

# Queensland Clinical Guidelines

*Translating evidence into best clinical practice*

Maternity and Neonatal **Operational Framework**

## Maternity shared care

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Author:	Queensland Clinical Guidelines
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Endorsed by:	Queensland Clinical Guidelines Steering Committee Statewide Maternity and Neonatal Clinical Network (Queensland)
Contact:	Email: <a href="mailto:Guidelines@health.qld.gov.au">Guidelines@health.qld.gov.au</a> URL: <a href="http://www.health.qld.gov.au/gcg">www.health.qld.gov.au/gcg</a>

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## Abbreviations

GP	General Practitioner
PHR	Pregnancy health record
PMC	Primary maternity carer

## Definitions

<b>Maternity care collaboration<sup>1</sup></b>	<p>In maternity care, collaboration is a dynamic process which facilitates communication, trust and pathways that enable health professionals to provide safe, woman-centred care. Collaborative maternity care enables women to be active participants in their care.</p> <p>Collaboration includes clearly defined roles and responsibilities for everyone involved in the woman's care, especially for the health care professional the woman nominates as her primary maternity carer (PMC).</p>
<b>Consultation</b>	<p>A discussion between health care professionals or health care professionals and the woman for the purpose of providing clinical care.</p> <p>Consultation can occur face to face, by videoconference, telephone, or email.</p>
<b>Primary maternity carer (PMC)</b>	<p>In the context of maternity shared care, the PMC is the community based health care professional, nominated by the woman, who provides and coordinates the majority of the woman's care.</p> <p>The PMC may be a GP, GP obstetrician, obstetrician, or midwife providing private maternity care in the community.</p>
<b>Referral</b>	<p>Communication, preferably in writing, from the health care professional making the referral for:</p> <p>Consultation (e.g. request for an opinion or specialised service where responsibility for the maternity care remains with the PMC)</p> <p><b>or</b></p> <p>Transfer of care (e.g. responsibility for maternity care is transferred from the PMC to an obstetrician). The PMC may continue to provide care within their scope of practice, in collaboration with the specialist team (e.g. the team may consist of obstetrician, physician, psychiatrist)</p> <p>Referrals should be accompanied by relevant personal and clinical information to enable an informed consultation or safe and timely transfer of care.</p>
<b>Shared care</b>	<p>In this context, shared care is a co-operative arrangement between a public birthing facility and a PMC not employed by the birthing facility and located in the community (e.g. GP or private practice midwife). The PMC provides the majority of the antenatal and postnatal care with the public birthing facility health care professionals providing care during labour and the intrapartum period.</p>

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## 1 Introduction

In 2014 32% of women who gave birth in Queensland, received antenatal care that was shared between a public maternity service and a private health care professional including general practitioners (GP), and/or private medical or midwifery practitioners.<sup>2</sup> Twenty seven percent of women received all their antenatal care from a private obstetrician and a small percentage received all their antenatal care from a private midwifery practitioner (less than 1%). Only a small percentage of maternity shared care in Queensland operates under a formal arrangement between the birthing facility and the primary maternity carer (PMC).

### 1.1 Purpose

This operational framework is designed to support effective communication and clear understanding of the respective roles and responsibilities of the health care professionals involved in maternity shared care.

### 1.2 Principles of maternity shared care

Table 1. Principles of shared maternity care

Aspect	Consideration
<b>Women centred care</b>	<ul style="list-style-type: none"> <li>• The views, beliefs and values of the woman in relation to her care and that of her baby are sought and respected<sup>3</sup></li> <li>• The woman is the central decision maker for herself and her baby<sup>1</sup></li> </ul>
<b>Informed decision making</b>	<ul style="list-style-type: none"> <li>• Offer recommendations and options for care in a manner that supports informed decision making<sup>4</sup></li> <li>• Provide information about the benefits, risks, alternatives and potential outcomes of all options for care, including the option to 'wait and see'</li> </ul>
<b>Collaboration</b>	<ul style="list-style-type: none"> <li>• Maternity shared care partners<sup>1</sup>:               <ul style="list-style-type: none"> <li>○ Promote collaboration between the woman, the PMC and the birthing facility health care professionals</li> <li>○ Communicate promptly and ensure timely exchange of information between the partners</li> <li>○ Use a consistent approach to care</li> <li>○ Respect and value each other's roles</li> </ul> </li> </ul>

### 1.3 Private practitioners not sharing care

If the woman plans most or all of her care with a private practitioner (midwife, GP obstetrician or obstetrician) and shared care is not the preferred model of care, provide the birth facility with a copy of the maternity health record or PHR or midwifery notes by 36 weeks gestation.

## 1.4 Pregnancy health record

The pregnancy health record (PHR) is the recommended mechanism for facilitating information exchange.

Table 2. Pregnancy health record

Aspect	Consideration
<b>Aim</b>	<ul style="list-style-type: none"> <li>• Facilitate women's participation in their care</li> <li>• Facilitate communication between care providers</li> <li>• Promote early and appropriate use of antenatal services, particularly amongst disadvantaged women</li> <li>• Promote a minimum standardised evidenced based framework of antenatal care for all women birthing in QLD</li> <li>• Promote early universal standardised screening and referral to appropriate services</li> <li>• Inform care givers of important diagnostic and treatment decisions</li> </ul>
<b>Content</b>	<ul style="list-style-type: none"> <li>• Is aligned with the Queensland Clinical Guidelines</li> <li>• Includes an antenatal pathway to act as a prompt for key actions during pregnancy</li> <li>• Contains a notes section beneath each visit to record areas of concern               <ul style="list-style-type: none"> <li>○ Record issues discussed with the woman and her decisions</li> <li>○ Identify follow-up actions</li> <li>○ The woman may also wish to record her individual experience of the pregnancy</li> </ul> </li> </ul>
<b>Clinician use</b>	<ul style="list-style-type: none"> <li>• The PHR is the substantive record of the woman's pregnancy</li> <li>• Use the PHR for all women involved in maternity shared care</li> <li>• At every visit, record information in the PHR that is sufficient to meet the care provider's duty of care in diagnostic and treatment decisions</li> <li>• Do not destroy/dispose of the PHR under any circumstances</li> <li>• Follow local arrangements and preferences for obtaining and commencing the PHR</li> </ul>
<b>Information for women</b>	<ul style="list-style-type: none"> <li>• Advise the woman:               <ul style="list-style-type: none"> <li>○ To take the PHR to all appointments during pregnancy</li> <li>○ That the PHR is the ONLY complete health record maintained by the birthing facility and becomes part of the birthing facility's health care record</li> </ul> </li> </ul>

## 2 Maternity shared care partners

Multiple health care providers may be involved in maternity shared care and provide care within their professional area of expertise. (e.g. physiotherapists, social workers, psychologists and dieticians). It is recommended that all partners use the PHR to document care provided.

Table 3. Maternity shared care partners

Aspect	Consideration
<b>Partners</b>	<ul style="list-style-type: none"> <li>• May provide care within a variety of models (e.g. acute or community health settings)</li> <li>• May be privately funded or funded by state or federal governments</li> <li>• Additional partners may include complementary care and support health care providers (e.g. doula, indigenous health worker, or other culturally appropriate services)</li> </ul>
<b>Responsibilities shared by all partners</b>	<ul style="list-style-type: none"> <li>• Each partner:               <ul style="list-style-type: none"> <li>○ If ordering a test or investigation, assumes responsibility for checking the results and communicating care and for any follow-up required</li> <li>○ Communicates promptly about outcomes of consultations where follow-up is required</li> <li>○ Advises of referrals to other health care professionals</li> <li>○ Uses the PHR to communicate care decisions and plans (e.g. tests, investigations, results)</li> </ul> </li> </ul>

## 2.1 Primary maternity carer responsibilities

Table 4. Primary maternity carer responsibilities

PMC role	Responsibility
<b>Communicating with the birthing facility</b>	<ul style="list-style-type: none"> <li>• Refer the woman to the intended birthing facility (before 12 weeks gestation whenever possible)</li> <li>• Use the locally preferred referral tool (e.g. PHR maternity booking-in referral form or electronic booking referral template)</li> <li>• Inform the birthing facility of PMC status in relation to the woman's maternity care</li> <li>• Use the PHR to communicate care decisions and results</li> <li>• Participate in multidisciplinary case conferencing and clinical handover as relevant to the woman's care (including by video/teleconference if necessary)</li> <li>• Review and check the accuracy of the discharge summary with the woman               <ul style="list-style-type: none"> <li>○ Offer a copy to the woman if she does not have one</li> </ul> </li> </ul>
<b>Professional development</b>	<ul style="list-style-type: none"> <li>• Is appropriately qualified, registered or credentialed as is relevant to the PMC's profession               <ul style="list-style-type: none"> <li>○ Diploma of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (DRANZCOG) is desirable but not compulsory for GPs<sup>5</sup></li> </ul> </li> <li>• Has current knowledge and skill in obstetric care</li> <li>• Is familiar with and follows the guidelines and policies of the participating birthing facility</li> <li>• Participates in programs offered by the birthing facility:               <ul style="list-style-type: none"> <li>○ Orientation programs and resources</li> <li>○ Training or up-skilling opportunities</li> <li>○ Credentialing or accreditation process in order to participate in maternity shared care arrangements (if required)</li> </ul> </li> </ul>

## 2.2 Birthing facility responsibilities

Table 5. Birthing facility responsibilities

Facility role	Responsibility
<b>Communication</b>	<ul style="list-style-type: none"> <li>• Acknowledge receipt of referral for booking-in</li> <li>• Commence the PHR if not already commenced</li> <li>• Offer multidisciplinary case conferencing and clinical handover as required (including by video/teleconference if necessary)</li> <li>• Document inpatient care provided during the antenatal, intrapartum and postnatal period</li> </ul>
<b>Labour and birth</b>	<ul style="list-style-type: none"> <li>• Care of the woman and baby during labour and birth</li> <li>• The PMC may or may not be involved</li> </ul>
<b>Discharge summary</b>	<ul style="list-style-type: none"> <li>• Provide a discharge summary to the PMC preferably within 5 days of birth to enable prompt and appropriate follow up (and to the GP if the GP is not the PMC) and where appropriate, the community child health service</li> <li>• Offer a copy of the PHR and the discharge summary to the woman</li> </ul>
<b>PMC support</b>	<ul style="list-style-type: none"> <li>• Offer the PMC opportunities to access               <ul style="list-style-type: none"> <li>○ Orientation programs and resources</li> <li>○ Training or up-skilling opportunities</li> <li>○ Credentialing or accreditation process in order to participate in maternity shared care arrangements (if required)</li> </ul> </li> </ul>

### 3 Providing shared care

Most women can be offered shared antenatal care. The decision is a joint one made by the woman, her PMC and the birthing facility health care professionals, all of whom share responsibility.

Table 6. Providing shared care

Aspect	Consideration
<b>Women with complex care needs</b>	<ul style="list-style-type: none"> <li>• Women with complex care needs may access maternity shared care providing all health care providers:               <ul style="list-style-type: none"> <li>○ Are familiar with relevant risk factors</li> <li>○ Follow consultation and referral/management guidelines</li> <li>○ Collaborate in a timely fashion</li> <li>○ Recognise the assessment of risk is a continuing process throughout the pregnancy</li> </ul> </li> </ul>
<b>Consultation and referral</b>	<ul style="list-style-type: none"> <li>• Discuss consultation and/or referral with the woman and document in the PHR</li> <li>• Refer to and follow consultation and referral guidelines<sup>6,7</sup> <ul style="list-style-type: none"> <li>○ Refer to Appendix A: Relevant documents</li> </ul> </li> </ul>
<b>When recommended care is declined</b>	<ul style="list-style-type: none"> <li>• A woman has the right to decline any or all recommended care (e.g. visits, screening tests, investigations, interventions, advice)</li> <li>• If the woman chooses a course of action that is outside the clinical advice, scope of practice or organisational policy of the PMC:               <ul style="list-style-type: none"> <li>○ The woman's right to autonomy is upheld and she is treated respectfully irrespective of her choices</li> <li>○ Document the woman's informed choice</li> <li>○ Seek guidance from professional organisations about ensuring adequate care provision (if required)</li> </ul> </li> </ul>
<b>Ongoing care after birth</b>	<ul style="list-style-type: none"> <li>• Maternity shared care partners negotiate who will provide postnatal care</li> <li>• Queensland Health facilities offer initial postnatal contact in the first weeks after birth as per their local arrangements</li> <li>• A midwife PMC usually provides care for up to six weeks postpartum and then refers to the woman's GP and/or the Community Child Health Service</li> <li>• Follow local protocols and pathways for referral to community, child and family health services</li> <li>• Offer postnatal outpatient appointments (as required) to women who have experienced specific problems during pregnancy or childbirth               <ul style="list-style-type: none"> <li>○ Offer opportunities for discussion and/or counselling if there have been unexpected outcomes</li> <li>○ Advise PMC if problems are identified during contacts</li> </ul> </li> </ul>



## References

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## Appendix A: Relevant documents

The documents listed below can be used in conjunction with this operational framework:

Document/Tool	Availability
Pregnancy Health Record (Form number SW071)	Contact the local birthing facility for ordering details
Maternity Booking In Referral Form	Queensland Health Pregnancy Health Record
Australian College of Midwives: National midwifery guidelines for consultation & referral (3 <sup>rd</sup> edition Issue 2, 2015)	<a href="https://issuu.com/austcollegemidwives/docs/guidelines2013/1">https://issuu.com/austcollegemidwives/docs/guidelines2013/1</a>
Royal Australian and New Zealand College of Obstetricians and Gynaecologists:  <i>Maternal suitability for models of care, and indications for referral within and between models of care</i> (2009)  <i>Collaborative maternity care</i> (2010)	<a href="https://www.ranzcog.edu.au/college-statements-guidelines.html">https://www.ranzcog.edu.au/college-statements-guidelines.html</a>
Queensland Clinical Guidelines, <i>Non-urgent referral for antenatal care operational framework</i> (2011)	<a href="http://www.health.qld.gov.au/qcg">http://www.health.qld.gov.au/qcg</a>
NHMRC (National Health and Medical Research Council). <i>National guidance on collaborative maternity care</i> . (2010)	<a href="http://www.nhmrc.gov.au/publications/synopses/cp124_syn.htm">www.nhmrc.gov.au/publications/synopses/cp124_syn.htm</a>
Australian Health Ministers' Advisory Council, <i>Clinical Practice Guidelines: Antenatal Care – Module 1</i> . Australian Government Department of Health and Ageing, Canberra (2012)	<a href="http://www.health.gov.au/antenatal">http://www.health.gov.au/antenatal</a>

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### **Original publication of version 1 in 2011**

#### **Working Party Clinical Lead**

Dr Wendy Burton, General Practitioner, Brisbane

Ms Kerry Ann Ungerer, Manager, Maternity Unit, Primary, Community and Extended Care Branch

#### **Working Party Members**

Ms Andrea Codega, Private Practice Midwife, Brisbane

Ms Carla Dillon, Midwife, Goondiwindi Health Service

Dr Giselle Donaldson, General Practitioner, Brisbane

Ms Carolyn James, Principal Project Officer, Maternity Unit, Primary, Community and Extended Care Branch

Ms Rebecca Jenkinson, Consumer Representative

Ms Janet Langush, Midwife, Royal Brisbane and Women's Hospital

Dr Jacki Mein, Public Health Medical Officer, Apunipima Cape York Health Council

Ms Caroline Nicholson, Director, Mater UQ Centre for Primary Health Care Innovation, Mater Health Services

Ms Rachel Thompson, Research Fellow, Queensland Centre for Mothers and Babies

### **Publication of version 2 in 2016**

#### **Clinical Lead**

Dr Wendy Burton, General Practitioner, Brisbane

#### **Queensland Clinical Guidelines Team**

Associate Professor Rebecca Kimble, Director

Ms Jacinta Lee, Manager

Ms Lyndel Gray, Clinical Nurse Consultant

Ms Stephanie Sutherns, Clinical Nurse Consultant

Dr Brent Knack, Program Officer

Steering Committee

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