The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Excellence in Women's Health

Maternity Care in Australia

1st EDITION

A framework for a healthy new generation of Australians.

First published November 2017

Foreword

Maternity care is fundamental to good public health. A woman's wellbeing in pregnancy and the postnatal period is the single most important influence on future health of the child – and indeed following generations – as well as the health of the mother.

Women and their families have the right to expect the highest standards of maternity care. Because pregnancy and birth outcomes are of such a high standard in Australia it is easy to underestimate the enormous demands maternity care places on the health system.

This document aims to set out a framework for maternity care for all Australians that is safe, inclusive, fair, and effective. It deals with all aspects of care, from pre-pregnancy health through to the postnatal period. It puts the health of women and their babies at the centre of planning, as it should be.

Through collaboration, judgement and the highest standards of training and skill maintenance, we can provide the best possible start to life for all Australians.

Professor Steve Robson
President

Ms Alana Killen
Chief Executive Officer

Maternity Care in Australia

Key Points

1. Maternity care is fundamental to the health of society. It should be based on the best available evidence applied with the individual woman as its focus.
2. Women should expect appropriately informed choice in maternity care. Appropriately informed choice means that women must always be provided with all information relevant to their individual circumstances that could have a material effect on the pregnancy care and birth choices they have to make.
3. Collaboration between the health professionals caring for pregnant women is the key to optimising outcomes for women and their babies.
4. Women in rural and remote Australia have additional needs and planning for maternity services must take these into account.
5. Where comprehensive maternity services are not immediately available (for example, in rural and remote areas) women should be made aware of service limitations to allow informed choice regarding planned location of birth.
6. Aboriginal and Torres Strait Islander women have additional needs, and these are best met by an expansion of the Indigenous healthcare workforce and multidisciplinary involvement in planning of maternity care.
7. In addition to obstetricians (both specialist and GP) and midwives, staffing for maternity services must include GPs, anaesthetists, neonatal paediatricians, physicians, mental health professionals and theatre staff.
8. GPs play a vital role in maternity care. They are usually responsible for pre-pregnancy care, the first antenatal visit, shared antenatal care, postpartum management, and care of the newborn. Enhanced relationships with a GP during pregnancy care may have long-term benefits for the entire family.
9. Health practitioners at all stages of maternity care should be trained in the recognition and management (usually by referral) of mental health disorders and domestic abuse.

Contents

	Introduction	6
	Purpose and intended audience	7
1	Access to maternity care	8
2	Choice	9
3	Collaboration is key to excellent outcomes for women and their babies	10
3.1	Collaborative care	11
3.2	Guiding principles for effective collaborative care	11
4	The care of women in rural and remote Australia	12
4.1	Recognising the special nature of maternity care in rural and remote Australia	13
4.2	Caring for women in rural and remote Australia	13
4.3	The vital role of rural and remote GP obstetricians in the maternity care workforce	14
4.4	The role of rural and regional specialist obstetricians	14
4.5	Credentialing and standards of healthcare in rural and remote Australia	15
4.6	Key community issues in rural and remote communities in Australia	15
5	Pre-pregnancy care	16
5.1	The importance of pre-pregnancy care	16
5.2	Clinical assessment	17
5.3	Genetic and family history	17
5.4	Medication use	17
5.5	Vaccinations	17
5.6	Lifestyle changes	18
5.7	Folic acid and iodine supplementation	18
5.8	Smoking, alcohol and illicit drug cessation	18

5.9 Healthy environment 19
5.10 Investigations 19
6 Staffing for maternity services 20
6.1 Midwives 21
6.2 Obstetricians 21
6.3 Anaesthetists 21
6.4 Paediatricians 22
6.5 General Practitioners 22
6.6 Physicians 23
7 Maternity care for Aboriginal and Torres Strait Islander Women 24
7.1 Indigenous maternity workforce 24
7.2 Programs for the delivery of maternity care to Indigenous communities 24
8 Maternity units with service limitations 25
9 Recognising diversity and the importance of cultural competence 27
10 Training and maintenance of professional competence in maternity units 28
10.1 Inter-professional communication 29
11 Clinical governance of maternity services 30
11.1 Documentation and confidentiality 32
11.2 Infection prevention and control 32
12 Care during pregnancy 33
12.1 Care during early pregnancy 34
12.2 Maternity booking and planning of care 35
12.3 Managing pre-existing medical conditions in pregnancy, including mental health issues 36
12.4 Women at social disadvantage 38
12.5 Antenatal screening 39
12.6 Routine antenatal care 39
12.7 Women with specific pregnancy-related conditions 40
12.8 Care during birth 41
13 Care of the newborn 42
13.1 Routine care of the healthy newborn 44
13.2 Postnatal assessment and care of the mother 45
13.3 Infant feeding 46
13.4 Care of babies requiring additional support 47
13.5 Promoting healthy parent–infant relationships 48
13.6 Supporting the transition to parenthood 48
13.7 Supporting families who experience bereavement, pregnancy loss, stillbirth or early neonatal death 49
14 Homebirth 50

Closing remarks 51

Supporting references 52

Introduction

The best outcomes for women and their babies occur when maternity care is provided by health professionals working collaboratively. With each maternity care provider working to a common purpose – providing appropriate and high-quality care that meets each woman's changing needs – every woman can receive the 'right care in the right place at the right time, by the right person'.

Maternity services must be configured to allow all women in Australia, wherever they live and whatever their personal circumstances, access to the most complete range of services possible with minimal financial and other barriers. To achieve this, attention must be paid to Australia's wide ethnic diversity: all women should receive care that is culturally appropriate for them and their families.

Purpose and intended audience

This document aims to articulate a framework for the planning and provision of maternity services to ensure all Australian women have access to safe, effective, accessible and culturally appropriate maternity care.

The intended audiences are many and varied, and include, but are not limited to: health professionals involved in the provision of maternity care; patients and their families; all levels of Government; non-Government organisations with an interest in maternity care; organisations involved in developing standards for maternity care; relevant medical colleges; and, women's health advocacy groups.

1. Access to Maternity Care

All women must have access to maternity care that is culturally appropriate and personally acceptable. Maternity services should ideally provide informed choice, and where possible women should be involved in both the planning and monitoring of services for their communities.

Planning and provision of maternity services should be based on accurate and timely assessment of relevant factors such as:

- Geographic location;
- Likely demand for services;
- Availability of health infrastructure and support services;
- The available workforce;
- Links with tertiary hospital providers;
- Transport and accessibility; and
- Ability to cope with special needs, for example, access for women with physical, mental, sensory or learning disabilities.

Particular attention should be paid to the needs of Indigenous women, and women from disadvantaged, migrant or other minority groups.

2. Choice

Choice in maternity care is important and each woman must have access to appropriate information about the benefits and potential risks of each and every option as it applies in her individual case. Choice must also take into account the impact of decision-making on the provision of care to other women, especially where resources are limited.

Women should be offered balanced information on the full range of options available to them throughout pregnancy, birth, and the postnatal period. This information should include not only the different models of maternity care available locally, but should also cover choices such as antenatal screening tests, antenatal education and information about birth, postnatal care, and infant care and feeding.

Information about choice in maternity care must be provided in such a way that women can understand their individual risks and how they should be managed, since safe risk management underpins all maternity care.

It is important that women and their families are allowed enough time to consider their choices and to make decisions after reflecting upon the information they have received. They should be encouraged to seek additional information and advice as they require, and allowed to make a considered decision. Women who have been fully informed regarding a recommended course of action, and the potential consequences of not pursuing such management, should have their decisions respected.

3.
Collaboration is key to excellent outcomes for women and their babies

Collaborative maternity care should aim to promote active participation of different health disciplines in providing quality care that is tailored to meet each individual woman's needs prior to, during and after pregnancy.

3.1
Collaborative care

- Acknowledges the unique aspirations and values of women and their families.
- Recognises that obstetric risk is a continuum, and that dividing women into 'low' and 'high' risk pregnancy is misleading.
- Provides mechanisms for continuous communication between caregivers.
- Includes collaborative planning by the team of caregivers, and provides the opportunity for escalation or easing the level of care according to changing clinical circumstances.
- Recognises that continuity of care contributes to better pregnancy outcomes.
- Provides an opportunity for the woman and her partner to meet, at an early stage, members of the team responsible for their care in the event of complications that may arise.
- Facilitates caregiver participation in clinical decision-making within and across disciplines.
- Fosters mutual respect and trust for the contributions of all disciplines.
- Values regular and timely inter-professional meetings to audit and, thereby, improve outcomes of care.

3.2
Guiding principles for effective collaborative care

- Maternity carers should share values, goals and a vision that is woman centred.
- There should be mutual trust and respect for each profession's perspective and outlook.
- There should be open, honest, and unbiased communication with the woman, her partner or support person, and between all maternity carers.
- Women should be offered informed choice with opportunities for discussion with a range of professionals.
- Professional competence and continuing professional development must be mandated for all professional groups involved in care.
- Each profession must recognise the need for the highest standards of practice, and the ethical responsibility and accountability that this requires.
- There is a clear understanding of each different profession's scope of practice.
- There is adherence to practice guidelines and an auditable standard.
- That protocols exist for clinical and administrative purposes that are regularly reviewed inter-professionally.
- That there is a willingness to devote time and energy to develop the collaborative model.
- That there is willingness to openly discuss and resolve differences.
- That there should be no disincentives to inter-professional referral within the collaborative team.
- That collaboration is structured so as to enhance inter-professional harmony rather than encouraging practice in isolated professional groups.
- That on occasions when members of the collaborative team differ in their vision for patient care, a defined team leader can facilitate resolution and achieve consensus to optimise the woman's care and promote continuing harmony within the team.

4.
The care of women in rural and remote Australia

Approximately one quarter of births occur in rural and remote areas of Australia. Given the geographic isolation of some women, provision of maternity services poses many challenges.

4.1
Recognising the special nature of maternity care in rural and remote Australia

The maternity care needs of women in rural and remote areas of Australia must be met within a context of competing social, political and financial priorities and, often, significant limitations in workforce availability.

In planning the location and nature of maternity services in rural and remote communities, there must be a clear understanding of the needs of women and their families. Each community should be assessed by taking into consideration local resources, rather than as a reactive response to a local crisis or as a matter of political expediency.

Planning must also account for the increasing cultural diversity and needs of rural Australia. Australia does not have a nationalised health service and so there will be changes in the availability of medical personnel and variations in population within rural communities. Steps must be taken to enhance the recruitment and support of new obstetricians, GP obstetricians and to avoid the early retirement of those winding down.

4.2
Caring for women in rural and remote Australia

Care for pregnant women in rural and remote Australia should be delivered **collaboratively** between specialists, GPs, midwives, Aboriginal health workers, and other recognised providers of healthcare. These groups should work together to support local maternity services: maternity care providers cannot act in isolation if optimal pregnancy outcomes are to be achieved.

Shared care arrangements between various members of the collaborating team should be encouraged, and should be well defined, according to locally agreed protocols and referral guidelines. Each maternity care service in rural and remote areas should establish assessment and referral criteria for pregnant women and newborn babies. Each woman should be assessed individually and repeatedly throughout pregnancy.

Communities should be well informed about the level of maternity and anaesthetic care available locally, and how those services might change (for example, on weekends and when various staff may be unavailable), and how these services are supported at regional and tertiary levels. Women and their healthcare providers must be aware of the potential limitations on local services if unexpected complications arise during pregnancy.

Opportunities should exist for all the carers to be involved in interdisciplinary meetings by various means (for example, by video/teleconference) on a regular basis with a view to optimising the care of pregnant women and to critically appraise and review the outcomes of maternity services. This is a particular issue when maternity services have frequent rotations of locum staff.

Women in rural communities should have early access to skilled GP assessment and counselling: this must include pre-pregnancy counselling. Individual risk assessment and counselling, particularly with respect to early pregnancy screening tests, are important in helping women to make well-informed decisions about their ongoing care.

4.3
The vital role of rural and remote GP obstetricians in the maternity care workforce

In many rural and remote areas, GPs are key figures in the initiation and maintenance of maternity care services. They may also fulfil other essential community roles such as providing anaesthetic or paediatric services – the loss of a GP from a community may also mean the loss of anaesthetic and paediatric expertise.

Rural GP obstetricians must be involved in the development of maternity service policies, protocols and guidelines to ensure an appropriate level of care for women in their local area. Rural GPs practising obstetric and other procedural activities should be provided with the appropriate time and remuneration to fulfil their ongoing Continuing Professional Development (CPD) and for re-accreditation of hospital procedural clinical privileges. There must also be adequate relief for study and recreational purposes.

To help sustain a rural GP obstetrician workforce, conditions of employment should be balanced to reduce the disparity of work conditions between urban and rural and remote practitioners. Carefully considered on-call arrangements are essential to maintain safe working conditions and a sustainable work-life balance.

4.4
The role of rural and regional specialist obstetricians

Specialist obstetricians have key roles in provision of regional maternity services. Specialists in the rural and remote areas work with other healthcare providers including GPs, midwives, Aboriginal health providers and others approved by local health services. One of the most important roles for specialist obstetricians is to provide support for GP obstetricians and local hospitals and health services.

In addition to their clinical expertise, specialist obstetricians contribute to maternity services with roles in clinical leadership, education, training and clinical governance activities. These activities should be acknowledged by appropriate rostering whether they are employed or contractors.

To help sustain a rural specialist obstetrician workforce, conditions of employment should be balanced to reduce the disparity of work conditions between urban and rural and remote practitioners. Carefully considered on-call arrangements for specialist obstetricians are essential to maintain safe working conditions and a sustainable work-life balance. Appropriate remuneration for, and access to, CPD should also be provided: this should include provision for locum relief to allow access to CPD activities. Such specialist practice improvement activities are essential in maintaining a well skilled rural specialist workforce.

4.5
Credentialing and standards of healthcare in rural and remote Australia

All maternity healthcare providers should have appropriate accreditation and credentialing. Credentialing must designate a scope of clinical privileges for each maternity care provider, and this should be the subject of regular review.

All maternity healthcare providers should be involved in continuing education and CPD activities, and should undertake regular inter-professional training in relevant areas such as fetal surveillance education and management of obstetric emergencies.

Monitoring of the quality of maternity care provision is important, and should include the quality and equity of access for rural women to services provided by obstetricians, midwives, maternal and child health nurses, physiotherapists, audiologists, radiology and laboratory service providers and other allied health professionals, including dieticians and diabetic educators. Funding models should support the use of modern communication technology (for example, telemedicine and videoconferencing facilities) to assist in efficient and optimal management of the complex problems inherent in obstetrics, social and neonatal care.

4.6
Key community issues in rural and remote communities in Australia

Access to efficient emergency transport services is critical to provision of high-quality rural maternity services. Women who must relocate to access appropriate pregnancy or newborn care should have access to appropriate travel and accommodation assistance to minimise the burden imposed by the need for relocation. Where possible, the woman's partner should accompany her as an integral part of the transfer.

5. Pre-pregnancy care

5.1 The importance of pre-pregnancy care

Pre-pregnancy planning offers a unique opportunity for the health practitioner to educate a motivated patient in a spectrum of health-related topics that have benefits for the woman, her yet-to-be conceived child and future family.

All women planning a pregnancy are advised to consult their GP with a view to:

- Detecting and assessing any specific health problems, including mental health problems, in the woman or her partner that may be relevant so that these can be appropriately managed prior to pregnancy.
- Obtaining general advice about optimising personal healthcare and lifestyle with pregnancy in mind.

Other healthcare professionals – such as obstetricians, infertility specialists and midwives – may also be presented with a valuable opportunity to assess and counsel a woman before a planned pregnancy.

5.2
Clinical assessment

A detailed history and clinical examination, including an assessment of the outcomes of any previous pregnancies (such as pregnancy loss, preterm birth, and gestational diabetes), should be undertaken to determine whether any measures could reduce the recurrence risk.

An assessment of any medical problems, and a discussion of how they may affect a pregnancy, should be undertaken. Stabilisation of pre-existing medical conditions and assessment of mental health status prior to a pregnancy is necessary to optimise pregnancy outcomes. A heart and lung examination should be undertaken. Where serious medical and/or mental health conditions are known or thought to exist, multidisciplinary pre-pregnancy planning should be undertaken.

5.3
Genetic and family history

If there a high risk of chromosomal or genetic conditions based on the family history or ethnic background, then pre-pregnancy genetic testing and counselling may enable the couple to consider the relative merits of pre-implantation genetic diagnosis versus prenatal diagnosis in pregnancy.

A family history should be obtained routinely. If there is an increased chance of genetic conditions based on family history or ethnic background, pre-pregnancy genetic testing and/or counselling may be able to refine these chances. This affords a woman and her partner knowledge of the specific condition and choice should they wish to consider pre-implantation genetic diagnosis before pregnancy or prenatal diagnosis in an established pregnancy.

5.4
Medication use

It is important to review all current medications, including over-the-counter, complementary and alternative medicines, to assess their appropriateness amy possible interactions and teratogenic potential. Consideration may be given to changing medication prior to a pregnancy with a view to achieving the dual objectives of optimising disease control while minimising teratogenic risk.

5.5
Vaccinations

All women considering a pregnancy should be aware of their vaccination status and, if uncertain, liaise with their GP. Vaccination history for measles, mumps, rubella, varicella zoster, diphtheria, tetanus and pertussis should be checked and maintained according to established recommendations. Rubella and varicella immunisation should be considered for women with incomplete immunity. Women who are already pregnant should be offered immunisation against influenza and pertussis.

5.6
Lifestyle changes

A healthy, well-balanced diet is strongly recommended before, during and after pregnancy. Discussion regarding weight management is appropriate with counselling regarding over- or underweight. Obesity is now one of the commonest and most important risk factors for infertility and adverse pregnancy outcomes, and risks can manifest even before conception and implantation. Obesity has an adverse impact on the rates of miscarriage, stillbirth and fetal conditions. Further, obesity exposes the mother to an increased risk of many pregnancy and anaesthetic complications.

Active steps to manage obesity (diet, exercise and, where appropriate, consideration of bariatric surgery) prior to a pregnancy are worthwhile. A recommendation for moderate-intensity exercise and assessment of any nutritional deficiencies is appropriate.

5.7
Folic acid and iodine supplementation

Folic acid should be taken for a minimum of one month before conception and for the first three months of pregnancy to reduce the probability of neural tube defects (NTDs). The recommended dose of folic acid is at least 0.4mg daily. Where there is an increased probability of NTD (use of anticonvulsant medication, pre-pregnancy diabetes mellitus, previous child or family history of NTD), a 5mg daily dose should be used. A higher dose of folic acid should be considered in risk groups, such as those with a high BMI. Women should start a dietary supplementation of 150µg of iodine prior to a planned pregnancy or as soon as possible after finding out they are pregnant.

5.8
Smoking, alcohol and illicit drug cessation

Cigarette smoking and illegal drug use during pregnancy can have serious consequences for and should be stopped before conception. Paternal tobacco smoking pre-conception has been associated with sperm DNA damage and increased risk of malignancy in their children. Counselling and pharmacotherapy should be considered for either or both parents when relevant. Advice to women that there is no known safe level of alcohol consumption during pregnancy is appropriate. Alcohol avoidance immediately prior to conception and during pregnancy should be recommended.

For women who have significant difficulties with alcohol and other drugs, referral to specialist alcohol and other drugs (AOD) services is warranted. For women who are tobacco addicted, referral to Quit programs is recommended.

5.9
Healthy environment

Assessment of the risk of exposure to toxins or radiation in the household, workplace or at recreational activities, including discussion to minimise the exposure, is worthwhile.

5.10
Investigations

Further assessment should be guided by the findings on history and examination. Patients should receive advice with respect to where and when to attend in early pregnancy and may wish to have their options of antenatal care discussed.

6. Staffing for maternity services

High-quality maternity services rely on having an appropriate workforce with the leadership, skill mix and competencies to provide excellent care. Medical, midwifery, and ancillary staffing levels must be appropriate to the clinical demand.
Providers of maternity services should ensure that:

- Clinical care and treatment are carried out under supervision and leadership.
- All clinicians participate in continuing professional development and maintain knowledge and skills relevant to their clinical work, as well as improving and updating their skills as required.
- Clinicians participate in regular multidisciplinary clinical audit and reviews of clinical services including outcomes.

Complex intrapartum cases require integrated, multi-professional specialist management and direct consultant involvement. All maternity units should have an obstetrician or GP obstetrician with primary administrative responsibility for the service.

6.1 Midwives

Maternity services should aim to develop the capacity for women to receive one-to-one midwifery care during pregnancy. There has been a major expansion in the availability of Midwifery Group Practice (MGP) models of care in all Australian states and territories in the last five years, and this is likely to continue. These models aim to provide antenatal, intrapartum and postnatal care by known carers. It is essential that each MGP develops close collaborative links with the supporting obstetric team, and that there be no barriers to timely referral should complications outside the midwife's scope of practice arise. Adherence to agreed guidelines for referral from midwife to obstetrician should be mandatory.

For women who are not suitable for, or choose not to access, MGP care, it is essential that there is a well-trained and experienced cohort of midwives to provide antenatal, intrapartum and postnatal care.

An obstetrician (specialist or GP), or obstetric trainee under supervision, must be contacted whenever a woman's condition gives rise for concern. There should be clear protocols, procedures and clinical guidelines for such interdisciplinary referral.

6.2 Obstetricians

All maternity units must have a designated lead obstetrician. Women with risk factors in pregnancy should be seen by an obstetrician (specialist or GP) or obstetric trainee under supervision. An obstetrician should be available within 30 minutes outside the hours of consultant presence and must attend in a timely manner whenever requested. Complicated births in obstetric units should be attended by the obstetrician or obstetric trainee, with a degree of supervision commensurate with training and expertise.

6.3 Anaesthetists

Anaesthetists provide care at more than half of all births in Australia. An anaesthetic service (specialist or GP) must be available during labour and birth. Maternity services must nominate a designated lead anaesthetist (specialist or GP) with responsibility for the organisation and management of the obstetric anaesthetic service. A duty anaesthetist (specialist or GP) of appropriate competence must be available in a timely manner, and the anaesthetic team's response time must be such that a caesarean section may be started within a time appropriate to the clinical condition. This will require good communication channels and requires all team members to be informed of the case appropriately. We refer readers to the Joint RANZCOG/ANZCA *Position statement on the provision of Obstetric Anaesthesia and Analgesia Services* (WPI 14) and the ANZCA guidelines PS03 *Guidelines for the Management of Major Regional Analgesia* for further specific information relating to anaesthesia.

6.4
Paediatricians

Obstetric units must ensure 24-hour timely availability of a paediatrician (specialist or GP) trained and competent in neonatal advanced life support. Maternity services must nominate a designated lead paediatrician (specialist or GP) with responsibility for the organisation and management of the neonatal paediatric service. Units should ensure that there are guidelines concerning the circumstances in which senior neonatal staff should attend preterm deliveries.

6.5
General Practitioners

GPs have a pivotal role in the care of women and their families.

a. Pre-pregnancy care

Regardless of whether the GP has a special interest in obstetrics, he or she will mostly be responsible for the delivery of pregnancy care as specified elsewhere in this document. This has important implications for both the undergraduate and postgraduate education of the medical workforce. Every GP must consider family planning &/or pre-pregnancy planning in any consultations with women of child-bearing age.

b. The first pregnancy consultation with a health practitioner

Almost inevitably, the first consultation in pregnancy will be with the woman's GP. Given the increasing complexities of first trimester care, particularly with respect to genetic counselling, this emphasises the considerable responsibility that all GPs have in the care of pregnant women. These initial consultations will usually achieve the following:

- Confirm a viable pregnancy or initiate measures to do so;
- Accurately date the pregnancy;
- Perform a heart and lung examination;
- Screen for relevant complicating factors including recommending relevant investigations (including offering genetic screening tests, undertaking mental health screening);
- Initial management of early pregnancy complications such as morning sickness; and
- Provide general advice of relevance to a pregnant woman, including nutrition, vaccination, listeria risk, exercise, sexual activity, employment issues, medications and vitamin and other supplementation.

After performing the above assessment, the practitioner should discuss appropriate alternative models of care and arrange for timely access to the chosen model.

c. The important role of GP shared care in the delivery of maternity care

GPs have long supported their hospital maternity colleagues in a joint arrangement for the delivery of antenatal care. GP visits cement continuity of care, while ensuring institutional resources are used for secondary care. More importantly, it provides the woman with a convenient and familiar provider of antenatal care.
To facilitate this process, there should be:

- Clear hospital or health service guidelines regarding suitability of women to undertake shared care with her GP; and
- Established pathways of communication between the GP, the patient and the maternity service.

d. Pregnancy as a unique opportunity for the GP to advance preventative healthcare and social health for both the woman and her family

Through antenatal care women have the opportunity to enhance the relationship with their GPs. During antenatal visits women are likely to be particularly receptive to relevant advice in preventative medicine including nutrition, vaccination and exercise. This has implications not only for the pregnancy but also the future health of both the woman and her family.

6.6
Physicians

Endocrinologists and obstetric physicians play a role in the care of pregnant women with conditions such a thyroid disorders or diabetes during pregnancy, or those with gestational diabetes mellitus (GDM). In women with these conditions, physicians (and diabetes educators) are key contributors to the multidisciplinary team.

7. Maternity Care for Aboriginal and Torres Strait Islander Women

7.1 Indigenous maternity workforce

There remains a serious shortage of Indigenous specialists across all disciplines. The role of the Aboriginal and Torres Strait Islander health workers is crucial to improving health outcomes of Aboriginal and Torres Strait Islander people. Aboriginal and Torres Strait Islander health workers and Aboriginal medical services are critical to the provision of safe and appropriate maternity care to Aboriginal and Torres Strait Islander women.

7.2 Programs for the delivery of maternity care to Indigenous communities

It is imperative that multidisciplinary discussion along with community consultation takes place before such programs are instituted. Above all, involvement of Indigenous obstetricians and midwives enables their professional expertise to be blended with the needs of the communities.

8.
Maternity units with service limitations

Good maternity care relies upon inter-agency collaboration, with a full range of services for all pre-existing or developing health or social needs of the mother and baby.

This requires links between health and social care and provision within maternity and neonatal care networks that have the capacity to meet demand. In locations where intrapartum support services are not immediately available, the woman and her family should be informed about those service limitations to allow an informed choice regarding planned place of birth.

Maternity services that do not have access to adult intensive care facilities, advanced imaging, cardiology and blood transfusion services must have protocols in place for the care of women with significant medical or obstetric illness. Maternity services that do not have appropriate level neonatal services should have defined arrangements for both in utero transfer and the transfer of a recently delivered mother and her newborn baby to a linked secondary or tertiary unit.

9. Recognising diversity and the importance of cultural competence

Ideally, providers of maternity care should come from diverse backgrounds. All healthcare providers must recognise and respect the diversity of ethnic, religious, social and cultural values and beliefs of the women for whom they care.

Cultural competency should underpin the reciprocal relationship between service provision and meeting the cultural needs of women. All maternity services and individual clinicians must place a high priority on cultural competency, and the principles and policies that promote effective performance in diverse circumstances. Maternity care organisations should strive to educate, support and empower:

- Recognition of the importance of reciprocal trust between healthcare provider and patient;
- Recognition that a woman's cultural background may influence their understanding, assimilation, and acceptance of health information and behaviour; and
- Recognition that by giving women and their families the ability to make informed choices better outcomes can be achieved for health services, healthcare providers and most importantly women themselves, irrespective of the cultural background of any person involved.

10. Training and maintenance of professional competence in maternity units

All maternity services are responsible for ensuring the provision of a skilled workforce of confident and competent practitioners, working in multidisciplinary teams to maximise the quality of care. Individual members of the team are responsible for developing and maintaining their knowledge and skills through training and continued professional development.

Doctors and midwives working with women in the pre-pregnancy and antenatal period should be competent in recognising, advising, and referring women who would benefit from more specialist service. They must be competent to assist women in considering their options for antenatal, birth and postnatal care, and the clinical risks and benefits involved.

Doctors and midwives should participate in a program of Continuing Professional Development that includes:

- Early identification and appropriate management and referral, if necessary, of women with obstetric or other complications, including perinatal mental health;

- Management of obstetric emergencies;
- Education in new management strategies (diagnostic or therapeutic) as they become available; and
- Maintenance of professional knowledge and skills.

Doctors and midwives must be able to recognise their limits of competence and work within those limits. They should be competent to elicit relevant information sensitively, and identify serious conditions occurring simultaneously, or a potentially serious past psychiatric history. Staff must have a working knowledge of the impact of domestic abuse, and should be competent in recognising the symptoms and presentations of such abuse and be able to make appropriate referrals.

Beyond doctors and midwives, advocates and translators also need specific training so that they understand the provision of maternity care and social services. This helps ensure that they can effectively help to guide women through the system.

10.1 Inter-professional communication

Good inter-professional communication is essential for effective and coordinated care. Training on how to communicate information in an effective sensitive manner should be provided to all healthcare professionals. There should be effective systems of communication between all team members and each discipline, as well as with women and their families.

Interpreting services should be provided for women where English is not their first language. It is preferable that relatives do not act as interpreters. All healthcare providers should be aware of the resources available for interpreting services.

There should be a personal handover of care on the birth suite when staff shifts change. This should be done at least twice daily, and should be conducted utilising a dedicated handover instrument that is contemporaneous. Senior staff should be present at handover, depending on the experience of the resident junior medical staff, and it is essential that clinical handover is multidisciplinary. Locums should receive a personal handover either by the post holder or senior member of the medical team and vice versa. Each institution should have written mechanisms to deal with situations that may arise where there is a difference of opinion between clinicians involved in intrapartum care.

11.
Clinical governance of maternity services

Safety should always be the **foremost priority** in maternity care. For this reason, a comprehensive clinical governance framework should be in place for all maternity services.

Such a framework will monitor the quality of care provided, foster clinical excellence and on-going improvement of standards. It will also provide clear accountability for all team members.

All health professionals must have a clear understanding of the concept of risk assessment and management to improve the quality of care and safety for mothers and babies, while reducing preventable adverse clinical incidents. Where an incident has occurred, every unit should follow a clear mechanism for managing the situation including investigation, learning and communication and, where necessary, implementing changes to existing systems, training or staffing levels. There should be evidence that appropriately trained and experienced professionals obtain informed consent for interventions and investigations, and this should be documented.

Maternity services should comply with evidence-based guidelines for the provision of high-quality clinical care. There should be an audit system in place to monitor important aspects of maternity care and ensure an audit cycle to effect change. A compliments, comments and complaints procedure should be in place to enable women to express views about their pregnancy and childbirth experience.

Incident forms should be completed whenever an identified trigger event has occurred or whenever an incident has occurred that is outside the normal or expected. There must be a transparent process in place whereby clinicians are able to see how issues that have been identified in a clinical governance and quality framework are dealt with.

11.1
Documentation and confidentiality

Records relating to the care of women and babies are an essential aspect of practice. Records aid communication between maternity staff, the woman, and others who provide care. Structured and accurate records must be kept of all antenatal, intrapartum and postnatal care. Maternity staff should keep, as contemporaneously as is reasonable, continuous and detailed records of observations made, care given, pain relief and any other form of medication administered to a woman or baby. Key information regarding a woman's pregnancy, including the number and timing of antenatal visits and antenatal investigations, must be made available to her treating clinicians and hospital.

In the absence of a contemporaneous electronic maternity record, women should be encouraged to carry a personal pregnancy health record, summarising their care and relevant investigations to date to facilitate clear communication and seamless care when seeking medical attention during pregnancy.

Healthcare services should be provided in environments which promote effective care and optimise health outcomes by being supportive of patient privacy and confidentiality.

11.2
Infection prevention and control

Good infection control and adherence to universal precautions will reduce hospital-acquired infections. Infection in healthcare settings is a major cause of morbidity and occasional mortality.

Maternity care providers must ensure that policies are in place in relation to preventing and controlling the risks of healthcare-associated infections – these should include:

- Aseptic technique policy;
- Safe handling of sharps policy;
- Prevention of occupational exposure to blood-borne viruses policy;
- Disinfection policy;
- Antibiotic prescribing policy;
- Uniform and work wear policy; and
- Staff vaccination policies, particularly those most relevant to maternity care providers, such as influenza vaccination.

Maternity service providers should ensure that prevention and control of infection is included in induction programs for new staff and in training and ongoing education programs for all staff.

Healthcare facilities should ensure that there is adequate provision of suitable hand-washing facilities and antibacterial hand rubs.

Guidance and policies should be in place to prevent mother–baby transmission of pre-existing conditions such as HIV, hepatitis B, C and streptococcus B.

12. Care during pregnancy

Early access to, and engagement with, maternity services enables a plan of care to be established. Care plans must be developed that are compatible with available resources, and that recognise the individual health and social care needs of the woman and her partner throughout pregnancy and the neonatal period. Late booking is associated with poorer outcomes – for this reason, antenatal care should be readily and easily accessible to all women.

Health Departments should ensure that campaigns and materials are targeted towards women in groups and communities who under-use maternity services or who are at greater risk of poor outcomes.

Locally, maternity services should be proactive in engaging all women, particularly women from disadvantaged and minority groups and communities, early in their pregnancy and maintaining contact before and after birth. Where possible, specialist services should be provided for pregnant teenagers, such as peer parent education and support groups.

There should be provision for translation, interpreting and advocacy services, based on an assessment of the needs of the local population. Services should attempt to meet the needs of all women, including the vulnerable and hard-to-reach groups.

Maternity services must be accessible and inclusive for women with learning and physical disabilities, and have pathways and processes to account for their communication, equipment and support needs.

12.1
Care during early pregnancy

Some women will develop pain and bleeding or have other concerns in early pregnancy, and will require timely assessment and sensitive management in a specialist setting. Poor clinical outcomes have been linked to inappropriate management.

Women who experience complications in early pregnancy should have prompt access to appropriate medical assessment. Models for this include early pregnancy assessment clinics at public hospitals, and urgent assessment by specialist obstetricians or experienced GP obstetricians, or other doctors experienced in women's health. When reviewing women with early pregnancy complications, a suitable environment should be provided for worried or distressed women and their partners with access to counselling and appropriate information.

Women who miscarry should be counselled by a practitioner experienced in the management of early pregnancy loss, or at the very least by a clinician with access to such advice. An individualised plan for management should be made in each case, giving full regard to each woman's circumstances and wishes. Appropriately skilled and senior staff should be available to support parents following maternal or neonatal death, stillbirth or miscarriage.

All Australian women, regardless of geographical location, should have access to affordable termination of pregnancy services (medical termination of pregnancy and surgical termination of pregnancy). There is recognised inequity of access to these services, particularly for women in rural/remote areas and/or financially disadvantaged women.

12.2
Maternity booking and planning of care

The booking process is the opportunity to establish contact and rapport with a pregnant woman and her family. The process should include a detailed evaluation of the first pregnancy, past reproductive and medical and mental health history, general physical health and include discussion with the woman about her rights, responsibilities and choices for maternity care. Those choices will be shaped by detailed history taking and physical examination and sharing of information regarding her options. The various models of antenatal care should be explained to the woman. Pregnant women should be offered information about locally available services to allow them to choose the most appropriate options for pregnancy care, birth and postnatal care. Consideration should be given to any risk factors in advising women about their options.

At the first contact, or over a series of visits, pregnant women should be offered information about:

- How the baby develops during pregnancy;
- Nutrition and diet, including vitamin supplements;
- Exercise;
- Mental health and wellbeing during and after pregnancy;
- Antenatal screening, including risks and benefits of the screening tests;
- Review of immunisation status;
- Her pregnancy care pathway;
- Points of contact should problems arise; and
- Information about the resources available during pregnancy in preparation for childbirth and breastfeeding.

Booking should take place in early pregnancy and ideally all pregnant women should have had their first full booking visit and an accessible hand held or electronic maternity record completed by 12 weeks of pregnancy. A risk and needs assessment that includes previous obstetric, medical and psychosocial history, including mental health history, must be carried out to ensure that every woman has a plan of care adapted to her individual requirements for antenatal care, delivery and postnatal care.

Women with complex needs should be referred to an obstetrician, where possible, as soon as possible after pregnancy is confirmed and, where necessary, be seen at a combined consultation with the team that will be caring for her. Information should be available in different languages, with relevant cultural beliefs or sensitivities appropriately catered for.

All pregnant women who smoke or have a partner who smokes should receive clear information about the risks of smoking and the support available to them to help them stop, such as the Quit line.

12.3
Managing pre-existing medical conditions in pregnancy, including mental health issues

Pregnant women with pre-existing medical conditions are at a higher risk of serious complications and morbidity. Identification of need will inform a plan of care, and care should be provided by an appropriate multidisciplinary team in order to optimise outcomes. Staff working with women in the pre-pregnancy and antenatal periods should be competent in recognising, advising and referring women who would benefit from more specialist services.

Women with complex medical conditions must be managed by a consultant obstetrician. Such conditions include epilepsy, neurological disorders, diabetes, asthma, renal disease, congenital or known acquired cardiac disease, autoimmune disorders, haematological disorders, obesity, severe pre-existing or past mental health disorder, and any condition for which they are under continuing specialist medical review.

A system of clear referral guidelines and pathways should be established so that pregnant women who require additional care are cared for and treated by the appropriate specialist teams, including anaesthetic assessment when problems are identified.

For women with diabetes, an individualised plan of care covering the pregnancy, birth and postnatal period up to six weeks postpartum should be clearly documented in the notes.

Women at socioeconomic disadvantage may be at higher risk from undiagnosed existing medical conditions. Clinicians caring for them should ensure that a comprehensive medical history has been taken at booking and, where appropriate, a full clinical assessment of their overall health, including a cardiovascular examination, is undertaken as soon as possible thereafter.

Women are at greater risk of developing a mental illness following childbirth than at any other time. Depression related to child-bearing can occur during pregnancy and after birth with estimates ranging from 12–20% of women giving birth affected.[3] All pregnant women should be asked early in their pregnancy about any previous history of psychiatric disorder and/or family history of serious mental illness, and provided with information on pregnancy and mental health that helps them to disclose and discuss their mental health issues. All maternity care providers and mental healthcare providers should have joint working arrangements in place for maternity and mental health services, including access to a perinatal psychiatrist as required.

Women with an existing mental disorder who are pregnant or planning a pregnancy and women who develop a mental disorder during pregnancy or the postnatal period should be given culturally sensitive information at each stage of assessment, diagnosis, course and treatment about the impact of the disorder and its treatment on their health and the health of their fetus or child.

During pregnancy, all women who are identified to be at risk of serious perinatal mental illness should be assessed by a psychiatrist or psychiatric team. The woman should have a written management plan of possible agreed multidisciplinary interventions to be undertaken, and the plan should include a pathway for supervision following birth.

All professionals involved in postnatal care should be trained to distinguish normal emotional and psychological changes from significant mental health problems, and to refer women for support according to their needs. Women who require admission to a psychiatric hospital following delivery should ideally be admitted to a specialist psychiatric mother and baby unit. Ideally these units would be in the same campus as the maternity unit to minimise further disruption of the family's life. However, it is recognised that such a system for care of women with perinatal mental health conditions is aspirational at this time.

Multidisciplinary care, provided through well-understood clinical and local social service networks, should be available for all women with pre-existing medical, psychological or social problems that may require specialist advice during pregnancy.

Recent studies show that men are at increased risk of mental health problems during both the perinatal period and the transition to fatherhood. Paternal mental health during the perinatal period has been shown to affect their child's emotional and behavioural development.[4] Several qualitative studies of fathers in the perinatal period conducted in Australia and internationally have identified that fathers want to be included in perinatal healthcare and engaged by health professionals about their health and wellbeing.[5]

12.4
Women at social disadvantage

Social factors have been shown to contribute to poor outcomes for both mother and baby. Some women and their families require specially developed services to ensure access, early engagement and continuing support and care.

Maternity services should have inter-agency arrangements in place (through clinical and local social services networks) including protocols for information sharing and a lead professional, to ensure that women from disadvantaged groups have adequate support and benefit from other agencies (such as housing) referring women, with consent, to local maternity services. Services should be flexible, accessible and culturally sensitive and planned individually to motivate all women, including the vulnerable and hard-to-reach to engage with maternity services and make use of specific culturally appropriate services, such as Aboriginal liaison officers.

Interpreting services should be provided for women for whom English is not their first language. Relatives should not act as interpreters. In hospital settings, this might include Government-funded access to telephone interpreter services.

Services should strive to be innovative and flexible in meeting the needs of women with communication and other disabilities.

Joint working arrangements should be fostered between maternity services and local agencies that carry responsibility for dealing with domestic abuse, and information about such services should be made available to all pregnant women. All women who have a significant drug and/or alcohol problem should receive their care from a multi-agency team that includes a specialist obstetrician, and involves social workers and other specialist health professionals.

Healthcare professionals should be alert to risk factors, signs, and symptoms of child abuse. If concerns are raised, healthcare professionals should follow local and statutory child protection policies.

Where possible, specialist services should be available for pregnant teenagers and arrangements in place for support in the community. Maternity services staff should have the knowledge and skills to engage with teenage mothers and fathers.

Intimate partner violence and a prior history of the woman or the partner having been in State care or previous children taken into care should be identified and social support arranged. In a violent relationship, the woman and the child are at increased risk of harm.

12.5
Antenatal screening

An integral component of antenatal care is the timely diagnosis and appropriate management of maternal problems, and detection of fetal conditions, together informing women's choices and allowing the development of a continuing plan of care.

All women should have access to comprehensive screening services including a detailed clinical history, (including social vulnerability), physical examination and relevant tests. A free online screening tool used to identify at-risk patients such as the Antenatal Risk Questionnaire (ANRQ) could be advantageous. Women who are identified in the screening program as at risk of pregnancy complications should be managed according to established and accepted guidelines.

Pregnant women should have access to first trimester ultrasound to confirm or determine gestational age, to detect multiple pregnancies and as a screening test for congenital conditions. The use of high-quality first trimester ultrasound is important if the woman is being offered non-invasive prenatal testing with cell-free DNA techniques, to clearly establish the gestation, viability and number of fetuses before the test is performed.

Where screening tests have been declined, the decision should be respected and documented to avoid repetition. It is also helpful to document the reason for declining the investigation.

12.6
Routine antenatal care

Each provider of maternity services should have an explicit plan for antenatal care for all women. The following, based on the RANZCOG statement *Routine antenatal assessment in the absence of pregnancy complications* (C-Obs 3b), are important not only for the pregnancy, but also for establishing patterns of healthy living for the entire family:

- Maintaining and improving health and general wellbeing;
- Emphasising the importance of a healthy diet and exercise;
- Providing advice to avoid smoking, alcohol and illicit drugs;
- Screening for the management of pregnancy complications through detailed history, clinical examination and appropriate investigations throughout the pregnancy; and
- Management of any pregnancy complications as they arise.

Health professionals should recognise the important role of partners/fathers and, where the woman wishes, make sure they are encouraged and supported to take a full and active role in pregnancy and birth.

Maternity services should provide comprehensive programs of education for birth and parenthood to women and their partners and families, taking care to include information with respect to:

- The course of an uncomplicated pregnancy;
- The possible need for obstetric intervention;
- The common obstetric procedures; and
- Options for pain relief in labour, without prejudice.

For women with an uncomplicated pregnancy, the visit schedule should commence in the first trimester and consider the need to:

- Adequately screen for pregnancy complications through clinical assessment and appropriately timed investigations; and
- Discuss the results of investigations such as screening tests in a timely manner.

Each antenatal appointment should be of appropriate duration, and be structured with focused content. Wherever possible, appointments should incorporate routine tests and investigations to minimise inconvenience to women. A system of clear referral paths should be established so that pregnant women who require additional care can be managed and treated by the appropriate specialist teams if problems are identified.

12.7
Women with specific pregnancy-related conditions

The purpose of antenatal care is early detection of problems that require additional support or treatment. Providers of maternity care should be aware of what facilities and which practitioners can be accessed to ensure any complications are managed appropriately.

Maternity services should comply with evidence-based guidelines for the provision of high-quality clinical care, including guidelines for the provision of antenatal, intrapartum and postpartum care, induction of labour and caesarean section. Individualisation of patient care remains a central tenet of quality obstetric management and efforts must be made to ensure that each patient's unique needs are met.

Women with pregnancies of high complexity, and those receiving care from a number of specialists or agencies, should receive the support of a single medical practitioner throughout the pregnancy. Ideally, this would be either the woman's GP or an obstetrician.

The development and routine use of an obstetric 'early warning chart' facilitates the timely recognition, treatment and referral of women who have, or are developing, a critical illness. The consultant obstetrician on call should be informed about all pregnant or postnatal women in hospital that are unwell, whether they have a medical or an obstetric problem.

Every pregnant woman attending an accident and emergency department for problems other than obvious minor injuries should be seen by a midwife or obstetrician. Where this is not possible, a midwife or obstetrician should be consulted.

All maternity care providers should ensure that consultant-led services have adequate facilities, expertise, capacity and support to allow for timely and comprehensive obstetric emergency care, including transfer to high-dependency and critical care environments.

12.8
Care during birth

Late pregnancy, labour and birth are associated with greatest risk to mother and baby. Fortunately, vigilant surveillance and timely assistance have made labour and birth very safe for most women in Australia.

To accomplish and maintain this level of safety, maternity services must have a robust and transparent clinical governance framework that is applicable to each birth setting. There should be a defined clinical leader who carries ultimate responsibility for clinical decisions. Effective multidisciplinary care is essential to the efficient delivery of the service, and professional communication is the essence of good clinical practice. Safe staffing levels of all professional and support staff must be provided, reviewed and audited regularly for each birth setting. This includes obstetric operating theatres, labour wards, ante- and postnatal settings.

The core responsibilities of team members – obstetricians, midwives, anaesthetists, and neonatal paediatricians – must be defined clearly. Each birth setting must have clinical protocols, procedures and guidelines to assist in the delivery of clinical care. Clinical protocols should strike a balance between the needs of the women they serve and the need to provide an equitable clinical service. To be effective, clinical protocols must be:

- Based on clinical, organisational, and system needs;
- Designed to guide clinical practice rather than obligate;
- Written to allow a diversity of clinical practice where more than one reasonable option is present; and
- Flexible enough not to preclude individualisation of patient care to best meet the unique needs of each individual woman.

Facilities in birth settings should be equipped and maintained at an appropriate standard. All services delivering intrapartum care should have timely access to:

- Operative care; and
- Specialist services, including anaesthesia, neonatal paediatrics and haematology, and blood transfusion services.

Where, by virtue of location, such services are not immediately available, the woman should be informed of service limitations to allow an informed choice regarding planned location of birth.

13. Care of the newborn

An appropriately trained practitioner, skilled in neonatal resuscitation, should be present at all births. This includes suitably qualified obstetricians, GPs, midwives, neonatal nurses, anaesthetists, paediatricians, or neonatologists. At births with no expectation of an increased need for neonatal resuscitation:

- A staff member trained in basic neonatal resuscitation should be in attendance and responsible only for the care of the newborn. The Australian Resuscitation Council recommends a clinician trained in advanced neonatal resuscitation should also be available, but not in attendance.

At births with an increased likelihood of a need for neonatal resuscitation:

- A clinician trained in advanced neonatal resuscitation should be in attendance and responsible only for the care of the newborn. More than one experienced person should be present to care for the newborn.

Maternity services must ensure that all staff carrying responsibility for neonatal resuscitation have adequate and appropriate training. Neonatal resuscitation should be anticipated by medical staff based on maternal, fetal and intrapartum risk factors. The requirement for the attendance of a clinician skilled in advanced neonatal resuscitation should be at the discretion of the person responsible for managing the birth, taking into consideration the presence of specific additional risk factors and the number of risk factors for neonatal compromise including (but not limited to):

- Significant fetal compromise; and
- Known and anticipated neonatal medical problems including:
  - Multiple birth
  - Preterm birth
  - Breech presentation
  - General anaesthesia.

Where transfer to neonatal or transitional care units is anticipated, the availability and proximity of a paediatrician should be determined. Factors affecting this include (but are not limited to):

- The presence of an immediately adjacent neonatal intensive care unit (NICU), staffed with neonatologists capable of reliably attending within seconds. This may raise the threshold for paediatrician attendance at birth.
- A situation where the most available paediatrician is a considerable time away – this would lower that threshold.

13.1
Routine care of the healthy newborn

The newborn infant physical examination is a key element of the child health surveillance program. Early recognition and treatment of some problems can have a significant impact on the health of the child.

The personal child health record should be given to all women as soon as possible and its use explained. All consultant-led obstetric units should have ready access to paediatricians who have responsibility for, and a special interest in, neonatology.

All examinations of the baby should be performed by a suitably qualified healthcare professional with appropriate training in neonatal examination techniques. All newborn infants should have a complete clinical examination within 72 hours of birth.

Prompt referral for further medical investigation or treatment should be provided through agreed clinical care pathways. Professionals should be skilled in sharing information, concerns and treatment choices with parents and other members of the maternity care team should any abnormal condition in the baby be diagnosed. Wherever possible, babies who require additional care should be nursed by appropriately trained staff on the postnatal wards to avoid separating babies from their mothers.

Babies at high risk of hypoglycaemia (for example, small for dates or born to women with diabetes) should be closely monitored in the postnatal period. Clear agreed guidelines should be in place.

Guidelines should be in place to minimise the number of infants who require rewarming or avoidable admission to special care baby unit (SCBU).

The newborn blood spot screening (heel prick) test is a screen for a range of rare, but serious, medical conditions, which should be offered and discussed with all women and their partners following the birth of the baby.

Vitamin K administration is recommended for all newborns.

Women and their families should be offered newborn screening for hearing problems, and prophylactic vaccinations such as hepatitis B in accordance with accepted protocols.

All maternity units should have clear processes and recommended timeframes for monitoring of infants for withdrawal of alcohol and other drugs, whether illicit or prescribed medications.

13.2
Postnatal assessment and care of the mother

Every mother must receive continuing assessment and support throughout the postnatal period to give her the best possible start with her new baby and for the change in her life and responsibilities. A postnatal plan of care should be developed with the woman soon after birth. This should take into account:

- Relevant factors from the antenatal, intrapartum, and immediate postnatal period; and
- Details of the healthcare professionals involved in her care and that of her baby, including roles and contact details.

All women should be assessed immediately after giving birth by a suitably qualified member of the birth team (doctor or midwife) and again prior to transfer to community care and/or within 24 hours of giving birth, by a midwife. Any symptoms reported by the mother or identified through clinical observations should be assessed, specifically, for recognition of complications e.g. infection, haemorrhage, thromboembolism and anaesthetic problems. All professionals involved in the care of women immediately following birth should be able to distinguish normal emotional and psychological changes from significant mental health problems and to refer women for support according to their needs. Anticipated length of stay in a maternity unit should be discussed, taking into account the mother's health and wellbeing and that of her baby, and the level of support available following discharge. Formal screening with a validated instrument such as the Edinburgh Postnatal Depression Scale (EPDS) should be considered.

13.3
Infant feeding

Maternity services should adhere to the principles and work towards the recommendations of UNICEF/ WHO Baby Friendly (vii) status. Attention should be paid to facilitating an environment that supports skin-to-skin contact where possible. Skin-to-skin time should last until after the first breastfeed or until the mother chooses to end it. Babies should remain with their mothers unless there is a medical indication not to, or mothers specifically request help to deal with their babies.

Maternity services should promote breastfeeding and support the mother to initiate and sustain breastfeeding regardless of the location of care. A woman's right to make an informed choice regarding the method of feeding is to be supported. All maternity services should have a written breastfeeding policy that is communicated to all staff and parents. Each maternity service should have a nominated person identified to implement the breastfeeding policy.

A woman who wishes to feed her baby formula milk should be taught how to make feeds using correct, measured quantities of formula, as based on the manufacturer's instructions, and how to clean and sterilise feeding bottles and teats and how to store formula milk.

Where postnatal care is provided in hospital, attention should be paid to facilitating an environment conducive to breastfeeding and appropriate facilities to enable correct formula preparation and storage.

Mothers should have access to nutritious food and drink on demand.

Women who are taking medicines, including psychiatric (psychotrophic) medicines, should receive specialist advice, based on the best available evidence, in relation to breastfeeding. Women should be provided with readily accessible information (including helpline numbers) and support in their chosen method of feeding, including access to peer support groups and voluntary organisations.

13.4
Care of babies requiring additional support

Some babies may have or can develop problems for which timely and appropriate treatment is essential. The effective use of networks will ensure the best possible outcome. All neonates should have a clinical examination by a competent healthcare professional to detect preclinical abnormalities within the first week of life for full-term babies, or prior to discharge home from neonatal care.

Concerns expressed by the parents as to the wellbeing of the baby, or identified through clinical observations, should be assessed. Health professionals should ensure that parents are offered newborn screening for their babies, and that appropriate follow-up care is arranged if necessary. Intensive support for breastfeeding should be provided to mothers who have had a multiple birth or have a premature or sick baby. Parents of babies with identifiable medical or physical problems should receive timely and appropriate care and support in an appropriate environment.

Care of the baby should ensure there is ongoing assessment, including recognition of group B streptococcal infection and jaundice.

Babies born to women with diabetes and others at high risk of hypoglycaemia (for example, small for dates or preterm) should be closely monitored. Ideally, they should remain with their mothers during this time unless there is a specific medical indication for admission to a special care nursery or neonatal intensive care unit.

Maternity services should have agreed arrangements for the transfer of a recently delivered mother and her newborn baby to a linked secondary or tertiary unit should problems arise.

Extremely premature births may take place rapidly when no senior members of the team are available, so advance liaison should take place whenever possible between the consultant obstetrician, consultant paediatrician and senior midwife to ensure that there is prospective understanding on the management and on who will try to be present at the delivery. All facilities should have the capacity to offer an appropriate level of care to neonates. This might either be a special care nursery (SCN) or a capacity for escalation of care through established and well-understood referral pathways.

All maternity services must have systems in place for identifying high-risk women, informing plans of care for women admitted with threatened preterm delivery, and for transporting preterm babies in a warmed transport incubator. Prompt referral to an obstetrician with appropriate expertise should be made in all cases of threatened preterm labour to assess the need for a tocolytic, to avoid delay in the administration of corticosteroids and to enable the appropriate use of magnesium sulphate for neuroprotection. The care of babies born at the threshold of viability will be partly determined by the available expertise and resources.

All professionals involved in postnatal care should be able to distinguish normal emotional and psychological changes from significant parent–infant relationship disturbances and to refer to recognised specialists in infant mental health. The use of free online mental health screening tools for depression, anxiety and distress such as the Edinburgh Postnatal Depression Scale (EPDS) is strongly recommended.

13.5
Promoting healthy parent–infant relationships

Specific professional input focusing on the parent–infant relationship, including the provision of appropriate services, may be required to ensure the development of a positive and healthy relationship. There may be factors inhibiting the development of positive parent–infant relationships that require professional intervention. Maternity services should provide postnatal care to facilitate the transition to motherhood by making sure that ill health is prevented or detected and managed appropriately. Women and their partners should be supported to make a confident and effective transition to parenthood.

Services responsible for postnatal care should be able to support parents in developing a basic understanding of attachment issues, infant health and their role in supporting their child's mental and emotional development. Services responsible for postnatal care should be able to ensure that parents' own mental health needs are recognised and addressed as well as being aware of the potential impact of the parents' condition on any dependants and young siblings.

Significant disturbance of parent–infant relationships should be referred to recognised specialists in infant mental health.

Intimate partner violence should be identified and social support arranged. In a violent relationship, the woman and the child are at increased risk of harm.

13.6
Supporting the transition to parenthood

Maternity services must support women and their partners in the transition to parenthood by discussing the postnatal health and social needs of the mother and her baby, and by developing an individual plan of postnatal care to address those needs. Postnatal care should include provision of information to both mothers and fathers on infant care, parenting skills, timely referral to a community child health service of the parents' choice and accessing local community support groups. A coordinating healthcare professional should be identified for each woman. In ideal circumstances, this should be the family doctor or suitable GP. Additional support can be obtained from maternal and child health nurses and clinics.

At the end of the postnatal period, the coordinating healthcare professional should ensure that the woman's physical, emotional and social wellbeing is reviewed. This may be performed at a postnatal visit by an obstetrician or GP obstetrician, but other suitably qualified clinicians might also perform this function. A system should be established to ensure that information on women and their babies in the postnatal period is collated and transferred between secondary and primary care in a reliable, timely and secure manner.

13.7
Supporting families who experience bereavement, pregnancy loss, stillbirth or early neonatal death

Bereavement can be extremely traumatic. Providers of maternity care need to ensure support and information for women and their families both during the acute event and through the weeks or months afterwards. Maternity care providers should ensure there are comprehensive, culturally sensitive, multidisciplinary policies, services and facilities for the management and support of families who have experienced pregnancy loss, stillbirth or neonatal death. Consideration should be given to lactation suppression in losses beyond the mid trimester.

Skilled staff should be available to support parents and family following a maternal or neonatal death, a stillbirth or miscarriage. Information that includes details about investigations (including post-mortems), birth and death registration and options for dealing with the body should be available in different languages with particular cultural beliefs or sensitivities appropriately reflected. Local guidelines must include clear communication pathways between secondary care and the primary care team with the woman's GP informed of any death as a matter of priority, and a list of mental health and counselling support services.

Parents of stillborn babies or babies with identifiable medical or physical problems should receive timely and appropriate care and support in an appropriate environment.

Information should be given to the woman and her partner about the grieving process, including local support offered and other agencies which also offer support following stillbirth or early neonatal death.

Following the death of a baby, preliminary results of placental and post-mortem histology should be available within six weeks of the examination. The woman and her partner should be given the opportunity to meet with the lead clinician (obstetrician and/or paediatrician) to discuss the results of a post-mortem examination and other investigations. There must be a clear and consistent local policy about sensitively dealing with fetal tissues after early pregnancy loss. Post-mortem examination of a baby should be performed by a specialist perinatal pathologist where resources allow.

Access to family planning/contraception should be available to parents following pregnancy loss, stillbirth or neonatal loss.

14. Homebirth

It is important to support informed choice in maternity care, but planned homebirth is a special case.

Many jurisdictions in Australia will have Government-funded homebirth services, although these services support only a small proportion of women. Planned homebirth is not recommended for women with recognised risk factors as it is associated with a significantly higher rate of adverse outcomes for women and/or their babies. Women contemplating planned homebirth must be provided with accurate information about the risks and benefits relevant to them as an individual, and should meet relevant eligibility criteria. Detailed information is available elsewhere (see RANZCOG's Home births statement). At the very least, planned homebirth services should be in collaboration with an obstetrician (GP or specialist) or suitably qualified and experienced eligible midwife.

Closing remarks

Australia is among the safest places in the world for maternity care. Multiple models of care in myriad circumstances and locations make uniformity of policy difficult and often inappropriate.

There are very significant challenges to delivering quality care to an older, more obese maternity population. The highest priority must be given to the needs of Aboriginal and Torres Strait Islander women, migrant and refugee women, and women in rural and remote settings.

It is only through collaboration of key professional groups in the development of policy, that these challenges will be met satisfactorily.

Supporting references

1. Australian and New Zealand College of Anaesthetists (ANZCA) Faculty of Pain Medicine. Guidelines for the Management of Major Regional Analgesia PS03. 2014.
2. RANZCOG/ANZCA. Joint RANZCOG/ANZCA Position statement on the provision of Obstetric Anaesthesia and Analgesia Services (WPI 14) 2015.
3. The Royal Australian and New Zealand College of Psychiatrists. Position Statement 57: Mothers, babies and psychiatric inpatient treatment. May 2015.
4. Wong O, Nguyen T, Thomas N, et al. Perinatal mental health: Fathers – the (mostly) forgotten parent. *Asia Pac Psychiatry.* 2016;8(4):247-55.
5. Centre of Perinatal Excellence (COPE). Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline. Melbourne. 2017.

RANZCOG resources supporting this document

RANZCOG Intrapartum fetal surveillance clinical guideline - Third edition. RANZCOG 2014.
Pre-pregnancy counselling (C-Obs 3a)
Routine antenatal assessment in the absence of pregnancy complications (C-Obs 3b)
Guidelines for the use of Rh D Immunoglobulin (Anti-D) in obstetrics in Australia (C-Obs 6)
Diagnosis of gestational diabetes mellitus (C-Obs 7)
Management of breech presentation at term (C-Obs 11)
Categorisation of urgency for caesarean section (C-Obs 14)
Instrumental vaginal birth (C-Obs 16)
Maternal Group B Streptococcus in pregnancy: screening and management (C-Obs 19)
Placenta accreta (C-Obs 20)
Timing of elective caesarean sections (C-Obs 23)
Vitamin and mineral supplementation and pregnancy (C-Obs 25)
Maternal suitability for models of care, and indications for referral within and between models of care (C-Obs 30)
Provision of routine intrapartum care in the absence of pregnancy complications (C-Obs 31)
Responsibility for neonatal resuscitation at birth (C-Obs 32)
Collaborative maternity care (C-Obs 33)
Prenatal screening for fetal genetic or structural conditions (C-Obs 35)
Term prelabour rupture of membranes (PROM) (C-Obs 36)
Delivery of the fetus at caesarean section (C-Obs 37)
Birth after previous caesarean section (C-Obs 38)
Caesarean delivery on maternal request (C-Obs 39)
Maternal and perinatal data collection (C-Obs 40)
RANZCOG Standards in maternity care in Australia and New Zealand (C-Obs 41)
Management of monochorionic twin pregnancy (C-Obs 42)
Management of postpartum haemorrhage (C-Obs 43)
Home births (C-Obs 2)
Pre-pregnancy and pregnancy-related vaccinations (C-Obs 44)
Influenza vaccination during pregnancy (C-Obs 45)
Management of vasa praevia (C-Obs 47)
Perinatal anxiety and depression (C-Obs 48)
Management of obesity in pregnancy (C-Obs 49)
Management of hepatitis B in pregnancy (C-Obs 50)
Management of hepatitis C in pregnancy (C-Obs 51)
Women and smoking (C-Obs 53)
Alcohol in pregnancy (C-Obs 54)
Substance use in pregnancy (C-Obs 55)
Mid-trimester fetal morphology ultrasound screening (C-Obs 57)
Prenatal screening and diagnosis of chromosomal and genetic conditions in the fetus in pregnancy (C-Obs 59)
Prenatal assessment of fetal structural conditions (C-Obs 60)
Screening in early pregnancy for adverse pregnancy outcomes (C-Obs 61)
Exercise during pregnancy (C-Obs 62)
Shared maternity care obstetric patients (WPI-9)
Antenatal care in Australian public hospitals (WPI-10)
Position Statement on the provision of obstetric anaesthesia and analgesia services (WPI-14)
Clinical handover (WPI-19)
Evidence-based medicine, obstetrics and gynaecology (C-Gen 15)
RANZCOG CPD information - https://www.ranzcog.edu.au/members/cpd/Fellows

Other documents referred to in this document

National Midwifery Guidelines for Consultation and Referral (3rd Edition, Issue 2). Australian College of Midwives.
Caring for Families Experiencing Stillbirth, Part 1: Diagnosis to Birth. Stillbirth Foundation Australia.
Caring for Families Experiencing Stillbirth, Part 2: The Birth. Stillbirth Foundation Australia.
Caring for Families Experiencing Stillbirth, Part 3: Care following Birth. Stillbirth Foundation Australia.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Excellence in Women's Health

AUSTRALIA
College House,
254–260 Albert Street
East Melbourne,
Victoria 3002, Australia.

t: +61 3 9417 1699
f: +61 3 9419 0672
e: ranzcog@ranzcog.edu.au
ranzcog.edu.au

NEW ZEALAND
Level 6 Featherston Tower
23 Waring Taylor Street
Wellington 6011
New Zealand

t: +64 4 472 4608
e: ranzcog@ranzcog.org.nz

SOCIAL MEDIA
@RANZCOG
facebook.com/RANZCOG

Maternity Care in Australia