NATIONAL MIDWIFERY GUIDELINES FOR CONSULTATION AND REFERRAL

4th EDITION

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DISCLAIMER

The National Midwifery Guidelines for Consultation and Referral (referred to as 'the Guidelines' throughout) provide information to assist midwives to integrate evidence and clinical judgment alongside of the preferences and needs of women for whom they are providing midwifery care. The Guidelines are intended to assist midwives in their discussions with women regarding the suitability of different maternity care options while facilitating safe, evidence based maternity care within a woman-centred framework. It is important to note that the Guidelines are not intended as a guide to the most appropriate place for birth.

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FOREWORD

Since the release of the first issue in 2004, the National Midwifery Guidelines for Consultation and Referral ("The Guidelines") have been a pivotal and essential resource for guiding clinical midwifery care. Although developed and informed by midwives for the purpose of informing midwifery practice, the Guidelines are applicable to all health care practitioners, across all contexts who will, or are likely to, provide care to women during the childbearing years.

The Guidelines foster a collaborative, multidisciplinary approach to the provision of maternity care across Australia. They reflect the dedication and commitment of all Australian maternity care providers to achieving respectful, collaborative and woman-centred maternity practice. More importantly, they are evidence of the pivotal role that midwives play in the provision of safe, humanised, high-quality, evidence-based care.

The Guidelines have been developed and refined by many people over the course of many years. The combined efforts and knowledge of these passionate and dedicated people have been integral to improving maternity care and raising the profile of midwifery and midwives in Australia. While there are too many people to name, we as the ACM would like to acknowledge Professor Sally Tracy (the founder of the Guidelines) and Associate Professor Donna Hartz for their continued dedication and commitment to ensuring maternity care is underpinned and supported by high-quality evidence. I would personally like to thank Sally and Donna who graciously imparted their knowledge and experience and entrusted the 4th edition of these guidelines, to me as Chair and lead.

The Guidelines have and will continue to provide clear guidance to midwives across all practice contexts. They detail the clinical indications for engagement of other health care professionals in the care of women, babies and families. Importantly, they reflect the scope of the midwife and the importance of midwives in maintaining high-quality maternity care. Furthermore, they highlight that a midwife's engagement in the care of women and families is always indicated.

The Australian College of Midwives values the partnership and teamwork that has occurred throughout the review process and would like to thank all stakeholders who have been involved. I would especially like to thank all members of the Executive Steering Group and Clinical Groups for their time and commitment to this project. I would also like to extend a special thank you to Samantha Tutton, the Programs and Member Service Manager of the Australian College of Midwives, for her exceptional support and administrative skills throughout the review process.

The Australian College of Midwives (ACM) is pleased to publish the 4th Edition of the National Midwifery Guidelines for Consultation and Referral. We trust that you will find them an essential resource as you continue to provide high quality maternity care for women, babies and families across Australia.

Dr Megan Cooper
Australian College of Midwives

ACKNOWLEDGEMENTS

The Australian College of Midwives (ACM) would like to acknowledge and thank the many organisations and individuals who have contributed to the 4th edition of the National Midwifery Guidelines for Consultation and Referral (the Guidelines).

This edition would not have been possible without the dedication and input from a team of volunteer midwives around the country. They graciously offered their time and expertise to review both the previous edition of the guidelines and the current literature base to inform changes and/or additions to the Guidelines; all while managing the additional challenges that came with the COVID-19 global pandemic. The ACM would like to acknowledge every one of you for the many hours of work that was dedicated to this edition, in what were, very trying circumstances.

We would also like to acknowledge and thank the organisations and members who reviewed and provided constructive feedback. Importantly, we also make special mention of our consumer organisations who provided feedback on behalf of the women and families of Australia. This edition has truly been a united effort and reflects what can be achieved when a mutually respectful and collaborative approach is employed.

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1 ABOUT THESE GUIDELINES

Prior to the first edition of the Guidelines, there was very little guidance available to midwives and doctors who were seeking to provide individualised maternity care within a collaborative, evidence-based framework. Specifically, there was no single, nationally consistent, evidence-based tool to guide midwives in their decision to consult with and/or refer care to a suitably qualified health practitioner. This posed a significant barrier to midwives scope of practice and therefore, their ability to fulfill the role as primary maternity health care providers. It also hampered the availability and offering of continuity of midwifery care as well as the successful establishment of midwifery-led services.

In response to this paucity, the first issue of the Guidelines was developed and published by the ACM in 2004. Based on similar guidelines from other OECD countries, the first iteration was informed by a thorough review of contemporary, evidence-based maternity care and practice. The Guidelines were well-received following their inception and subsequent editions have continued to influence the way midwives work and provide care to women around Australia.

Over the past 17 years, the Guidelines have provided midwives with the guidance they need to make sound clinical decisions and to consult and refer to qualified health professionals where the need arises. Previous editions of the Guidelines have been endorsed in most States and Territories of Australia and are used to inform and underpin both maternity service policy and clinical care guidelines.

The revised and updated fourth edition of the Guidelines, provides for previously agreed recommendations, changes in existing advice (where necessary) and the inclusion of new clinical considerations. Adoption of the fourth edition by all institutions and midwives will help to ensure maternity services provide high quality, safe, collaborative and consistent care to women, babies and their families.

1.1 Who are these Guidelines for?

Midwives working across Australia, in all models of care, use these Guidelines, alongside of experience and high-quality evidence, to help inform their clinical decision-making. The Guidelines are relevant to all midwives and all health practitioners providing maternity care across all contexts and models of care.

This edition of the Guidelines reflects the agreed scope of practice of all midwives practising in the Australian context.[1] The content aligns with the agreed highest standard of safe, collaborative, evidence-based maternity care. This edition also recognises the scope of a midwife, including those who are endorsed to prescribe scheduled medicines as denoted by the inclusion of the A* level of consultation. This was first introduced in the third edition.

1.2 Background

At the outset, the Guidelines were evaluated by a randomised controlled trial of midwifery care at the Royal Hospital for Women, Sydney and the Mater Mother's Hospital, Brisbane.[2] A paper published in 2012, outlined their value in nurturing collaborative models of maternity care.[3]

The Australian Government's National Maternity Services Plan identified the Guidelines in the Standards of Care initiative while the Guidelines complemented the proposed National Maternity Services Capability Framework, and were endorsed in NSW, QLD, Victoria, and South Australia, and acknowledged in WA. They were also referenced in the National Consensus Framework for Rural Maternity Services.

A further two editions were published to reflect the changing landscape of Australian maternity care and further indications for consultation and referral. This was particularly important given the expansion of midwifery-led care and midwife-led research.

The fourth edition of the Guidelines is the most comprehensive yet. It has been underpinned and informed by the *Woman-centred care: strategic directions for Australian Maternity Services* as published by COAG in 2019 and developed following rigorous review and extensive consultative processes.

The guidance provided throughout the five sections of this edition will not only assist midwives and other health care providers involved in the provision of maternity care, but it will also inform policies, clinical practice standards and guidelines both across each of the Australian jurisdictions.

1.3 Review and consultation

The ACM is committed to reviewing and updating the Guidelines regularly to ensure they remain evidence-based, comprehensive and usable. While the review process has varied slightly over time, the purpose has always been to reflect the most up-to-date and contemporaneous evidence and clinical practice changes. The fourth edition has been a united effort of an Executive Steering Group, four Clinical Reference Groups and the Professional Practice Unit team at the Australian College of Midwives.

In 2020, the ACM established an Executive Steering Group to lead the 4th edition. This was followed by the distribution of an expression of interest (EOI) to all ACM members who could self-nominate to be engaged in the review process. The ACM received a large number of responses to the EOI.

Following a review of all responses to the EOI, members of the Executive Steering Group identified and invited the strongest candidates to chair and lead the four Clinical Reference Groups (CRGs). The four leads where then assigned one of the four existing indication sections from the third edition of the Guidelines to review and update. Terms of reference for each of the CRGs were developed and distributed to the Chairs. Candidates from the pool of EOI applications were then chosen to join the four CRGs.

Chairs of the CRGs were provided with proformas which ensured that changes, additions and any relevant evidence could be captured throughout the review process. Multiple meetings between the Chair of the Executive Steering Committee and the Chairs of the CRGs occurred throughout 2020.

Following review and updates made by the CRGs, the guidelines were reviewed by the Executive Committee Chair and collated in preparation for consultation.

The consultation process was a phased approach. The phases are detailed below:

1. Maternity care stakeholders including midwives, doctors, health service managers, regulators, employers and consumers were offered the opportunity to provide feedback through an online survey. Feedback received informed changes to the levels of consultation and referral and the inclusion of any additional indications.

2. Following minor changes, the guidelines were distributed for public consultation. The public consultation began in early 2021 and lasted for more than 30 days, with this reflecting the National Health and Medical Research Council (NHMRC) guidelines for public consultation.

3. A legal review of Appendices A, B and C was completed. Amendments to the appendices were made in response to this review.

4. All feedback, comments and suggestions were then collated and used to inform minor changes to the Guidelines before the draft was sent for final review by the Executive Steering Committee.

5. The final draft was then sent to the ACM Board of Directors for endorsement.

The review process identified the need for an additional "Social Indications" section to be added to the Guidelines. This was supported by feedback received during the consultation phases. As such, the 4th edition includes five sections, to capture additional considerations in the provision of maternity care that were not reflected in previous iterations.

References

1 Nursing and Midwifery Board of Australia. (2018). Code of Professional Conduct for Midwives in Australia.

2 Tracy, S.K., Hartz, D., Hall, B. et al. A randomised controlled trial of caseload midwifery care: M@NGO (Midwives @ New Group practice Options). BMC Pregnancy Childbirth 11, 82 (2011). https://doi.org/10.1186/1471-2393-11-82

3 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

Collaboration

Collaboration refers to all members of the health care team working in partnership with both the woman and each other to provide the highest standard of, and access to, health care. Collaborative relationships depend on mutual respect. Successful collaboration is contingent upon open communication, consultation and joint decision-making within a risk management framework, to enable appropriate identification of risk and any requirement for consultation and/or referral. Collaboration ensures effective, efficient and safe health care.[4]

Commencement of care

Commencement of care refers to the first contact between a maternity care or other health provider and the woman, in the antenatal period. Antenatal care may commence as part of the initial health care interaction for the purposes of confirming pregnancy or following a referral to a maternity care provider or service (e.g., the local hospital, midwife, obstetrician, GP or Aboriginal Health Service). Regardless of context, the first antenatal visit should be longer than most other antenatal visits due to the large volume of information that is shared with women in early pregnancy. This clinically relevant information shared between the woman and health care provider will inform any need for consultation and/or referral.[5]

4. Nursing and Midwifery Board of Australia. (2020). Decision-making framework for nursing and midwifery, https://www.nursingmidwiferyboard.gov.au/documents/default.aspx?record=WD19%2f29157&dbid=AP&chksum=9LilUkdFvM5AJeKlaJZd1A%3d%3d, p. 11.
5. Department of Health (2018) Clinical Practice Guidelines: Pregnancy Care. Canberra: Australian Government Department of Health.

Consultation

Consultation is the seeking of professional advice from a qualified, competent health care provider with the relevant knowledge and skills to make decisions about the woman's care, in collaboration with the woman and midwife. It is dependent on mutual respect, open communication, the sharing of information and recognition of the equally important roles that each care provider has in providing high-quality, evidence-based care to women, babies and families.[6]

Referral

Referral is defined as the transfer of primary responsibility from the midwife to another qualified health service provider or professional. The midwife recognises that the care required falls outside of their scope of practice. In response, the midwife discusses the indication(s) for referral with the woman, seeks her informed consent and then refers the woman to the most appropriate health professional for ongoing care. Despite the indicated need for referral, the midwife remains a key member of the multidisciplinary team and continues to provide midwifery care to the woman.[7]

6. Nursing and Midwifery Board of Australia. (2020). Decision-making framework for nursing and midwifery, https://www.nursingmidwiferyboard.gov.au/documents/default.aspx?record=WD19%2f29157&dbid=AP&chksum=9LilUkdFvM5AJeKlaJZd1A%3d%3d, p. 7, 11.
7. Nursing and Midwifery Board of Australia. (2020). Decision-making framework for nursing and midwifery, https://www.nursingmidwiferyboard.gov.au/documents/default.aspx?record=WD19%2f29157&dbid=AP&chksum=9LilUkdFvM5AJeKlaJZd1A%3d%3d, p. 13.

3 INTRODUCTION

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; throughout labour and birth; and in the postnatal period. The fourth edition also includes guidance surrounding social indications that may warrant consultation with and/or referral to, medical practitioners or other relevant health care providers.

As primary maternity care providers, midwives hold responsibility for making decisions about whether a woman needs medical attention during pregnancy, labour, birth or the postnatal period (up to 6 weeks after the baby is born). The Guidelines are designed to facilitate consultation, referral and integration of care between midwives, medical practitioners and other health professionals, giving confidence to providers as well as 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 evidence-based, best practice.

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 wellbeing of both the woman and her infant/s. This is aided by a comprehensive assessment at the commencement of care and ongoing assessment and communication throughout the childbearing experience.

3. Midwifery care is underpinned by woman-centred care. The woman and the midwife develop a relationship of mutual trust and reciprocity whereby the sharing of information facilitates informed decision-making. The woman and the midwife work together during the whole maternity experience, recognising the active role that each play in achieving the best possible outcomes.

4. Where a woman has selected a midwife for her care, any referral to a medical practitioner or other health care provider is carried out by the midwife.

5. Midwifery care may continue even where care has been referred to a medical practitioner or other health care provider (that is, the midwife continues to provide midwifery care to the woman). Good communication between care providers is essential for safe, effective, and collaborative maternity care.

6. Collaboration and cooperation between the woman and all health professionals involved in the provision of maternity care is of major importance and ensures optimal, high quality care. This involves recognition of the particular expertise of each health care provider involved in the woman's childbearing experience.

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

8. Following consultation and/or referral, it is expected that the midwife will receive return communication from the medical practitioner or health care provider. 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 any other health practitioner that will be involved in the woman's ongoing care.

3.2 Guiding principles

3.2.1 Use of the Guidelines

1. Midwives, medical practitioners and all other health care professionals involved in a woman's childbearing experience, are responsible for their own professional decision-making. These Guidelines assist maternity health care providers in making decisions about the care of a woman and her baby.

2. Midwives, medical practitioners and other health care providers respect the conditions under which information about the woman and her infant(s) may or may not be shared with others.

3. If problems occur during pregnancy, birth or the postnatal period, the midwife may decide to discuss with peers in the first instance; or consult directly with a medical practitioner or other health care provider. A referral should occur where indicated.

4. At all times, the woman must be included in discussions that relate to both her and her baby such that she is able to make an informed decision and provide informed consent, with this including the recommendation for referral.

5. The midwife, medical practitioner and other health care providers involved in providing care to a woman and her baby will collaborate and cooperate in accordance with the Guidelines.

6. The level of consultation and/or referral that may be required will be influenced by the midwife's endorsement to prescribe scheduled medicines.

7. Where indicated, a medical practitioner may assume ongoing clinical responsibility of the woman's care. However, this does not preclude the midwife from providing midwifery care. As such, the ongoing role of the midwife in providing care will be agreed between the woman, the midwife, and the medical practitioner. This discussion will also include the possibility of and/or timing of transfer back to the midwife once the woman's condition permits.

8. The severity of the woman's condition will influence these decisions.

3.2.2 Informed choice

1. Before the commencement of care, the midwife should outline the scope and boundaries of midwifery care to the woman and where relevant, her partner and family. This will include an explanation of how these Guidelines influence the provision of care and any associated decisions.

2. Midwifery care must be provided in accordance with the principle of informed decision-making. The midwife, medical practitioner and any other health care provider must provide the woman with sufficient information for the woman to offer informed consent to any procedure or intervention. The woman should be afforded sufficient time to (1) consider the advice and any recommended procedures or interventions, (2) ask questions about any of the same and (3) make a decision. The woman is free to accept or decline any advice, procedures and/or interventions offered by any health care professional.

3. When a woman exercises a choice that is contrary to professional advice or care outlined in the Guidelines, the health care professional should carefully document the woman's concerns and decision as well as any advice and/or information provided in the woman's clinical record by following local policy and protocol. Refer to Appendices A and B and the ACM position statement about caring for women who make choices outside professional advice. It is also recommended that where midwives are unsure about whether or not to continue to provide care, they seek appropriate professional advice (legal or otherwise).

3.3 Structure of the Guidelines

To assist midwives in providing the best quality and most effective care possible, the Guidelines provide indications for consultation and/or referral. This guidance supports midwives to quickly identify situations that require the input of other health care professionals.

The Guidelines are organised into five sections:

- Indications at the commencement of care
- Clinical indications developed or identified during the antepartum period
- Clinical indications during the intrapartum period
- Clinical indications during the postpartum period
- Social indications

Each section contains reference tables that list specific conditions or circumstances that a woman and/or her baby may present with. The tables provide a recommended response to the woman's presentation, to assist the midwife in planning the appropriate referral and consultation pathways.

4 THE THREE LEVELS OF CONSULTATION AND REFERRAL

4.1 The Levels of Consultation and Referral Explained

When a variance from normal is identified during a woman's care, it is recommended that the midwife use their clinical judgement and the following guidance to determine the appropriate level of consultation and/or referral.

Table 4.1 Levels of consultation and referral

LEVEL	DESCRIPTION	GUIDANCE
A/A*	Discuss	Care is provided by the midwife. (Note: the midwife may discuss clinical situations with a midwifery colleague, medical practitioner, and/or health care provider, but this is not indicated).
B	Consult	Consult with a relevant medical practitioner or other health care provider.
C	Refer	Refer a woman and/or her baby to a relevant medical practitioner or other health care provider.

A: Midwife with endorsement to prescribe scheduled medicines*

Important notes related to level of consultation or referral:

- Where there are variations in the severity of a condition, more than one level may be recommended e.g., B/C; A/B/C.
- Clinical judgement should be used to determine the level of referral and/or consultation based on the woman and/or baby's presentation.
- If a woman presents with multiple indications, the level of consultation and/or referral will depend on the clinical judgement of the midwife in consultation with relevant medical practitioners (or other health care providers).
- **It does not follow that "two B's equal a C" or that multiple indications indicate automatic referral (level C) to a medical professional.** That is, for a woman who presents with multiple indications that are both level B, the midwife should follow the guidance for a Level B and in collaboration with the medical practitioner (or other health care provider) to determine whether referral is required.
- It is important to acknowledge that **regardless of the level of consultation and/or referral, the midwife will continue to provide midwifery care to the woman in partnership and collaboration with the woman herself, and the medical practitioner** (or other health care provider). Even where the indication is to refer (level C), a well-documented plan devised through multi-disciplinary collaboration will enable the woman to continue to receive midwifery care.
- It is important that midwives work within the boundaries of the Nursing and Midwifery Board of Australia's *Decision-making framework for nursing and midwifery practice* to ensure safe and appropriate professional practice.[8]

4.2 Discuss

Table 4.2: Level A/A* - Discuss

LEVEL	DESCRIPTION	GUIDANCE
A/A*	Discuss	Care is provided by the midwife. (Note: the midwife may discuss clinical situations with a midwifery colleague, medical practitioner, and/or health care provider, but this is not indicated).

4.2.1 It is the midwife's responsibility to initiate a discussion with the woman at the commencement of care to seek clinically relevant information, understand the woman's needs and preferences, and plan ongoing care.

4.2.2 The discussion with the woman, including the exchange of information and/or any advice regarding the ongoing plan must be clearly documented.

8. Available at https://www.nursingmidwiferyboard.gov.au/ codes-guidelines-statements/frameworks.aspx

4.2.3 The midwife may choose to discuss clinical situations with a midwifery colleague, medical practitioner, and/or health care provider, but this is not indicated. Such a discussion does not transfer the responsibility for care. Any discussion had should be clearly documented.

4.3 Consult

Table 4.3: Level B - Consult

LEVEL	DESCRIPTION	GUIDANCE
B	Consult	Consult with a relevant medical practitioner or other health care provider.

4.3.1 Following a discussion with the woman about the need for consultation and the woman offering informed consent, it is the midwife's responsibility to initiate consultation with a medical practitioner (or other health care provider), as indicated. The midwife must clearly communicate and document the indication(s) that require consultation with a relevant medical practitioner or other health care provider.

4.3.2 If the woman declines consultation, the midwife must follow the 'ACM position statement about caring for women who make choices outside professional advice' (See appendix B) and where necessary, seek additional professional advice (legal or otherwise).

4.3.3 A consultation with a medical practitioner or other health care provider may be:

a) Via a 'face to face' assessment with the woman specific to the indication for consultation, OR

b) Between the midwife and the medical practitioner (or other health care provider) where the woman is unable or chooses not to attend. In this situation, the consultation is undertaken by the midwife, on behalf of the woman.

4.3.4 The consultation may occur:

a) in person

b) by telephone

c) by telehealth

d) by other electronic means, OR

e) a combination of any of the above.

4.3.6 The outcome of the consultation must be documented in the woman's handheld pregnancy record, clinical notes and/or via electronic means as determined by local policy or protocol.

4.3.7 Seeking consultation per the Guidelines does not automatically transfer the midwife's responsibility of care to the health professional who has been consulted.

4.3.8 The midwife will continue to provide maternity care to the woman and coordinate such care in consultation with the medical practitioner and/or other health care provider.

4.3.9 Where consultation occurs, the ongoing responsibilities of the midwife, medical practitioner and/or other health care providers, including how they will collaborate with the woman and among each other, must be discussed.

4.3.10 If the medical practitioner's assessment of the clinical issue or situation is such that the woman's ongoing care requires responsibility to be transferred to the medical professional, the woman will be included in all discussions and provide informed consent prior to the transfer of care. The midwife will remain a key member of the multidisciplinary health care team where referral is indicated.

4.4 Refer

Table 4.4: Level C - Refer

LEVEL	DESCRIPTION	GUIDANCE
C	Refer	Refer a woman and/or her baby to a relevant medical practitioner or other health care provider.

4.4.1 When maternity care is referred (either permanently or temporarily) from the midwife to a medical practitioner, that medical practitioner, in consultation with the woman, assumes responsibility for maternity care.

4.4.2 The woman must provide informed consent prior to any transfer of care. This will include a discussion about appropriate timing, nature of the transfer, ongoing involvement of the midwife in providing midwifery care and the possibility of care being transferred back to the midwife where the clinical condition(s) permit.

4.4.3 The midwife will continue to provide midwifery care for the woman, working in partnership and collaboration with the medical practitioner and other members of the multidisciplinary team, even in the event that a medical practitioner (or other health care provider) assumes primary responsibility for the care of the woman.

4.4.4 If the indication or reason for referral is resolved, the woman may be referred back to the midwife, for ongoing maternity care. This will be following a discussion with the woman and only after her informed consent.

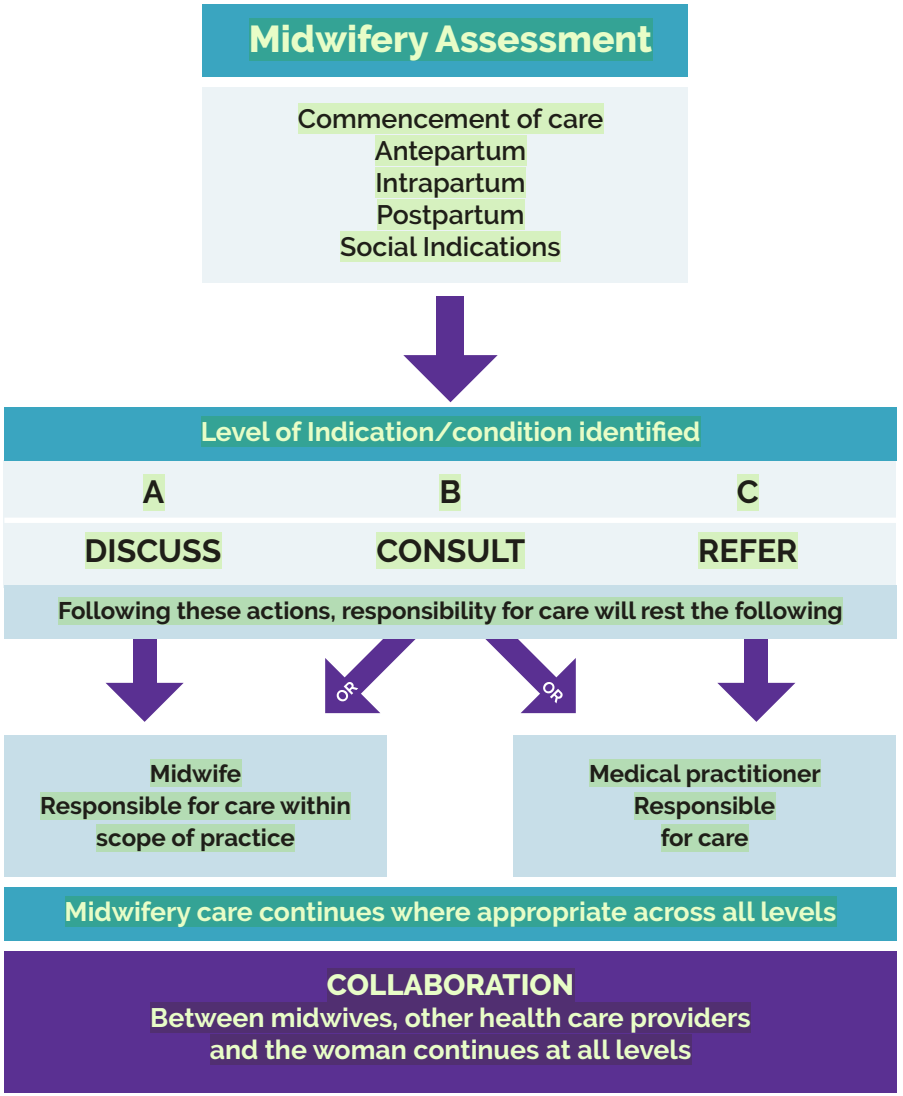
4.4.5 The outcome of the referral must be documented in the woman's handheld pregnancy record, clinical notes and/or via electronic means as determined by local policy or protocol.

Regardless of the nature or level of discussion, consultation or referral, communication between members of the multidisciplinary team about changes to care plans should always include the woman and be clearly documented and communicated to all parties involved.

Table 4.4 Summary of levels and associate care provider responsibilities

LEVEL	DESCRIPTION	CARE PROVIDER WITH PRIMARY RESPONSIBILITY
A/A*	Discuss	The midwife assumes primary responsibility for the maternity care of the woman. (Note: the midwife may discuss clinical situations with a midwifery colleague, medical practitioner, and/or health care provider, but this is not indicated).
B	Consult	The midwife will consult with a medical practitioner or other health care provider as indicated but only after the woman has provided consent. The indications for consultation will be reviewed and evaluated and used to inform the provision of care. The midwife will continue to provide midwifery care to the woman in collaboration with the medical practitioner or other health care provider(s). Roles and responsibilities of all involved in the woman's care will be discussed. The woman will be involved in all discussions where possible.
C	Refer	The midwife will refer the woman's care to a medical practitioner or other health care provider as indicated but only after the woman has provided consent. The indications for referral will be reviewed and evaluated and used to inform the provision of care. Responsibility of care may be transferred to the medical practitioner. Where appropriate, the midwife will continue to provide midwifery care. Care may be transferred back to the midwife where the woman's condition permits.

5 HOW TO USE THESE GUIDELINES



6 INDICATIONS AT THE COMMENCEMENT OF CARE

6.1 Medical Conditions

6.1.1	**Anaesthetic considerations**	
	Malignant hyperthermia	C
	Neuromuscular disease or family history	B
	Difficult or unsuccessful epidural	C
	Difficult intubation	B
	Body Mass Index (BMI)	
	Identified bariatric habitus (BMI > 40) or BMI >35 with co-morbidity (heart disease, hypertension, sleep apnoea)	C
	Body mass index (>35 but <40 with no associated co-morbidity)	B
6.1.2	**Autoimmune conditions**	
	Periarteritis nodosa	C
	Scleroderma	C
	Rheumatoid arthritis	C
	Sjrgen's syndrome	C
	Connective tissue autoimmune disease if inactive	B
	Connective tissue autoimmune disease active	C
	Other autoimmune disease	B/C
6.1.3	**Cardiovascular disease**	
	Arrhythmia/palpations; murmurs: recurrent, persistent	C
	Cardiac valve disease	C
	Cardiac valve replacement	C
	Cardiomyopathy	C
	Congenital cardiac disease	C
	Hypertension	C
	Ischaemic heart disease	C
	Rheumatic heart disease	C
	Pulmonary hypertension	C

	Other cardiac disease	B/C
6.1.4	**Dermatological diseases requiring systemic therapy**	B
6.1.5	**Drug dependence or misuse**	
	Alcohol dependency	B/C
	Illicit or prescribed drug dependency	B/C
6.1.6	**Endocrine**	
	Addison's disease, Cushing's disease or other endocrine requiring treatment	C
	Pre-existing Type I and Type II diabetes	C
	Newly diagnosed Type I and II diabetes	C
	Gestational Diabetes Mellitus in a prior pregnancy (recommend early OGTT)	A
	Hypothyroidism – stable	B
	Hypothyroidism - unstable	C
	Other thyroid disease	B/C
6.1.7	**Gastro-intestinal and hepatobiliary**	
	Inflammatory Bowel Disease including ulcerative colitis and Crohn's disease	C
	Cholelithiasis	A
	Cholestasis	C
	Gastric banding/sleeve	B
	Gastric bypass surgery	C
	Other bariatric surgery including abdominoplasty/ cosmetic surgery	B
	Unexplained weight loss prior to pregnancy	C
	Other gastro-intestinal disease	B
6.1.8	**Genetic conditions**	B
6.1.9	**Haematological**	
	Anaemia at the commencement of care Hb <90g/L	B
	Haemolytic anaemia	C
	Megaloblastic anaemia	B
	Other anaemia	B/C
	Von Willebrand's Disease	C
	Other coagulation disorders	C
	Sickle cell conditions	C
	Thalassaemia	C
	Other haemoglobinopathies	B/C
	Rhesus antibodies	C
	Rhesus negative requiring anti-D	A*/B
	Other antibodies detected	B/C
	Thrombocytopenia <150 (x109/L)	C
	Previous history of Deep Vein Thrombosis (DVT) or Pulmonary Embolism in a prior pregnancy	B
	Acute or current Deep Vein Thrombosis or Pulmonary Embolism	C
	Thrombo-embolic process - family history or underlying pathology	C
	Thrombophilia including: • Anti-phospholipid antibodies and hereditary thrombophilia other than MTHFR mutation (heterozygous) • No previous obstetric complications or maternal thrombosis • On warfarin, previous obstetric complications or maternal thrombosis	C
	Thrombophilia – MTHFR mutation (heterozygous)	B
	Women declining the use of blood products *Note: Please use Appendix B*	B/C
6.1.10	**Infectious Diseases**	
	Hepatitis B with positive serology (HBsAg+)	C

	Hepatitis C	B
	Cytomegalovirus	C
	Previous GBS positive neonate	B
	Chlamydia	A*/B
	Genital herpes – primary infection	B
	Genital herpes – recurrent infection	A*/B
	Syphilis – positive serology and treated	A/B
	Syphilis – positive serology and not yet treated	C
	Trichomoniasis	A*/B
	Gonorrhoea	B
	Human Papilloma Virus (HPV)	A/B
	HIV infection	C
	Listeriosis	B
	Toxoplasmosis – acute infection in first trimester	C
	Parasitic infection	A/B
	Rubella	C
	Varicella/zoster virus – current infection	C
	Tuberculosis - active	C
	Tuberculosis – past history and treated	B
	Hepatitis A/B/C/D/E	A/B/C
	History of pre-pregnancy • Cytomegalovirus • Rubella • Parvovirus • Toxoplasmosis • Varicella	A
	Identified public health concerns e.g., Influenza H1N1, SARS-CoV-2 COVID-19	C
	Other infection	B
6.1.11	**Malignancy – history or current**	**C**
6.1.12	**Maternal Age**	
	<16 years	B
	>40 years	B
	First pregnancy and >40 years	B
6.1.13	**Neurological**	
	AV malformations	C
	Bell's palsy	A
	Epilepsy with medication or seizure in the past 12 months	C
	Epilepsy – past history or without medication and no seizures in the past 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
6.1.14	**Organ transplants**	C
6.1.15	**History of or pre-existing psychological or perinatal mental health concerns**	
	Edinburgh Postnatal Depression Scale (EPDS) >12	B
	EPDS – positive response to self-harm question (Q10)	B/C
	Pre-existing psychiatric condition requiring medications	B
	Pica	B
6.1.16	**Renal Function Disorders**	
	Renal function disorder with or without dialysis	C
	Glomerulonephritis	C
	Pyelitis	B
	Previous kidney surgery (potential to impair kidney function during pregnancy)	C

	Urinary tract infections (UTI) - current	A/A*/B
	UTI – past history of recurrent	A/B
	Other renal	B
6.1.17	**Respiratory Disease**	
	Asthma well controlled	A
	Asthma partly controlled	B
	Asthma poorly controlled	B/C
	H1N1	C
	Severe lung function disorder	C
	Sarcoidosis	C
	History of Covid-19 (history of past infection)	B
	Cystic fibrosis	C
	Smoking at first antenatal appointment	B
6.1.18	**Skeletal Problems**	
	History of developmental skeletal disorders	B
	Osteogenesis imperfecta	B/C
	Scheuermann's disease	B/C
	Scoliosis without rods	B
	Scoliosis with rods	C
	Spondylolisthesis	B/C
	History of pelvic fracture and/or surgery	B
	History spinal injury and/or surgery	B
6.1.19	**System, connective tissue diseases or other systemic and rare disorders (also see 6.1.2 & 6.1.8)**	
	Marfan's syndrome	C
	Raynaud's disease	C
	Other systematic or rare disorders	C
	Genetic conditions	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/Cutting (FGM/C)**	B
6.2.3	**Fibroids**	B
6.2.4	**Intrauterine contraceptive device (IUD) in situ**	B/C
6.2.5	**Assisted reproduction or fertility treatment**	
	Fertility medications – FSH, Clomid	A/B
	Assisted Reproductive Technology (ART) - IUI	A
	Assisted Reproductive Technology (ART) - IVF	B
6.2.6	**Pelvic deformities (trauma, symphysis rupture, rachitis)**	B
6.2.7	**Pelvic floor reconstruction**	B
	Colpo-suspension following prolapse, fistula and/or previous rupture	C
6.2.8	**Uterine abnormalities**	
	Myomectomy or hysterotomy	C
	Bicornuate/unicornuate uterus	C
	Other congenital reproductive tract anomaly e.g., vaginal septum	C

Previous maternity history

6.3 Antenatal

6.3.1	**ABO-incompatibility**	B
6.3.2	**Active blood incompatibility**	
	Anti-red cell antibodies (Rh, Kell, Duffy, Kidd)	C
	Anti-platelet antibodies (neonatal alloimmune thrombocytopenia- NAIT)	C
6.3.3	**Autoimmune thrombocytopenia**	C
6.3.4	**Cardiac issues**	B/C
6.3.5	**Cervical weakness**	C
	History of cervical cerclage	C
6.3.6	**Endocrine**	
	Gestational diabetes – diet controlled	B
	Gestational diabetes – uncontrolled +/- medication	B/C
6.3.7	**Fetal**	
	Small for gestational age (SGA)	B
	Large for gestational age (LGA)	B
	Fetal growth restriction (FGR) - <10th centile	B
	Macrosomia - >4500g	B
	Intrauterine fetal demise (IUFD)	B/C
	Rhesus isoimmunisation	C
6.3.8	**Grandmultiparity ≥5**	B
6.3.9	**Haematological conditions**	
6.3.10	**Hypertension**	
	Chronic hypertension	B/C
	Gestational/pregnancy-induced hypertension	B
	Pre-eclampsia	B
	Severe eclampsia	C
	Eclampsia	C
	HELPP syndrome	C
6.3.11	**Obstetric cholestasis**	B/C
6.3.12	**Placenta**	
	Abruption	B
	Accreta, increta, percreta	C
	Manual removal	B/C
6.3.13	**Preterm labour/birth**	
	History of threatened preterm labour	B
	History of preterm prelabour rupture of membranes +/- preterm birth	B
	History of preterm birth	B/C
6.3.14	**Recurrent miscarriage** 3 or more first trimester	B
6.3.15	**Symphysis pubis dysfunction**	A
6.3.16	**Termination of pregnancy**	
	>3	B
	Termination of pregnancy for genetic/congenital reasons	C
6.3.17	**Trophoblastic disease** Hydatidiform or vesicular mole	C

6.4 Intrapartum

6.4.1	**Caesarean section**	
	Classical/midline incision	B/C
	T incision	B/C
	Lower segment caesarean section	B
	Two or more previous caesarean sections (no history of vaginal birth)	B/C
	Two or more previous caesarean sections (history of vaginal birth/successful VBAC)	B/C
6.4.2	**Forceps or vacuum birth**	A/B
6.4.3	**Maternal collapse**	C
6.4.4	**Other significant obstetric event**	A/B/C
6.4.5	**Perineal or other laceration**	
	Third or fourth degree perineal laceration – functional recovery	B
	Third or fourth degree tear – persistent pelvic floor or other dysfunction	C
	Cervical laceration	B/C
	Episiotomy – midline, bilateral, with extension	A/B/C
6.4.6	**Postpartum haemorrhage**	
	>500mL, non-symptomatic, no treatment	B
	Minor 500-1000mL, symptomatic +/- additional treatment	B/C
	Major 1000-2000mL +/- treatment +/- HDU admission	C
	Severe >2000mL +/- HDU admission +/- massive transfusion	C
6.4.7	**Shoulder dystocia**	B
6.4.8	**Vulval or perineal haematoma requiring surgical treatment**	A/B

6.5 Postpartum

6.5.1	**Pelvic floor dysfunction**	
	Dyspareunia	B/C
	Faecal incontinence	B/C
	Urinary incontinence	B/C

6.6 Neonatal

6.6.1	**Congenital and/or hereditary disorder of a previous child**	B
6.6.2	**Infection**	
	GBS infection in neonate	B
	Neonate with other infection requiring admission	B/C
6.6.3	**Neonatal asphyxia** APGAR <7 at 5 mins	B
6.6.4	**Stillbirth or neonatal loss**	B/C

6.7 History of psychological or mental health

6.7.1	**Perinatal mental health concerns**	
	Antenatal depression and/or anxiety	B
	Postnatal depression	A/B/C
	Puerperal psychosis	C
	Other significant perinatal mental illness	A/B/C

6.8 Other considerations

6.8.1	**Breast implants**	A/B
6.8.2	**Breast reduction surgery**	A/B
6.8.3	**Consanguineous relationship**	B
6.8.4	**Identified dental health concerns**	A/B

7 CLINICAL INDICATIONS DEVELOPED OR IDENTIFIED DURING THE ANTEPARTUM PERIOD

7.1.1	**Cardiac**	
	Palpitations	A/B
	Palpitations – prolonged, symptomatic or associated with significant symptoms	B/C
	New onset cardiac conditions	C
7.1.2	**Cervical Weakness**	**B/C**
	Cervical shortening <25mm	B
	Cervical shortening with risk factors for preterm birth	C
	Preterm cervical dilation	C
7.1.3	**Cervix cytology abnormalities**	**A/B/C**
	Human Papilloma Virus (HPV) positive (not type 16/18) with liquid-based cytology (LBC) or possible or low-grade squamous intraepithelial lesion (pLSIL/LSIL)	A
	HPV positive (not type 16/18) with LBC, possible or confirmed high grade squamous intraepithelial lesion (pHSIL/HSIL) or any glandular abnormality in pregnancy	B
	HPV positive (type 16/18) in pregnancy	B
	Evidence of invasive disease	C
7.1.4	**Clinical discrepancies with symphysio-fundal height (SFH), fetal growth and/or amniotic fluid**	
	Discrepancy with SFH (the SFH for a normally growing baby will match the number of weeks of pregnancy plus or minus 3 centimetres)	A*, A/B
	Risk factors for FGR or unsuitable for assessment by SFH	A*, A/B
	LGA with no other risk factors	A
	LGA with risk factors (e.g., diabetes, previous shoulder dystocia)	B
	Macrosomia (>4000g or 90th centile)	C
	Small for gestational age (SGA) with normal liquor and dopplers	A/B
	Fetal growth restriction (FGR)	B/C
	FGR with concerning features e.g., oligohydramnios, abnormal umbilical doppler)	C
	Polyhydramnios (mild) - defined as >24cm AFI or >7cm deepest (maximal) vertical pocket (DVP)	B
	Polyhydramnios (severe) – defined as >34cm AFI or >15 DVP	C
	Oligohydramnios	C
7.1.5	**Ectopic Pregnancy**	C
7.1.6	**Endocrine**	
	Gestational diabetes - diet-controlled	B
	Gestational diabetes – uncontrolled and/or requiring medication	C
	Subclinical hypothyroidism	A
	Hypothyroidism	B
	Hyperthyroidism	B
	Pre-existing endocrine disorder Including Addison's disease, Cushing's disease	B
	New diagnosis in pregnancy	C
7.1.7	**Fetal anomaly**	A/B/C
7.1.8	**Fetal movements Changes in pattern, frequency and strength**	A*, A/B
7.1.9	**Fibroids**	B
7.1.10	**Gastro-intestinal and hepatobiliary**	
	Cholecystitis or binary colic	B
	Obstetric cholestasis	C
	Hepatitis B or C (positive serology)	B

	Acute hepatitis or jaundice	B
	Inflammatory bowel disease	B
	Appendicitis	C
	Acute abdominal pain (suspected cause not related to pregnancy)	B
	Other acute presentation (gastrointestinal/hepatobiliary)	B
7.1.11	**Haematological**	
	Iron-deficiency anaemia • Hb >110 g/L and Ferritin ≤30 mcg/L • Hb 70-110 g/L and Ferritin ≤30 mcg/L	B
	Anaemia • Hb 70-110 g/L and Ferritin >30 mcg/L • Hb 70-110 g/L and MCV ≥ 100 fL	B/C
	Severe anaemia • Hb <70 g/L +/- MCV ≥ 100 fL	C
	Megaloblastic anaemia	B
	Other anaemia	B
	Blood group incompatibility	C
	Blood group antibodies	B
	Coagulation disorders	B/C
	Mean corpuscular volume (MCV) <80	B
	Rhesus negative requiring anti-D	A/B
	Pulmonary embolism	C
	Thrombosis or thrombophilia	C
	Thrombocytopenia	
	<150 X 109/L but >100 x 109/L	B
	<100 x 109/L	C
7.1.12	**Hernia nuclei pulpsi (slipped disc)**	B
7.1.13	**Hyperemesis Gravidarum**	B

7.1.14	**Hypertension**	
	Chronic hypertension <20 weeks	B/C
	Gestational hypertension >20 weeks	B/C
	Pre-eclampsia • BP of > 140/90 and/or relative rise of >30/15mmHg from BP at commencement of care With one or more of the following: • Proteinuria >0.3g/24 hours; or protein/creatine ratio >30mg/mmol or 2+ protein on dipstick testing • Platelets <150 X 109/L • Abnormal renal or liver function • Imminent eclampsia	C
	Eclampsia	C
	Any type with proteinuria (>2+ or >0.3g/24hrs)	C
	HELLP syndrome	C
7.1.15	**Induction of labour**	B/C
	Membrane sweep	A
7.1.16	**Infectious disease**	
	Chlamydia	A*/B
	Cytomegalovirus	
	Primary infection	C
	Recurrent infection	B
	GBS infection	A/B
	Genital herpes	
	Herpes Simplex Virus Type 1 (HSV1) – active lesions in late pregnancy	C
	HSV2 – active lesions in late pregnancy	B
	HSV1 - primary infection	B/C
	HSV2 – primary infection	B/C
	Recurrent infection (Consider antivirals to begin at 36 weeks)	A*/B

	Gonorrhoea	B
	HIV infection	
	Newly diagnosed in pregnancy	C
	High viral load	C
	Low viral load	B
	Human Papilloma Virus (HPV)	A/B
	Listeriosis	
	Acquired in first or second trimester	B
	Acquired in third trimester	C
	Parvovirus	B
	Rubella	
	Primary infection	C
	Recurrent infection	B
	Syphilis	B/C
	Toxoplasmosis	
	Acute or recent infection in first trimester	C
	Acute infection in second or third trimester	B
	Tuberculosis	
	Active	B
	Past history and treated	B
	Varicella/Zoster virus infection	B
	Zika	B
	Other infection of no familiarity	B
7.1.17	**Intrauterine fetal demise**	C
7.1.18	**Malpresentation/non cephalic presentation at full term**	
	Breech presentation (refer for ECV at 36-37 weeks)	B
	Successful ECV	A/B
	Breech presentation – maternal choice to attempt vaginal birth	B/C
	Brow, face or shoulder presentation	B/C
	Unstable lie	B/C
7.1.19	**Multiple pregnancy**	C
7.1.20	**Neurological**	
	Migraines	B
	Carpal tunnel syndrome	A/B
	Stroke	C
	Cerebral venous thrombosis	C
	New onset of seizures	C
	Neuropathies or palsies	B/C
	Other neurological conditions first diagnosed in pregnancy	B
7.1.21	**No prior prenatal care (at full term)**	B
7.1.22	**Placental/cord indications**	
	Placental abruption	C
	Placenta accreta, increta or percreta	C
	Placenta praevia	C
	Vasa praevia	C
	Single umbilical artery	B
7.1.23	**Post-term or post-dates pregnancy**	
	Post-term pregnancy (≥42 completed weeks or 294 days)	B/C
	Post-dates pregnancy (41-42 completed weeks or 287 days)	A/B
7.1.24	**Preterm labour and/or birth**	B/C
	Threatened preterm labour	B
	Preterm labour <34 weeks	C
	Preterm labour >34 weeks	B/C

7.1.25	**Preterm prelabour rupture of membranes**	
	<34 weeks	B/C
	>34 weeks	B
7.1.26	**Psychological or perinatal mental health concerns (diagnosis in pregnancy)**	
	Antenatal depression and/or anxiety	B
	EPDS >12 OR positive response to Q10 self-harm during pregnancy (intention to self-harm)	B/C
	Mental health issue requiring medication	B
	Acute and unstable mental health concern	C
	Other significant perinatal mental illness	A/B/C
7.1.27	**Renal function disorders**	
	Haematuria	A/B
	Proteinuria (≥2)	B
	Urinary Tract Infections	A*/B
	Pyelonephritis	C
7.1.28	**Respiratory disease**	
	Asthma well controlled	A
	Asthma partly controlled	B
	Asthma poorly controlled	C
	Influenza (A or B)	B/C
	H1N1	C
	Pneumonia	C
	Severe lung function disorder	C
	Sarcoidosis	C
	COVID-19	C
7.1.29	**Sepsis**	C
7.1.30	**Surgery during pregnancy**	
	Minor surgery	B
	Major surgery	C
7.1.31	**Symphysis pubis dysfunction (pelvic instability)**	A
7.1.32	**Trophoblastic disease** Hydatidiform or vesicular mole	B/C
7.1.33	**Uncertain duration of pregnancy by amenorrhoea >20weeks**	B
7.1.34	**Vaginal blood loss**	
	Recurring loss prior to 12 weeks	A/B
	Recurring loss at or after 12 weeks	B
	Antepartum haemorrhage Also see 7.1.21	B/C

8 CLINICAL INDICATIONS DURING THE INTRAPARTUM PERIOD

8.1.1	**Amniotic fluid embolism**	C
8.1.2	**Artificial rupture/release of membranes (ARM)**	
	Induction of labour/augmentation with fetal head engaged	A/B
	Controlled ARM (non-engaged fetal head) Ensure immediate access to an emergency caesarean section	B
8.1.3	**Breech presentation**	
	Diagnosed prior to labour – maternal choice for vaginal birth	B/C
	Diagnosed during labour – vaginal birth	B/C
	Diagnosed during labour – caesarean section indicated	C
	Undiagnosed with good progress in labour, frank or complete breech	B/C
	Undiagnosed with delayed/stalled progress in labour, footling or kneeling breech	C
	Breech extraction	C
8.1.4	**Caesarean section**	C
8.1.5	**Cord prolapse or presentation**	C
8.1.6	**Fetal death during labour/stillbirth**	C
8.1.7	**GBS positive**	A/B
8.1.8	**Genital herpes (active late pregnancy or at labour onset)**	C
8.1.9	**Haemoglobin <110g/L in labour**	C
8.1.10	**Haemorrhage**	
	Intrapartum haemorrhage	
	Asymptomatic and/or <50mL	A/B
	Symptomatic and/or >50mL	C
	Postpartum haemorrhage	
	Estimated blood loss (EBL) <500mL and symptomatic	B
	EBL up to 1000mL and asymptomatic	A/B
	EBL >500ml and symptomatic	B
	EBL >1000ml and/or symptomatic	B/C
	EBL >2000mL +/- massive transfusion protocol	C
8.1.11	**Hypertension**	
	Gestational	B/C
	Pre-eclampsia	B/C
	Eclampsia	C
8.1.12	**Maternal collapse/shock**	C
8.1.13	**Maternal sepsis**	C
8.1.14	**Meconium stained liquor**	
	Non-significant (defined as pale green/yellow thin diluted non-particulate)	A/B
	Significant (defined as dark green or black that is tenacious, or any meconium stained liquor containing lumps of meconium)	B/C
8.1.15	**Multiple pregnancy**	C
8.1.16	**Non-vertex presentation other than breech** Including brow, face and shoulder	C
8.1.17	**Fetal monitoring**	
	Reassuring, normal, low probability of or unlikely risk of fetal compromise per cardiotocograph (CTG) trace	A
	Suspicious with abnormal features, possible fetal compromise per CTG trace	B
	Non-reassuring, pathological, likely fetal compromise per CTG trace	C
	Life-threatening CTG trace e.g., prolonged bradycardia, prolonged deceleration	C
8.1.18	**Induction of labour**	B/C
8.1.19	**Instrumental birth**	C

8. Clinical Indications During the Intrapartum Period *continuation*

8.1.20	**Maternal vital signs** Persistent deviation from normal including: • Bradycardia • Tachycardia • Hypertension • Hypotension • Tachypnoea • Pyrexia >38 (2 consecutive readings at least an hour apart)	B/C
8.1.21	**Newborn**	
	APGAR <7 @ 5 minutes	C
	Resuscitation indicated	B/C
	Cord avulsion	B/C
	Hypoglycaemia	A/B/C
	Meconium aspiration	B/C
	Respiratory distress	B/C
	Transient tachypnoea	B
	Suspected fetomaternal haemorrhage	C
8.1.22	**Oxytocin infusion**	
	Induction of labour	B
	Augmentation	B
	Indications other than induction of labour/augmentation e.g., PPH management	B/C
8.1.23	**Placental abruption and/or praevia (suspected or confirmed)**	C
	Preterm labour	
	<37 weeks but >34 weeks	B/C
	<34 weeks	C
8.1.24	**Prolonged labour** Consider ease of access and/or transfer to referral services	B/C
	Prolonged active first stage (>6cm dilated) • No cervical change in 4 hours • Nil descent of presenting part • Incoordinate contractions • Cessation or change in strength, duration and frequency of contractions • Deep transverse arrest	B/C
	Prolonged second stage - Nullipara • Birth is expected to occur within 3 hours • Refer after 2 hours if birth is not imminent	B/C
	Prolonged second stage – Multipara • Birth is expected to occur within 2 hours • Refer after 1 hour if birth is not imminent	B/C
8.1.25	**Regional Anaesthetic**	
	Epidural	B/C
	Spinal	C
8.1.26	**Retained placenta**	
	Physiological 3rd stage • >1 hour • Asymptomatic and/or • EBL <500mls	A/B
	Active management (following administration of oxytocic) • >30 minutes • No evidence of placental separation e.g., lengthening of cord, separation bleed	B/C
8.1.27	**Rupture of membranes**	
	Rupture of membranes at term >24 hours in the absence of abnormal fetal heart rate, meconium stained liquor, signs of infection as examples – expectant management (maternal choice)	B

	Rupture of membranes >24 hours associated with abnormal fetal heart rate, meconium stained liquor, signs of infection as examples	B/C
	Rupture of membranes with known GBS or previous history of baby with early-onset GBS	B/C
8.1.28	**Shoulder dystocia**	B/C
8.1.29	**Third or fourth degree perineal tear**	C
8.1.30	**Unengaged head in active labour**	
	Primipara	B
	Multipara	A/B
8.1.31	**Uterine inversion**	C
8.1.32	**Uterine rupture**	C
8.1.33	**Vasa praevia**	C

9 CLINICAL INDICATIONS DURING THE POSTPARTUM PERIOD

Postpartum/Postnatal from 1st hour post birth until 6 weeks post birth

9.1 Maternal

9.1.1	**Lactation**	
	Engorgement	A*, A/B
	Under supply	A*, A/B
	Over supply	A*, A/B
	Suppression	A*, A/B
9.1.2	**Hypertension**	
	Persistent hypertension	C
	Postpartum preeclampsia	C
	Postpartum eclampsia	C
9.1.3	**Incontinence**	
	Faecal	C
	Urinary	A/A*/B
9.1.4	**Psychological or perinatal mental health concerns**	
	History of antenatal depression/anxiety during pregnancy	A/B/C
	Postpartum blues	A
	Suspected/actual postnatal depression and/or anxiety	B/C
	Puerperal psychosis	C
	Psychological birth trauma	A/B/C
	Other serious psychological disturbance	C
9.1.5	**Post-dural headache**	C
9.1.6	**Postpartum haemorrhage**	
	Primary postpartum haemorrhage – dependent on symptoms and clinical condition	A/B/C
	Secondary postpartum haemorrhage - asymptomatic	B/C
	Secondary postpartum haemorrhage - symptomatic	C

9. Clinical Indications During the Postpartum Period *continuation*

9.1.7	**Prolapse**	
	Uterine	C
	Cystocele	C
	Rectocele	C
9.1.8	**Pulmonary embolism**	C
9.1.9	**Stroke**	C
9.1.10	**Substance use/misuse**	A/A*/ B/C
9.1.11	**Suspected or actual maternal infection**	
	Pyrexia >38˚C	A*/B
	Mastitis	A*/B
	Urinary tract infection	A/A*/B
	Pyelonephritis	B/C
	Wound infection – e.g., caesarean incision, perineal, episiotomy	B
	Suspected retained placenta	B/C
	Sepsis	C
9.1.12	**Thrombophlebitis or thromboembolism**	C

9.2 Newborn

Definition of newborn – birth to 28 days post birth

9.2.1	**Abnormal finding on newborn examination**	B
9.2.2	**Birth injury/trauma requiring investigation**	B/C
9.2.3	**Birth weight** • Use centile charts to gestation • <10th centile • >90th centile	C
9.2.4	**Congenital abnormalities**	C
9.2.5	**Failure to pass urine or meconium within 24 hours of birth**	A/B
9.2.6	**Failure to pass urine or meconium within 36 hours of birth**	B
9.2.7	**Faltering growth** Including: • Weight • Head circumference • Length • Feeding problems	A*, A/B
9.2.8	**Infection of umbilical stump site**	B
9.2.9	**Jaundice**	
	<24 hours or persistent >14 days	C
	>24 hours but <14 days	A/A*/B
9.2.10	**Cyanosis or pallor**	B/C
9.2.11	**Preterm birth <37 weeks**	B/C
9.2.12	**Seizure activity, observed or suspected**	C
9.2.13	**Temperature instability**	C
9.2.14	**Single umbilical artery**	A/A*/ B/C
9.2.15	**Neonatal abstinence syndrome/substance withdrawal**	B/C
9.2.16	**Vomiting** Green, bile stained Projectile Excessive	A*, A/B/C

10 SOCIAL INDICATIONS

10.1.1	**Adoption**	A/B
10.1.2	**Current or previous child protection concerns**	A*, A/B
10.1.3	**Family/domestic violence**	B
10.1.4	**Financial issues**	B
10.1.5	**Identified asylum seeker status**	A/B
10.1.6	**Identified homelessness**	A/B
10.1.7	**Identified migrant status**	A/B
10.1.8	**Identified refugee status**	A/B
10.1.9	**Incarceration**	A/B
10.1.10	**Lack of social support**	B
10.1.11	**Legal matters**	A/B
10.1.12	**Learning disabilities**	A/B
10.1.13	**Pregnancy during teenage years**	A/B
10.1.14	**Recent stressful event**	A/B
10.1.15	**Recent significant loss**	A/B
10.1.16	**Significant social isolation**	B
10.1.17	**Unemployment**	A/B
10.1.18	**Other identified vulnerabilities**	A/B/C

11 APPENDIX A:

WHEN A WOMAN CHOOSES CARE OUTSIDE THE ACM NATIONAL MIDWIFERY GUIDELINES FOR CONSULTATION AND REFERRAL[9]

The ACM respects and supports a woman's autonomy and right to make decisions regarding her care following consideration of her needs and beliefs, as well as the risks and benefits of any aspect of her care. 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.

Background

The 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 and informed 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 their ability to safely manage within their 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.[10, 11, 12, 13]

9. This document is designed to act as a guideline only. It is not meant to be prescriptive. You should seek advice from ACM, your insurer or your employer if you are still not sure how to proceed. This document was informed by the College of Midwives of Ontario 'When A Client Chooses Care Outside Midwifery Standards of Practice' January 1, 2014, Revised April 2016.
10. Nursing and Midwifery Board of Australia. (2018). Midwife Standards for Practice
11. International Confederation of Midwives. (2008). International Code of Ethics for Midwives
12. Nursing and Midwifery Board of Australia. (2018). Code of Conduct for Midwives
13. Nursing and Midwifery Board of Australia. (2020). Decision-making framework for nursing and midwifery

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. As part of that discussion, it is important to understand the woman's reasoning and the basis for her decision, and to explain why the woman's decision is inconsistent with the Guidelines. It is also 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.

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:
   - another midwife, and/or
   - 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 his/her:

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

In making the decision, the midwife should consider herself, the woman and her baby, the woman's nominated partner(s), family and friends, and other health professionals.

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 have or who may 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 that midwifery care is being discontinued.
b. Follow this discussion with written advice to the woman confirming the reasons why 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.

Again, it is important that all discussions and decisions are documented. In relation to any advice or referrals which are sent, these should be sent in such a way that the sending and receiving can be confirmed (such as by registered post).

When an emergency or issues arise in labour

If issues arise during labour or in urgent or emergency circumstances, the midwife is obliged to attend to 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:
   - Call an ambulance to facilitate the most timely transfer of care should the woman decide to change her decision.
   - With the woman's consent, notify the hospital receiving the transfer.
   - Attempt to access appropriate resources including by phone and from additional personnel.

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. Attempt to provide care within midwifery standards of practice, and otherwise 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).

12 APPENDIX B: RECORD OF UNDERSTANDING[14]

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)	

14. This form will be updated from time to time. For a copy of the most recent version of this form and the accompanying explanatory notes, go to www.midwives.org.au

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, values, 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)? Does this include benefits and risks of each option?
What questions/ concerns do you have?	
What is your understanding of the answers you have received to your questions or concerns?	With whom have you discussed the woman's care?

	Name	Date	Method
Midwife			
Medical Practitioner			
Other [state type]			

Did you discuss your maternity care option(s) with your midwife and/ or other care providers? Why/why not?	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
What is your understanding of those discussions?	
What questions do you have about your midwife's recommendations to you?	Following your discussions, what, if any, alternate care plan have you recommended to the woman?
	When was the woman advised of your recommendation? ___/___/___
	On what date have you agreed to further discuss the woman's decision about your recommendation? ___/___/___

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.[15]

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).
	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)

Date: ___/___/___

15. The ACM has been guided by the established principles of the Nursing and Midwifery Board of Australia, as well as 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.

13 APPENDIX B: 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 will communicate 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 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.

16. This sample letter is based on an example in Pairman S, Tracy SK, Thorogood C, Pincombe J. (2018). Midwifery: Preparation for Practice. p. 344-5.

SAMPLE referral letter

Date:
Obstetric Clinic/Hospital Address:

Dear Consultant

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

Thank you for seeing "Jennifer Jones" who is now ## 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.[16]

www.midwives.org.au