a representative to participate in a Reference Group.

Submissions received were reviewed by a multidisciplinary Expert Working Group comprising midwives, medical practitioners, managers and consumers from across Australia. The Expert Working Group met in June 2007 to identify consensus changes to the Guidelines to ensure they continue to reflect contemporary research evidence, are clearly communicated, and remain relevant to the provision of maternity care in Australia. The revised draft of the Guidelines was ready for further consultation by December that year.

In April 2008, the revised version of the Guidelines was circulated to members of the Reference Group, comprised of representatives of organisations identified as having a stakeholder interest in the provision of maternity care by midwives. Members of the Reference Group did not meet as a group but were invited to submit initial comments or recommendations on the first edition of the revised Guidelines in April 2007 and then to review amendments made to the revised edition before re-publication in 2008. Unfortunately, some identified stakeholder organisations declined to be represented on the Reference Group.

The Expert Working group considered further feedback before finalising the document ready for re-publication, once approved by the ACM Board of Directors.
Acknowledgements

The Australian College of Midwives would like to thank all those individuals and organisations who have given their time and expertise in contributing to these Guidelines and their revision.

In particular, the College acknowledges and thanks Professor Sally Tracy, Chair of the Expert Working Group and all other members of the group, who gave generously of their time and expertise on a voluntary basis. These revised Guidelines would not have been possible without the serious and considered input provided by the Expert Working Group. Members of this group contributed as individual volunteers, not as representatives of their employers.

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Thanks also to Therese Lahoud for taking minutes.
1. Preamble

In early 2007, the Australian College of Midwives (ACM) commissioned
the revision of the National Midwifery Guidelines for Consultation and
Referral (the Guidelines). First published in 2004, the Guidelines have been
developed based on comparable guidelines in use in other OECD countries
1,2,3,4 as well as on a thorough review of current evidence based practice in
maternity care.

In the first edition of the Guidelines, the College made clear its commitment
to reviewing and updating them once they had been in widespread use to
ensure they were clear, comprehensive and usable. Regular revision ensures
that the Guidelines continue to reflect the latest available research evidence
on best practice.

After three years of widespread use by maternity services across Australia,
the first revision of these Guidelines commenced in 2007. The ACM
established a multidisciplinary Expert Working Group and called for
submissions from a wide range of experts—including midwives, doctors,
health service managers, regulators, employers and consumers—on the
evidence base, clarity and usefulness of the 2004 Guidelines. It also invited
numerous stakeholder organisations to contribute to a Reference Group to
review the recommendations of the Expert Working Group and ensure broad
input into its deliberations.

When the Australian College of Midwives first published these Guidelines,
it did so in an environment in which there was a lack of comprehensive
guidelines to provide an evidence-based framework for collaboration
between midwives and doctors in the care of individual women. In particular
there was no single, nationally consistent and evidence based tool to assist
midwives to make decisions about when to discuss care with other midwives,
and/or to consult with or transfer a woman’s care to a suitably qualified
doctor. This was identified as a barrier to the successful establishment of
midwifery services where midwives are primary care givers, offering women
continuity of care in collaboration with other healthcare providers. These
Guidelines were first developed to address this gap and the revised edition
continues to meet the same need.

However, the Guidelines are relevant not only to services and individuals
offering midwifery continuity of care. The Guidelines are intended to help
all maternity services to meet national policy priorities aimed at improving
the quality and safety of health care. When the Australian Council for Safety
and Quality in Health Care launched its National Action Plan in 2001, its then Chair, Professor Bruce Barraclough, argued that improving the safety and quality of patient care is one of the most important challenges facing health professionals: “…We must stop blaming individuals and put much greater effort into making our systems of care safer and better”.

In 2006, the Council became the Australian Commission on Safety and Quality in Health Care. One of its key priorities is to support the development of nationally agreed standards that promote safer, more effective and more responsive care for consumers.

These Guidelines are intended to address this imperative by providing evidence based, national guidelines for midwives that are responsive to the identified needs and wishes of individual women and their families. Since their publication in 2004, the Guidelines have been well received. They are now in use in most maternity services across Australia. The adoption of this 2nd 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.


2. Guidelines Aims

The aim of the National Midwifery Guidelines for Consultation and Referral is to provide individual midwives with an evidence informed national framework for consultation and referral of care between midwives, doctors and other health care providers in consultation with the woman receiving care.

The Guidelines have been organised in a structured framework to inform decision-making by midwives on the care and advice provided to women and appropriate consultation and referral:

• at booking
• during pregnancy and the antenatal period
• during labour and birth
• during the postnatal period
3. Introduction

The Australian College of Midwives National Midwifery Guidelines for Consultation and Referral (the Guidelines) have been developed to assist midwives responsible for providing care to a woman to decide when it is appropriate to discuss care of that woman with a medical or midwifery colleague, or to refer a woman for further care and/or advice.

The aim of the Guidelines is to promote a system of care based upon the principle of close mutual co-operation between primary, secondary or tertiary level maternity caregivers and the woman involved.

Primary maternity care is where the responsibility for maternity care rests with the primary level maternity care provider, in this case, the midwife.

Secondary maternity care is where the responsibility for maternity care rests with the medical practitioner such as a general practitioner, specialist obstetrician, or the medical staff on duty in the referral hospital.

Tertiary maternity care is when responsibility for maternity care rests with a team of providers in a specialised hospital. This may include an obstetrician, neonatologist, midwife or other specialised services.

Midwives, as primary carers, need to make decisions when a woman in their care may need medical attention during pregnancy, labour, birth or the post-natal period. These Guidelines have been developed to provide midwives with support in doing this in consultation with the woman to whom the midwife is providing care. It is the intention that the Guidelines be used to facilitate consultation and integration of care between midwives and doctors, thereby giving confidence to providers, women and their families.

---

1 The distinction between primary, secondary and tertiary level maternity caregivers should be seen as distinct from the levels of hospital grading currently under revision in Australia.
3.1 BASIC ASSUMPTIONS FOR MIDWIFERY CARE:

These Guidelines have been developed around the following set of core assumptions 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 awareness of physical, emotional, social and cultural aspects of wellbeing for both the woman and her infant(s).

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

4. The woman and the midwife work together during the whole maternity experience, building a relationship of trust with each other, sharing information and decision making and recognising the active role that both play in the woman’s maternity care.

5. Where a woman has selected a midwife for her care, the referral to secondary or tertiary level maternity care is carried out by the midwife (primary level caregiver), who is qualified for this task.

6. Midwifery care may continue even when referral to care by a secondary or tertiary level health care provider is necessary i.e. the midwife continues to provide midwifery care or support to the woman.

7. In order to ensure that selection and referral take place appropriately, the expertise of the secondary and/or tertiary level health care-providers must be accessible to the midwife by means of consultation and advice.

---


3.2 GUIDING PRINCIPLES:

**Use of the Guidelines:**

1. As a primary caregiver, the midwife is responsible for her professional decision-making. These Guidelines are for the use of the midwife in making decisions.

2. If problems occur during pregnancy or birth, the midwife may consult with her peers in the first instance; or consult directly with a secondary or tertiary level health care provider and refer when appropriate.

3. The midwife discusses care of a woman, consults, or refers primary care responsibility according to the Guidelines.

4. The secondary or tertiary level health care-provider may also refer the woman back to primary care by the midwife at any time if the condition that prompted referral is no longer a risk factor.

5. The severity of the condition will influence these decisions.

**Informed Choice**

1. At booking, the midwife should outline the scope and boundaries of midwifery care. This will include an explanation of these Guidelines with the woman.

2. Midwifery care must be provided within the principle of informed choice. The midwife must provide the woman with sufficient information to inform the woman’s consent to any procedure or advice. The woman has the right to give or refuse consent to any procedure or advice.

3. When a woman's choice is significantly at variance from professional advice or guidelines, the woman’s decision and the information provided by the midwife should be carefully documented. In these circumstances Appendix A: “When a woman chooses care outside the recommendations of the ACM Guidelines”\(^3\) provides guidance to the midwife, and a standardised consent form.\(^4\)

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\(^3\) College of Midwives of Ontario. *When A Client Chooses Care Outside Midwifery Standards of Practice* January 1994, Revised September 22, 2004

\(^4\) This Midwifery/Multi Disciplinary Care Plan was developed by the Government of South Australia and was considered by the Expert Working Group as a negotiation tool. The document demonstrates a three way sign off by the midwife, the women and other health provider if involved. The tool defines the terms of engagement and helps providers acknowledge that women have choice. This tool is a negotiated care pathway which gives fully informed participation in decision making to the woman.
3.3 STRUCTURE OF THESE GUIDELINES

To optimise the quality and efficiency of the care provided, the Guidelines provide indicators to identify situations where midwives carry out risk-assessment and referral decisions. For the convenience of the practitioner, the Guidelines are organised into four main sections:

• Indications At Booking
• Indications Developed or Discovered During Pregnancy
• Indications During Labour and Birth
• Indications During the Postnatal Period

Each section contains ready-reference tables listing specific conditions or circumstances that a woman or her baby may present with, and includes the recommended response by the midwife in making a decision about appropriate care.
4. The Three Levels of Consultation and Referral

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

A. Discuss the situation with a colleague - midwife, and/or with a medical colleague or other health care provider

B. Consult with a medical or other health care provider

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

4.1 DISCUSS

A: Discuss the situation with a colleague - midwife and/or with a medical colleague or other health care provider

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. The midwife may recommend to the woman (or parents in the case of the baby) that consultation with another health care provider or medical practitioner is warranted, given that her pregnancy, labour, birth or postnatal time (or the baby) may be affected by the condition or situation.

4.1.3. Areas of discussion and involvement must be agreed upon and clearly documented.
4.2 CONSULT

B: Consult with a medical or other health care provider.

4.2.1 A consultation refers to the situation where a midwife recommends the woman consult a medical practitioner, or where the woman requests another opinion of a health care provider.

4.2.3 It is the midwife’s responsibility to initiate a consultation and to clearly communicate to the health care provider that she is seeking a consultation.

4.2.4 The consultation involves addressing the variance from normal* e.g., a ‘face to face’ assessment, the prompt communication of the findings and recommendations to the woman and the health care provider to whom referral is made.

4.2.5 Where a consultation occurs, the decision regarding ongoing clinical roles/ responsibilities must involve a three-way discussion between the health care provider, the midwife and the woman concerned. This should include discussion about any need for, and timing of, medical practitioner review.

4.2.6 The midwife or health care provider will not automatically assume responsibility for ongoing care. This will depend on the clinical situation and the wishes and needs of the individual woman.

4.2.7 After consultation with a medical practitioner, it should be clear whether primary care and responsibility:
   a) continues with the midwife, or
   b) is transferred to the medical practitioner.

4.2.8 The midwife maintains overall responsibility for midwifery care within her scope of practice in collaboration with the medical practitioner and remains responsible for this discrete area of the woman’s care.

4.2.9 Where urgency, distance, or adverse circumstances make a ‘face to face’ consultation impossible between a woman and a health care provider the midwife should seek advice by phone. The midwife should document this request for advice in her records, and discuss with the woman the advice received.

4.2.10 Areas of discussion and involvement must be agreed upon and clearly documented.
4.3 REFER
C: Refer a woman or her infant to Secondary or Tertiary Care.

4.3.1. When primary care is referred, permanently or temporarily, from the midwife to a medical practitioner, that professional, in consultation with the woman and midwife, assumes full responsibility for subsequent decision-making.

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

4.3.3. Areas of discussion and involvement must be agreed upon and clearly documented.
A midwife is a person who, having been regularly admitted to a midwifery education programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.

The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife’s own responsibility and to provide care for the newborn and infant. This care includes preventive measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical or other appropriate assistance and the carrying out of emergency measures.

The midwife has an important task in health counseling and education, not only for the woman, but also within the family and community. This work should involve antenatal education and preparation for parenthood and may extend to women’s health, sexual or reproductive health and childcare.

A midwife may practice in any setting including the home, community, hospitals, clinics or health units.

Adopted 19th July 2005 ICM Congress, Brisbane, Australia.

Supersedes the ICM International Definition of the Midwife 1972 and its amendments of 1990.

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Table 4.1 Summary of Codes used for the health care providers

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Care provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Discuss</td>
<td>The responsibility for maternity care in the situation described is with the midwife.</td>
<td>Midwife 5</td>
</tr>
<tr>
<td>B Consult</td>
<td>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.</td>
<td>Medical/ Health care practitioner and/ or midwife depending on agreements</td>
</tr>
<tr>
<td>C Refer</td>
<td>This is a situation requiring medical care at a secondary or tertiary level for as long as the situation exists.</td>
<td>Medical practitioner (Where appropriate the midwife continues to provide midwifery care)</td>
</tr>
</tbody>
</table>

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5 A midwife is a person who, having been regularly admitted to a midwifery education programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.
5. How to use these Guidelines

Figure 1. A decision diagram for use by Midwives in daily practice

Booking
Uncomplicated history
| Complicated history
Care provided by midwife
| Consult Guidelines
| Decide A, B or C.

Pregnancy
Uncomplicated
| Complicated
| Consult Guidelines
| Decide A, B or C.
| Ongoing assessment
Care provided by midwife

Labour & birth
Uncomplicated
| Complicated
| Consult Guidelines
| Decide A, B or C.
| Ongoing assessment
Care provided by midwife

Postnatal time
Uncomplicated
| Complicated
| Consult Guidelines
| Decide A, B or C.
| Ongoing assessment
Care provided by midwife

A  Discuss with midwife/medical practitioner and care provided by midwife
B  Consultation with medical practitioner and care continues with midwife or is transferred to medical practitioner
C  Refer care to medical practitioner

When there is any doubt, consultation is recommended.

6. Indications at Booking

The following are specific indications for discussion, consultation and/or referral of care **when first discussing a woman’s needs during a booking visit**. The main purpose of the indication list is to provide a guide for risk-selection.

The Codes in the Tables for A ‘Discussion’, B ‘Consultation’ and C ‘Referral of Care’ are explained in Part 4 of these Guidelines.

### 6.1. Medical Conditions

<table>
<thead>
<tr>
<th>6.1.1 Anaesthetic difficulties</th>
<th>B C</th>
</tr>
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<tbody>
<tr>
<td>· Previous failure or complication (e.g. difficult intubation, failed epidural)</td>
<td></td>
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<tr>
<td>· Malignant hyperthermia or neuromuscular disease</td>
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</table>

<table>
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<tr>
<th>6.1.2 Autoimmune disease</th>
<th>B</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>6.1.3 Cardiovascular disease / Hypertension</th>
<th>C</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>6.1.4 Drug dependence or misuse</th>
<th>B B</th>
</tr>
</thead>
<tbody>
<tr>
<td>· Use of alcohol and other drugs</td>
<td></td>
</tr>
<tr>
<td>· 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</td>
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<table>
<thead>
<tr>
<th>6.1.5 Endocrine</th>
<th>C C B C</th>
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<tr>
<td>Diabetes mellitus</td>
<td></td>
</tr>
<tr>
<td>· Pre-existing insulin dependent or non insulin dependent</td>
<td></td>
</tr>
<tr>
<td>· Gestational diabetes requiring insulin</td>
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<tr>
<td>· Hypothyroidism</td>
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<tr>
<td>· Hyperthyroidism</td>
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<tr>
<td>· Addison’s Disease; Cushing’s Disease or other endocrine disorder requiring treatment</td>
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<tr>
<th>6.1.6 Gastro-intestinal</th>
<th>B B B</th>
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<tbody>
<tr>
<td>· Hepatitis B with positive serology (Hbs-AG+)</td>
<td></td>
</tr>
<tr>
<td>· Hepatitis C</td>
<td></td>
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<tr>
<td>· Inflammatory Bowel Disease</td>
<td></td>
</tr>
<tr>
<td>· This includes ulcerative colitis and Crohn’s disease.</td>
<td></td>
</tr>
</tbody>
</table>
### 6.1.7 Genetic – any condition

#### B

### 6.1.8 Haematological

- Thrombo-embolic process. Of importance is the underlying pathology and the presence of a positive family medical history
- Coagulation disorders
- Anaemia at booking irrespective of how treated or whether it responds to treatment
  - Anaemia defined as Hgb < 9g/dL

#### C

### 6.1.9 Infectious Diseases

- HIV-infection
- Rubella
- Cytomegalovirus
- Parvo virus infection
- Varicella/Zoster virus infection
- Herpes genitalis: primary infection
- Herpes genitalis: recurrent infection
- Tuberculosis: active tuberculous or a history of Tuberculosis
- Syphilis
  - Positive serology and treated
  - Positive serology and not yet treated
  - Primary infection
- Toxoplasmosis
  - If there is a history of viral, microbial, or parasitic infections whether active or a previous medical history then medical consultation is required.

#### C

### 6.10 Maternal Age (under 14 and older than 45 years)

#### A/B

### 6.11 Maternal Weight > 100kg or Body Mass Index <17 and >35

#### B

### 6.1.12 Neurological

- Epilepsy, without medication or in the past without treatment and no seizures in the last 12 months
- Epilepsy, with medication or seizure in the last 12 months
- Subarachnoid haemorrhage, aneurysms
- Multiple sclerosis
- AV malformations
- Myasthenia gravis
- Spinal cord lesion (para or quadraplegia)
- Muscular dystrophy or Myotonic Dystrophy

#### B/C

### 6.1.13 History of Mental Health Disorders

- Care during pregnancy and birth will depend on the severity and extent of the mental health disorder.

#### B
6.1.14 Renal function disorders
- Disorder in renal function, with or without dialysis
- Urinary tract infections
- Pyelitis

6.1.15 Respiratory Disease
- Asthma Mild
- Asthma Moderate (i.e. oral steroids in the last year and maintenance therapy)
- Severe Lung function disorder

6.1.16 System/connective tissue diseases
- These include rare maternal disorders such as systemic lupus erythematosus (SLE), anti-phospholipid syndrome (APS), scleroderma, rheumatoid arthritis, periarteritis nodosa, Marfan’s syndrome, Raynaud’s disease and other systemic and rare disorders.

6.2. Pre-existing gynaecological disorders

6.2.1 Pelvic floor reconstruction
- This refers to colpo-suspension following prolapse, fistula and/or previous rupture.

6.2.2 Cervical Abnormalities
- Cervical amputation
- Cervical cone biopsy
- Cervical surgery with or without subsequent vaginal birth
- Abnormalities in cervix cytology (diagnostics, follow-up)

6.2.3 Uterine Abnormalities
- Myomectomy /hysterotomy
- Bicornuate uterus

6.2.4 Intra Uterine Contraceptive Device (IUCD) in situ

6.2.5 Infertility treatment

6.2.6 Pelvic deformities (trauma, symphysis rupture, rachitis)

6.2.7 Female Genital Circumcision
### 6.3 Previous Obstetric history

| 6.3.1 | **Active blood group incompatibility** *(Rh, Kell, Duffy, Kidd)* | C |
| 6.3.2 | **ABO-incompatibility** | B |
| 6.3.3 | **Hypertension in the previous pregnancy** | A/B |
| 6.3.4 | **Pre-eclampsia in the previous pregnancy** | B |
| 6.3.5 | **Eclampsia** | C |
| 6.3.6 | **Recurrent miscarriage** *(3 or more times)* | A/B |
| 6.3.7 | **Pre-term birth (<37 weeks) in a previous pregnancy** | A/B |
| 6.3.8 | **Cervical incompetence** *(and/or Shirodkar-procedure)* | C |
| 6.3.9 | **Placental abruption** | B |
| 6.3.10 | **Forceps or vacuum extraction** | A/B |
| 6.3.11 | **Caesarean section** | B |
| 6.3.12 | **Fetal growth disturbance** | B |
| 6.3.13 | **Asphyxia** *(defined as an APGAR score of <7 at 5 minutes)* | B |
| 6.3.14 | **Perinatal death** | B |
| 6.3.15 | **Child with congenital and/or hereditary disorder** | B |
| 6.3.16 | **Postpartum haemorrhage as a result of**  
  1. episiotomy  
  2. cervical tear  
  3. other causes (>1000 ml) | A/C/B |
| 6.3.17 | **Manual removal of placenta** | A |
| 6.3.18 | **Placenta accreta** | C |
| 6.3.19 | **3rd or 4th degree perineal laceration**  
  1. functional recovery  
  2. no/poor function recovery | B/B |
| 6.3.20 | **Symphysis pubis dysfunction** | A/C |
| 6.3.21 | **Postpartum depression** | A/B |
| 6.3.22 | **Postpartum psychosis** | C |
| 6.3.23 | **Grand multiparity** – defined as parity >5. | A/B |
| 6.3.24 | **Shoulder Dystocia** | B |
### 7. Indications Developed/Discovered During Pregnancy

The following are specific indications for discussion, consultation and/or referral of care in response to conditions or abnormalities that are identified during pregnancy. The main purpose of the indication list is to provide a guide for risk-selection. The Codes in the Tables for A Discussion, B Consultation and C Referral of Care are explained in Part 4 of these Guidelines.

<table>
<thead>
<tr>
<th>7.1.1</th>
<th>Uncertain duration of pregnancy by amenorrhoea &gt;20 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>· Consultation is required when the duration of pregnancy is uncertain after 20 weeks amenorrhoea. The primary care provider has access to sufficient additional diagnostic tools in the first 20 weeks.</td>
</tr>
<tr>
<td></td>
<td>B</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>7.1.2</th>
<th>Laparotomy during pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>C</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7.1.3</th>
<th>Cervix cytology</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>· CIN III or higher</td>
</tr>
<tr>
<td></td>
<td>· CIN 1 &amp; 2</td>
</tr>
<tr>
<td></td>
<td>C B</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7.1.4</th>
<th>Mental Health disorders (neuroses/psychoses)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>7.1.5</th>
<th>Hyperemesis gravidarum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>· Referral to secondary care is necessary for treatment of this condition. After recovery the pregnancy and birth can take place at primary care level.</td>
</tr>
<tr>
<td></td>
<td>B</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7.1.6</th>
<th>Ectopic pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>C</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7.1.7</th>
<th>Antenatal screening</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>· Attention should be given to the presence of risk factors for congenital abnormalities. If no abnormalities can be found, then further care may take place at a primary level.</td>
</tr>
<tr>
<td></td>
<td>A/C</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7.1.8</th>
<th>(Suspected) fetal abnormalities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A/C</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7.1.9</th>
<th>Pre-term rupture of membranes (&lt;37 weeks amenorrhea)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>C</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>7.1.10</th>
<th>Gestational Hypertension (GH) (&gt;20 weeks gestation):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>· average SBP &gt; 140mmHg and/or DBP &gt;90 mmHg (after overnight rest, or after completion of a day assessment visit), without any evidence of multisystem dysfunction. GH resolves within 3 months postpartum.</td>
</tr>
<tr>
<td></td>
<td>B</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>7.1.11</th>
<th>Preeclampsia (PE):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>· Development of SBP &gt; 140mmHg and/or DBP &gt;90 mmHg Preeclampsia usually occurs after 20 weeks gestation in women with no previous history of hypertension, cardiac or renal, plus evidence of other organ involvement (eg proteinuria, renal insufficiency, liver disease, neurological problems, haematological disturbances, fetal growth restriction.) PE resolves within 3 months postpartum.</td>
</tr>
<tr>
<td></td>
<td>C</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7.1.12</th>
<th>Eclampsia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>C</td>
</tr>
</tbody>
</table>
### 7.1.13 Chronic Hypertension:
- Hypertension that is present in the pre-conception 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)

<table>
<thead>
<tr>
<th>7.1.13</th>
<th>Chronic Hypertension:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Diastolic pressure should be recorded as Point V Korotkoff (K5) (i.e. the point of disappearance of sounds)</td>
</tr>
</tbody>
</table>

| 7.1.14 | Blood group incompatibility | C |
| 7.1.15 | Coagulation disorders | B |
| 7.1.16 | Recurring vaginal blood loss prior to 16 weeks | A/B |
| 7.1.17 | Vaginal blood loss at or after 16 weeks | B |
| 7.1.18 | Placental abruption | C |
| 7.1.19 | Size/date discrepancy: Small for dates. Large for dates. (Definition: symphysis fundal height >3cm or <3cm from gestational age) | B |
| 7.1.20 | Post-term pregnancy (This refers to amenorrhoea lasting longer than 42 completed weeks or 294 days.) | B |
| 7.1.21 | Threat of, or actual, pre-term birth. | B |
| 7.1.22 | Incompetent cervix | C |
| 7.1.23 | Symphysis pubis dysfunction (pelvic instability) | A |
| 7.1.24 | Multiple pregnancy | C |
| 7.1.25 | Non cephalic presentation at full term (Breech presentation (refer for ECV at 35 weeks)) | C | C |
| 7.1.26 | Failure of head to engage at full term If at full term there is a suspected cephalo-pelvic disproportion, placenta praevia or comparable pathology, consultation is indicated. | B |
| 7.1.27 | No prior prenatal care (± full term) | B |
| 7.1.28 | Baby for adoption. | B |
| 7.1.29 | Fetal death in utero. | C |
| 7.1.30 | Fibroids | B |
### 7.1.31 Endocrine
- Diabetes mellitus
  - Gestational diabetes requiring insulin
- Thyroid disease
  - Hypothyroidism
  - Hyperthyroidism
- Addison’s Disease; Cushing’s Disease or other endocrine disorder requiring treatment.

### 7.1.32 Gastroenterology
- Hepatitis B with positive serology (Hbs-AG+)
- Hepatitis C
- Inflammatory Bowel Disease
  - This includes ulcerative colitis and Crohn’s disease.

### 7.1.33 Hernia nuclei pulposi (slipped disc)

### 7.1.34 Haematological
- Thrombosis
- Coagulation disorders
- Anaemia at booking or close to term

### 7.1.35 Infectious Diseases
- HIV-infection
- Rubella
- Toxoplasmosis
- Cytomegalovirus
- Parvo virus infection
- Varicella/Zoster virus infection
- Tuberculosis: an active tuberculous process
- Herpes genitalis
  - Primary infection
  - If late in pregnancy
  - Recurrent
- Syphilis
  - Positive serology and treated
  - Positive serology and not yet treated
  - Primary infection

### 7.1.36 Renal function disorders
- Urinary tract infections
- Pyelitis

### 7.1.37 Respiratory Disease
- Asthma
8. Indications During Labour and Birth

The following are specific indications for discussion, consultation and/or referral of care in response to conditions or abnormalities that are identified during labour and birth. The main purpose of the indication list is to provide a guide for risk-selection. The Codes in the Tables for A ‘Discussion’, B ‘Consultation’ and C ‘Referral of Care’ are explained in Part 4 of these Guidelines.

| 8.1.1 | Gestational hypertension (GH) | C |
| 8.1.2 | Preterm labour < 37 weeks | C |
| 8.1.3 | Preterm pre-labour rupture of membranes (PROM) before 37 weeks | C |
| 8.1.4 | Prolonged rupture of membranes (PROM) >18 hours | B |
| 8.1.5 | Abnormal presentation | C |
| 8.1.6 | Breech Presentation | C |
| 8.1.7 | Meconium stained liquor | A/C |
| 8.1.8 | Suspected placenta abruption and/or praevia | C |
| 8.1.9 | Pre-eclampsia | C |
| 8.1.10 | Pyrexia | C |
| 8.1.11 | Active genital herpes in late pregnancy or at onset of labour | C |
| 8.1.12 | Multiple pregnancy | C |
| 8.1.13 | Confirmed non-reassuring fetal heart patterns | C |
| 8.1.14 | Prolonged active phase | B |
| 8.1.15 | Prolonged second stage | B |
| 8.1.16 | Unengaged head in active labour in primipara | B |
| 8.1.17 | Prolapsed cord or cord presentation | C |
| 8.1.18 | Vasa praevia | C |
| 8.1.19 | Shoulder dystocia | C |
| 8.1.20 | Uterine rupture | C |
| 8.1.21 | Third or fourth degree perineal tear | C |
| 8.1.22 | Retained placenta | B |
| 8.1.23 | Uterine inversion | C |
| 8.1.24 | Post partum haemorrhage >1000mls | C |
| 8.1.25 | Fetal death during labour | C |
| 8.1.26 | Shock / Maternal Collapse | C |
### 9. Indications During Post-partum 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. The main purpose of the indication list is to provide a guide for risk-selection.

The Codes in the Tables for A Discussion, B Consultation and C Referral of Care are explained in Part 4 of these Guidelines.

#### 9.1 Indications: Postpartum (Maternal)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.1.1</td>
<td>Suspected maternal infection e.g. breast, abdomen, wound, uterine, urinary tract, perineum</td>
<td>B</td>
</tr>
<tr>
<td>9.1.2</td>
<td>Temperature over 38°C on more than one occasion</td>
<td>B</td>
</tr>
<tr>
<td>9.1.3</td>
<td>Persistent hypertension</td>
<td>B</td>
</tr>
<tr>
<td>9.1.4</td>
<td>Serious psychological disturbance</td>
<td>B</td>
</tr>
<tr>
<td>9.1.5</td>
<td>Haemorrhage &gt; 1000mls</td>
<td>C</td>
</tr>
<tr>
<td>9.1.6</td>
<td>Postpartum eclampsia</td>
<td>C</td>
</tr>
<tr>
<td>9.1.7</td>
<td>Thrombophlebitis or thromboembolism</td>
<td>C</td>
</tr>
<tr>
<td>9.1.8</td>
<td>Uterine prolapse</td>
<td>C</td>
</tr>
<tr>
<td>9.1.9</td>
<td>Significant social isolation and lack of social support</td>
<td>B</td>
</tr>
</tbody>
</table>

#### 9.2 Indications: Postpartum (Infant)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.2.1</td>
<td>Apgar less than 7 at 5 minutes</td>
<td>C</td>
</tr>
<tr>
<td>9.2.2</td>
<td>&lt; 37 weeks gestational age</td>
<td>B</td>
</tr>
<tr>
<td>9.2.3</td>
<td>Infant less than 2500 g</td>
<td>B</td>
</tr>
<tr>
<td>9.2.4</td>
<td>Less than 3 vessels in umbilical cord</td>
<td>B</td>
</tr>
<tr>
<td>9.2.5</td>
<td>Excessive moulding and cephalhaematoma</td>
<td>B</td>
</tr>
<tr>
<td>9.2.6</td>
<td>Abnormal findings on physical examination</td>
<td>B</td>
</tr>
<tr>
<td>9.2.7</td>
<td>Excessive bruising, abrasions, unusual pigmentation and/or lesions</td>
<td>C</td>
</tr>
<tr>
<td>9.2.8</td>
<td>Birth injury requiring investigation</td>
<td>B</td>
</tr>
<tr>
<td>9.2.9</td>
<td>Birth trauma</td>
<td>B</td>
</tr>
<tr>
<td>9.2.10</td>
<td>Congenital abnormalities, for example: cleft lip or palate, congenital dislocation of hip, ambiguous genitalia</td>
<td>C</td>
</tr>
<tr>
<td>9.2.11</td>
<td>Major congenital anomaly requiring immediate intervention, for example: omphalocele, myelomeningocele</td>
<td>C</td>
</tr>
<tr>
<td>9.2.12</td>
<td>Abnormal heart rate or pattern</td>
<td>B</td>
</tr>
<tr>
<td>9.2.13</td>
<td>Abnormal cry</td>
<td>B</td>
</tr>
<tr>
<td>9.2.14</td>
<td>Persistent abnormal respiratory rate and/or pattern</td>
<td>B</td>
</tr>
</tbody>
</table>
28

| 9.2.15 | Persistent cyanosis or pallor | B |
| 9.2.16 | Jaundice in first 24 hours | B |
| 9.2.17 | Suspected pathological jaundice after 24 hours | B |
| 9.2.18 | Temperature instability | C |
| 9.2.19 | Temperature less than 36° C, unresponsive to therapy | B |
| 9.2.20 | Temperature more than 37.4° C, axillary, unresponsive to non-pharmaceutical therapy | C |
| 9.2.21 | Vomiting or diarrhoea | C |
| 9.2.22 | Infection of umbilical stump site | B |
| 9.2.23 | Feeding problems | A/C |
| 9.2.24 | Significant weight loss in the first week (usually more than 10% of body weight) Failure to regain birth weight in three weeks | B |
| 9.2.25 | Failure to thrive | B |
| 9.2.26 | Failure to pass urine or meconium within 24 hours of birth | A/B |
| 9.2.27 | Failure to pass urine or meconium within 36 hours of birth | B |
| 9.2.28 | Suspected clinical dehydration | B |
| 9.2.29 | Suspected seizure activity | C |
10. Review of these Guidelines

It is the intention of the Australian College of Midwives to continue to update and republish these Guidelines at timely intervals. Organisations and individuals are invited to send any comments on these guidelines to:

Post: Australian College of Midwives
PO Box 87 Deakin West,
ACT 2600, Australia or

Email: executiveofficer@midwives.org.au
11. Bibliography


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

Australian Commission on Safety and Quality in Health Care: www.safetyandquality.org/internet/safety/publishing.nsf

Evidence based guidelines for midwifery care
Google Scholar:
  http://scholar.google.com.au
Midwives Information and Resource Service (MIDIRS):
Waterbirth:
  http://www.birthinternational.com/product/video/title-w.html
Appendix A:

WHEN A WOMAN CHOOSES CARE OUTSIDE THE RECOMMENDED ACM NATIONAL MIDWIFERY GUIDELINES FOR CONSULTATION AND REFERRAL

The following document was developed from a similar document published by the College of Midwives of Ontario ‘When A Client Chooses Care Outside Midwifery Standards of Practice’ January 1994, Revised September 22, 2004. The document aims to assist midwives to support a woman’s decisions after a discussion regarding informed choice has taken place.

A woman in the care of midwives may occasionally choose not to accept a care pathway as recommended in the Australian College of Midwives’ (ACM’s) National Midwifery Guidelines for Consultation and Referral (the Guidelines). It is also possible that a woman in midwifery care may choose care that the midwife judges is beyond her ability to safely manage, or decline care that the midwife considers essential for the provision of safe care.

Ethical principles underlying health care and health law emphasize the importance of respecting the autonomy of those receiving health care and the rights of individuals to choose among alternative approaches, weighing risks and benefits according to their needs and values. Midwives, like all health professionals, are responsible for being clear about their scope of practice and limitations, giving recommendations for care if appropriate and for informing women about risks, benefits and alternative approaches.

Midwives are also responsible for providing care consistent with the national professional standards for midwives. These include national midwifery competency standards6, codes of ethics7 and professional conduct8, and relevant state or territory based regulatory requirements for midwifery practice.

Should a situation arise in which the woman chooses care outside the recommendations in the Guidelines the midwife must engage with the woman and her family and with hospital staff through identified channels where applicable, in a thorough discussion of the request, looking for options and resolutions within midwifery professional standards to address the woman’s needs.

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6 Australian Nursing and Midwifery Council, 2006, National Competency Standards for the Midwife
7 Australian College of Midwives, Australian Nursing and Midwifery Council, Australian Nursing Federation, 2008, Code of Ethics for Midwives in Australia
8 Australian College of Midwives, Australian Nursing and Midwifery Council, Australian Nursing Federation 2008, Code of Professional Conduct for Midwives in Australia
In exceptional circumstances, the issue may not be able to be resolved to both the woman’s and the midwife’s satisfaction. This appendix is meant to assist midwives in addressing those occasions when a solution within the recommended care pathways of the Guidelines cannot be found.

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

1. **Advise** the woman not only of the recommended guideline but also of the rationale and the evidence behind the guideline in this case;

2. **Consult** with at least one of the following:
   a. another midwife,
   b. a physician,
   c. a peer review group or
   d. an ethicist.

   Consultation should include discussion of appropriate next steps if the woman continues to choose care outside the recommended guideline, and consideration of the safest and most ethical course under these circumstances, i.e. continuation of primary midwifery care or referral of care;

3. **Share the advice** of the consultation with the woman; and

4. **Document** in the accompanying care plan and the woman’s notes the informed choice process, when and with whom the consultation took place, the recommendations arising from the consultation, the date on which the woman was advised of the recommendations and the woman’s response.

After completing steps 1 to 4 above, if a satisfactory resolution has not been achieved for the woman or the midwife, the midwife has two choices. Using her ethical judgment, the midwife must decide to either:

a) Continue care and respect the woman’s choice for her care and:
   1. continue making recommendations for safe care;
   2. continue to engage other caregivers as appropriate who might become involved in provision of care (e.g. Hospital staff, other midwives in practice);
   3. continue to document all discussions and decisions.

OR

b) Discontinue care:
   1. clearly communicate to the woman that the midwife is unable to continue to provide care;
2. send a written referral that confirms the termination of care by a date that provides the woman with a specific amount of time to find another caregiver. This time should be reasonable and will vary according to location and circumstance. If, during this time, the woman cannot arrange alternate care, the midwife should make a reasonable attempt to find a caregiver who is willing to see the woman and provide alternate care;

3. maintain a copy of this letter including the proof of receipt, in the woman’s health record.

In the course of labour or urgent situations, the midwife may not refuse to attend the woman. When the steps for discontinuing care of the woman have not been undertaken or completed prior to the onset of labour, the midwife must attend the woman.

In circumstance where a woman refuses emergency transport or transfer of care in the course of active labour, the midwife must remain in attendance as the primary care provider, and 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 these situations the midwife should:

1. Attempt to provide care within professional standards
2. Attempt to provide care to the best of her ability
3. Attempt to access appropriate resources and/or personnel to provide any needed care
<table>
<thead>
<tr>
<th>Care Plan</th>
<th>WHEN A WOMAN CHOOSES CARE OUTSIDE THE RECOMMENDED ACM GUIDELINES</th>
<th>Affix patient label</th>
</tr>
</thead>
</table>

**Reason for medical/other consultation:**

____________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

**Discussed with:** ___________________________ **Date:** __________________________

☐ consult ☐ in person ☐ phone ☐ transfer

**Care Plan:**

____________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

**Source:** We would like to acknowledge the Children, Youth and Women’s Health Service Government of South Australia and the Women’s and Children’s Hospital, Adelaide, South Australia for the template on which this document is based.
Midwifery Practice Review

For Midwives

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