

THE ROYAL AUSTRALIAN AND
NEW ZEALAND COLLEGE OF
OBSTETRICIANS AND GYNAECOLOGISTS



STANDARDS OF MATERNITY CARE IN AUSTRALIA AND NEW ZEALAND

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STANDARDS OF MATERNITY CARE IN AUSTRALIA AND NEW ZEALAND

The Royal Australian and New Zealand College of Obstetricians
and Gynaecologists

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) wishes to acknowledge the access provided by the Royal College of Obstetricians and Gynaecologists, UK, to their document on Standards in Maternity Care, which was central to the development of this document.

These Standards and the College Statements and Guidelines referenced in this publication are available on the RANZCOG website at: www.ranzcog.edu.au/publications/collegestatements.shtml

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Organisation of Maternity Care

1. Provision of choice for women and their families

In many circumstances, women will have a choice about the model of care they wish for their pregnancy, and of management within that model. Choice should always be informed, taking into account the risks and benefits of each option as they apply in every 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.

Standards

- 1.1 Women should be offered information on the full range of options available to them throughout pregnancy, birth and the postnatal period. This information should include the models of care available locally, screening tests, and information about birth and postnatal care. Any discussions of choice in maternity care must ensure the woman and her family have an understanding of the concept of risk management and how this underpins obstetric interventions.
- 1.2 Obstetricians (specialist or GP) must assist women and their families with the decision-making about their management options for antenatal care, birth, and postnatal care. These discussions must take into account the clinical risks and benefits involved with their choices.
- 1.3 It is important that women and their families are given enough time to consider their choice and make decisions after an opportunity to reflect upon the information they have received. They should be encouraged to seek additional information and advice as desired.
- 1.4 Before birth, all women should receive information about the options available for intrapartum pain relief, including non-pharmacological techniques of established benefit, as well as established methods on inhalational, injectable and regional anaesthesia.
- 1.5 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 if they decline.

Related RANZCOG Statements

[Obstetricians and Childbirth: responsibilities \(C-Obs 1\)](#)

[Maternity Services to Remote and Rural Communities in Australia \(C-Obs 34\)](#)

[Guidelines for consent and the provision of information regarding proposed treatment \(C-Gen 2\)](#)

Organisation of Maternity Care

2. Planning appropriate maternity services for local communities

Communities should have access to maternity services which meet the needs of the local population. These services should be appropriate, acceptable and accessible to women and their families, and should ideally provide choice. Women should be involved in the planning and monitoring of such services.

Standard

- 2.1** The provision of maternity services should be based on an accurate and contemporaneous assessment of the needs and wishes of the local population. These include local transport services, wheelchair access, and the special needs of women with physical, sensory or learning disabilities, as well as the needs of women from disadvantaged or minority groups.

Related RANZCOG Statements

[Maternity Services to Remote and Rural Communities in Australia \(C-Obs 34\)](#)

[Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care \(C-Obs 30\)](#)

Organisation of Maternity Care

3. Appropriate 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 at the point of delivery.

Standards

General

- 3.1 All maternity units should have an Obstetrician or GP Obstetrician with primary administrative responsibility for the service.
- 3.2 Maternity service providers must ensure that medical, midwifery and ancillary staffing levels are appropriate to the clinical demand.
- 3.3 Maternity services that provide intrapartum care require a 24-hour anaesthesia and analgesia service, haematology and blood transfusion services, and a neonatal care service. Where, by virtue of location these services are not available, the woman and her family should be made aware of the limitations and be given an opportunity to birth elsewhere.
- 3.4 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.
- 3.5 Complex intrapartum cases require integrated, multi-professional specialist management and direct consultant involvement.
- 3.6 Maternity care providers must ensure that all healthcare professionals directly involved in birth are competent in basic adult, obstetric and neonatal resuscitation and immediate care. All staff who provide services to mothers and babies, in any location, must be trained to carry out adult and neonatal life support.

Midwives

- 3.7 An experienced midwife ('shift coordinator') should be available for each shift on the labour ward.
- 3.8 Maternity care providers should ensure that maternity services develop the capacity for every woman to have a designated midwife to provide care for them when in established labour, ideally for the entire time.
- 3.9 Each woman should receive one-to-one midwifery care during established labour and childbirth by a trained midwife or trainee midwife under adequate supervision.
- 3.10 An obstetrician (specialist or GP) or obstetric trainee under adequate supervision, must be contacted whenever a patient's condition gives rise for concern. There must be clear protocols, procedures and clinical guidelines for such interdisciplinary referral.

Obstetricians

- 3.11 All obstetric units must have a designated lead obstetrician.
- 3.12 All women with risk factors for their pregnancy should be seen by an obstetrician (specialist or GP) or obstetric trainee under adequate supervision.

- 3.13 An obstetrician (specialist or GP) should be available within 30 minutes outside the hours of consultant presence.
- 3.14 The obstetrician must attend in a timely manner whenever requested.
- 3.15 Complicated births in obstetric units should be attended by the obstetrician or obstetric trainee, with the degree of supervision commensurate with his/ her level of training and expertise.

Anaesthetists

- 3.16 Maternity services must nominate a designated lead anaesthetist (GP or specialist) with responsibility for the organisation and management of the obstetric anaesthetics service.
- 3.17 An anaesthetic service (specialist or GP) must be available at all times during childbirth.
- 3.18 A duty anaesthetist (specialist or GP) of appropriate competency must be available in a timely manner.
- 3.19 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 requires all team members to be informed of the case appropriately).
- 3.20 Trainee anaesthetists must be able to obtain prompt advice and help from a designated consultant anaesthetist at all times. They and their consultants must know the limits of their competence and when close supervision and help are needed. Morbidly obese women should not be anaesthetised by trainees without direct supervision.
- 3.21 All women requiring conduct of general anaesthesia should be seen and assessed by an anaesthetist before an elective procedure.

Paediatricians

- 3.22 Maternity services must nominate a designated lead paediatrician (GP or specialist) with responsibility for the organisation and management of the neonatal paediatric service.
- 3.23 There must be 24-hour availability in obstetric units within 30 minutes of a paediatrician (GP or specialist) trained and assessed as competent in neonatal advanced life support.
- 3.24 Units should ensure that there are guidelines concerning the circumstances in which senior neonatal staff should attend preterm deliveries.

Related RANZCOG Statements

[Policy Statement on Shared Maternity Care Obstetric Patients in Australia \(WPI 9\)](#)

[Antenatal care in Australian public hospitals \(WPI 10\)](#)

[Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care \(C-Obs 30\)](#)

[Maternity Services to Remote and Rural Communities in Australia \(C-Obs 34\)](#)

[Guidelines for the Assistance of Hospital Committees in the Delineation of Credentials and Scope of Clinical Practice for General Practitioner Obstetricians and Rural Non Specialist Obstetricians Practising Obstetrics in Australia \(WPI 6\)](#)

[RANZCOG / ANZCA / RACGP / ACCRM Position Statement on the provision of obstetric anaesthesia services \(WPI 14\)](#)

Organisation of Maternity Care

4. Provision of care in 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 or baby. This requires links between health and social care and provision within maternity and neonatal care networks that have the capacity to meet demand.

Standards

- 4.1 Where, by virtue of remote location, intrapartum support services are not immediately available, the woman and her family should be informed about those service limitations allowing an informed choice made regarding planned place of birth.
- 4.2 Maternity services that do not have adult intensive care facilities, advanced imaging and cardiology on site must have protocols in place for the care of women with significant medical or obstetric illness, to ensure that such women are delivered in a unit that can provide these resources.
- 4.3 Maternity services that do not have high 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.

Related RANZCOG Statements

[Statement on Stand-alone Primary Childbirth Units \(WPI 15\)](#)

[Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care \(C-Obs 30\)](#)

Organisation of Maternity Care

5. Training and maintenance of professional competence in maternity units

All maternity care providers are responsible for ensuring the provision of a skilled maternity care 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.

Standards

- 5.1 Obstetricians (GP and Specialist) 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
- 5.2 Obstetricians (GP and Specialist) and midwives must be competent to assist women in considering their options for antenatal, birth and postnatal care, and the clinical risks and benefits involved.
- 5.3 Obstetricians (GP and Specialist) and midwives should participate in a program of continuing professional development which includes:
 - a) Early identification and appropriate management, and referral if necessary, of women with obstetric or other complications.
 - b) Management of obstetric emergencies.
 - c) Education in new management strategies (diagnostic or therapeutic) as they become available.
 - d) Maintenance of professional knowledge and skills.
- 5.4 Specific training is needed so that advocates and translators understand the provision of maternity care and social services, to ensure that they can effectively help to guide women around the system.
- 5.5 Obstetricians (GP and Specialist) and midwives must be able to recognise their limits of competence and work within those limits.
- 5.6 Obstetricians (GP and Specialist) and midwives should be competent to elicit relevant information sensitively, and identify serious conditions occurring simultaneously, or a potentially serious past psychiatric history.
- 5.7 Obstetricians (GP and Specialist) and midwives should have a working knowledge of the impact of domestic abuse. Staff should be competent in recognising the symptoms and presentations of such abuse and be able to make appropriate referrals.

Related RANZCOG Statements

[Guidelines for the Assistance of Hospital Committees in the Delineation of Credentials and Scope of Clinical Practice for General Practitioner Obstetricians and Rural Non Specialist Obstetricians Practising Obstetrics in Australia \(WPI 6\)](#)

[Policy Statement on Shared Maternity Care Obstetric Patients in Australia \(WPI 9\)](#)

[Obstetrician's Competence and performance \(WPI 11\)](#)

[Re-entry guidelines following a prolonged period of absence from practice and retraining programs for Fellows \(WPI 13\)](#)

[Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care \(C-Obs 30\)](#)

Organisation of Maternity Care

6. Inter-professional communication

Good inter-professional communication is essential for effective and coordinated care.

Standards

- 6.1 Training on how to communicate information in an effective sensitive manner should be provided to all healthcare professionals.
- 6.2 There should be effective systems of communication between all team members and each discipline, as well as with women and their families.
- 6.3 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.
- 6.4 There should be a personal handover of care on the labour ward when midwifery and medical shifts change. Locums should receive a personal handover either by the post holder or senior member of the medical team and vice versa.
- 6.5 Each institution should have mechanisms to deal with situations that may arise where there is a difference of opinion between clinicians involved in the management of women in labour.

Related RANZCOG Statements

[Policy Statement on Shared Maternity Care Obstetric Patients in Australia \(WPI 9\)](#)

[Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care \(C-Obs 30\)](#)

Organisation of Maternity Care

7. Clinical governance of maternity services

Safety should always be the foremost priority in clinical 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.

Standards

- 7.1 Clinical governance structures should be implemented in all places of birth.
- 7.2 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.
- 7.3 Where an incident has occurred, every unit should follow a clear mechanism for managing the situation including investigation, learning, communication and where necessary, implementing changes to existing systems, training or staffing levels.
- 7.4 Maternity services should comply with evidence-based guidelines for the provision of high-quality clinical care.
- 7.5 There should be evidence that appropriately trained and experienced professionals obtain informed consent for interventions and investigations, and this should be documented.
- 7.6 There should be an audit system in place to monitor important aspects of maternity care and ensure an audit cycle to effect change.
- 7.7 A compliments, comments and complaints procedure should be in place to enable women to express views about their pregnancy and childbirth experience.
- 7.8 Incident forms should be completed whenever an identified trigger event has occurred or whenever an incident has occurred which is outside the normal or expected.
- 7.9 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.

Related RANZCOG Statements

[Guidelines for consent and the provision of information regarding proposed treatment \(C-Gen 2\)](#)

Organisation of Maternity Care

8. 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 providing care.

Standards

- 8.1 Structured and accurate records should be kept of all antenatal, intrapartum and postnatal care.
- 8.2 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.
- 8.3 The initial antenatal booking should take place in early pregnancy, ideally by 12 completed weeks of pregnancy.
- 8.4 Referring family doctors should provide as detailed and informative an account of the woman's general health as possible, along with a referral for pregnancy care.
- 8.5 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.
- 8.6 Women should be encouraged to carry their personal pregnancy record, summarising their care and relevant investigations to date to facilitate clear communication and seamless care when seeking medical attention during pregnancy.
- 8.7 Healthcare services should be provided in environments which promote effective care and optimise health outcomes by being supportive of patient privacy and confidentiality.
- 8.8 The personal child health record should be given to all women as soon as possible after birth (if it has not been received antenatally) and its use explained.

Related RANZCOG Statements

[Maternal and Perinatal Data Collection \(C-Obs 40\)](#)

[Pre-pregnancy Counselling & Antenatal Screening Tests \(C-Obs 3\)](#)

Organisation of Maternity Care

9. Infection prevention and control

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

Standards

9.1 Healthcare providers must ensure that there are in place policies in relation to preventing and controlling the risks of healthcare-associated infections.

Specifically in maternity services these should include:

- ~ aseptic technique policy
- ~ safe handling of sharps policy
- ~ prevention of occupational exposure to blood-borne viruses policy
- ~ disinfection policy
- ~ antimicrobial prescribing policy
- ~ uniform and work wear policy

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

9.3 Maternity service providers should ensure that there is adequate provision of suitable hand washing facilities and antibacterial hand rubs.

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

Related RANZCOG Statements

[Hepatitis B \(C-Gen 3\)](#)

[Hepatitis C \(C-Gen 4\)](#)

[Screening and Treatment for Group B Streptococcus in Pregnancy \(C-Obs 19\)](#)

Pre-Pregnancy Care

10. Preparation for pregnancy

Improving the general health of the whole population through increasing knowledge and understanding of healthy lifestyles should be an underlying philosophy of all health, education and social services. 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 her future family.

Standards

- 10.1** All providers of health services should prioritise the health of women of reproductive age, recognising the importance of prior health on a subsequent pregnancy.
- 10.2** Every visit of a woman of reproductive age to their medical practitioner should be seen as an opportunity to plan for pregnancy or contraception if required.
- 10.3** Pre-pregnancy advice should include the following: interim contraception (if needed), nutrition, exercise, weight targets, sexual health, smoking, alcohol, illicit drugs, advice regarding necessary vaccinations (prior to or during pregnancy) and PAP smear

Related RANZCOG Statements

[Pre-pregnancy Counselling & Antenatal Screening Tests \(C-Obs 3\)](#)

[RANZCOG / RACGP Statement on Pap Smears \(C-Gyn 19\)](#)

[Women and smoking \(C-Gen 5\)](#)

[Alcohol in pregnancy \(C-Gen 13\)](#)

Pre-Pregnancy Care

11. Pre-pregnancy care for women with existing medical conditions, or significant family or obstetric history

Although the majority of reproductive age women are healthy, a number will have pre-existing conditions that may become important during pregnancy. Women with existing medical conditions need to be aware of the effect of their condition(s) on pregnancy, and of pregnancy on their condition. Those with a family or personal history of medical disorders or poor obstetric outcomes need to discuss and understand their relevance and implications in a future pregnancy. This is of particular importance for women at social disadvantage. Ideally, pre-pregnancy counselling should be provided by specialist obstetricians, if necessary working in collaboration with suitably qualified and experienced clinicians working in other disciplines (for example physicians, psychiatrists, and genetic counsellors).

Standards

- 11.1 All providers of maternity care should ensure that family doctors, general practitioners, medical specialists and other health professionals (for example, genetic counsellors, family planning or sexual health clinicians) work closely together to identify women with existing medical or familial conditions who may become pregnant and ensure they have access to specialist advice pre-pregnancy.
- 11.2 Women with existing serious medical conditions should have pre-pregnancy counselling at every opportunity, even if they are not immediately seeking pregnancy. This is especially the case if they seek assisted reproduction.
- 11.3 Pre-pregnancy counselling and support, both opportunistic and planned, should be provided for women of childbearing age with existing serious medical or mental health conditions which may be aggravated by pregnancy. Conditions of particular importance include: epilepsy, diabetes, congenital or known acquired cardiac disease, autoimmune disorders, obesity (body mass index greater than 30) or a history of severe mental illness.
- 11.4 Specific pre-pregnancy services should be available to women with a poor obstetric or medical history, a previous poor fetal or obstetric outcome, or where there is a family history of significant illness.

Related RANZCOG Statements

[Pre-pregnancy Counselling & Antenatal Screening Tests \(C-Obs 3\)](#)

[Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care \(C-Obs 30\)](#)

Care During Pregnancy

12. Access to maternity care

It is known that early access to, and engagement with, maternity services enables a plan of care to be established. Planning the type of care must take into account the available resources and 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.

Standards

- 12.1 Antenatal care should ideally be readily and easily accessible to all women.
- 12.2 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.
- 12.3 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.
- 12.4 Where possible, specialist services should be provided for pregnant teenagers, such as peer parent education and support groups.
- 12.5 There should be provision for translation, interpreting and advocacy services, based on an assessment of the needs of the local population.
- 12.6 Services should attempt to meet the needs of all women, including the vulnerable and hard to reach groups.
- 12.7 Local maternity services should ensure that they are inclusive for women with learning and physical disabilities and take into account their communication, equipment and support needs.

Related RANZCOG Statements

[Pre-pregnancy Counselling & Antenatal Screening Tests \(C-Obs 3\)](#)

[Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care \(C-Obs 30\)](#)

Care During Pregnancy

13. Early pregnancy services

A significant proportion of women develop pain and bleeding in early pregnancy and require timely assessment and sensitive management in a specialist setting. Poor clinical outcomes have been linked to inappropriate management.

Standards

- 13.1** Women who experience complications in early pregnancy should have prompt access to a medical assessment. Models for this include early pregnancy assessment clinics at public hospitals, urgent assessment by specialist obstetricians or experienced general practitioner obstetricians, or other doctors experienced in women's health.
- 13.2** 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.
- 13.3** 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.
- 13.4** Appropriately skilled and senior staff should be available to support parents following maternal or neonatal death, stillbirth or miscarriage.

Related RANZCOG Statements

[Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care \(C-Obs 30\)](#)
[Pre-pregnancy Counselling & Antenatal Screening Tests \(C-Obs 3\)](#)

Care During Pregnancy

14. Maternity booking and planning of care

The booking process is the opportunity to establish contact and rapport with a pregnant woman. It should include a detailed evaluation of the index pregnancy, past reproductive and medical history, general physical health, and include discussion with the woman about her rights, responsibilities and choices for her maternity care. Those choices will be shaped by detailed history taking and physical examination and sharing of information regarding her options.

Standards

- 14.1 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.
- 14.2 At the first contact, pregnant women should be offered information about: how the baby develops during pregnancy, nutrition and diet, including vitamin D supplements, exercise, antenatal screening, including risks and benefits of the screening tests, the pregnancy care pathway, points of contact should problems arise, and information about the resources available during pregnancy for preparation for childbirth and breastfeeding
- 14.3 Booking should take place in early pregnancy and ideally all pregnant women should have had their first full booking visit and a hand held maternity record completed by 12 weeks of pregnancy.
- 14.4 A risk and needs assessment including previous obstetric, medical and social history, must be carried out to ensure that every woman has a plan of care adapted to her own particular requirements for antenatal care, delivery and postnatal care.
- 14.5 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.
- 14.6 Information should be available in different languages, with particular cultural beliefs or sensitivities appropriately reflected.
- 14.7 All pregnant women and their partners who smoke should receive clear information about the risks of smoking and the support available to them to help them stop, such as the Quit line.

Related RANZCOG Statements

[Pre-pregnancy Counselling & Antenatal Screening Tests \(C-Obs 3\)](#)

[Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care \(C-Obs 30\)](#)

[Maternal and Perinatal Data Collection \(C-Obs 40\)](#)

Care During Pregnancy

15. 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 to be provided by an appropriate multidisciplinary team to optimise and improve outcomes.

Standards

- 15.1** 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.
- 15.2** 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 (body mass index 30 or more), severe pre-existing or past mental health disorder and any condition for which they are under continuing specialist medical review.
- 15.3** 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.
- 15.4** For women with diabetes, an individualised plan of care covering the pregnancy, birth and postnatal period up to 6 weeks postpartum should be clearly documented in the notes.
- 15.5** Women at socio-economic disadvantage may be at particular risk from previously 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.
- 15.6** 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 which helps them to disclose and discuss their mental health issues.
- 15.7** All maternity care providers and mental health care providers should have in place joint working arrangements for maternity and mental health services, including access to a perinatal psychiatrist as required.
- 15.8** 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.
- 15.9** 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.
- 15.10** During pregnancy, all women who are at identified 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, which includes a system of close supervision following birth.
- 15.11** All professionals involved in the care of women immediately following childbirth 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.

- 15.12** Women who require to be admitted 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.

Related RANZCOG Statements

[Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care \(C-Obs 30\)](#)
[Maternal and Perinatal Data Collection \(C-Obs 40\)](#)

Care During Pregnancy

16. Women with social needs

Rationale

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.

Standards

- 16.1** Maternity services should have in place inter-agency arrangements (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.
- 16.2** 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.
- 16.3** Interpreting services should be provided for women where 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.
- 16.4** Services should strive to be innovative and flexible in meeting the needs of women with communication and other disabilities.
- 16.5** Joint working arrangements should be fostered between maternity services and local agencies with responsibility for dealing with domestic abuse and information about such services should be made available to all pregnant women.
- 16.6** All women who have a significant drug and/or alcohol problem should receive their care from a multi-agency team which will include a specialist obstetrician, and involving social workers and other specialist health professionals.
- 16.7** Healthcare professionals should be alert to risk factors and signs and symptoms of child abuse. If there is raised concern, healthcare professionals should follow local and statutory child protection policies.
- 16.8** 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.

Related RANZCOG Statements

[Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care \(C-Obs 30\)](#)
[Policy Statement on Shared Maternity Care Obstetric Patients in Australia \(WPI 9\)](#)

Care During Pregnancy

17. Antenatal screening

An integral component of antenatal care is the timely diagnosis and appropriate management of maternal problems and detection of fetal conditions to inform choice and the continuing plan of care.

Standards

- 17.1 All women should have access to comprehensive screening services including a detailed clinical history, physical examination and investigations.
- 17.2 Specific investigations should be offered or recommended according to RANZCOG guidelines. Where investigations are 'recommended', the reason for that recommendation should be explained. Where investigations are 'offered', relevant information should be provided to assist the patient in making a decision.
- 17.3 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.
- 17.4 All women who are identified in the screening programme as at risk of pregnancy complications should be managed according to college guidelines
- 17.5 Ideally, pregnant women should have access to a first trimester ultrasound scan to determine gestational age (*in lieu* of last menstrual period [LMP] for all cases), to detect multiple pregnancies and / or as a screening test for congenital anomalies.

Related RANZCOG Statements

[Pre-pregnancy Counselling & Antenatal Screening Tests \(C-Obs 3\)](#)

[Prenatal Screening tests for Trisomy 21 \(Down syndrome\), Trisomy 18 \(Edwards syndrome\) and Neural Tube defects \(C-Obs 4\)](#)

[Joint HGSA/RANZCOG Prenatal Diagnosis Policy \(C-Obs 5\)](#)

[Prenatal Screening for Fetal Abnormalities \(C-Obs 35\)](#)

Care During Pregnancy

18. Routine antenatal care

Routine antenatal care focuses upon:

- a) Maintaining and improving health and general wellbeing, emphasising the importance of a healthy diet, exercise and avoiding smoking, alcohol and illicit drugs are all important for the pregnancy, the mother and unborn child – as well as establishing patterns of healthy living for the entire family.
- b) Continuing to screen for the management of pregnancy complications through vigilant history, clinical examination and appropriate investigations through the pregnancy according to college guidelines.
- c) management of any pregnancy complications as they arise

Standards

- 18.1** Each provider of maternity services should have an explicit plan for antenatal care for all women.
- 18.2** 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 childbirth.
- 18.3** Maternity services should provide comprehensive programmes of education for childbirth and parenthood to women and their partners and families, taking care to include information with respect to:
 - a) the course of an uncomplicated pregnancy
 - b) the possible need for obstetric intervention
 - c) the common obstetric procedures
 - d) options for pain relief in labour without prejudice
- 18.4** For women with an uncomplicated pregnancy, the visit schedule should commence in the first trimester and consider the need to:
 - a) adequately screen for pregnancy complications through clinical assessment and appropriately timed investigations according to college guidelines
 - b) discuss the results of investigations such as screening tests in a timely manner
- 18.5** Each antenatal appointment should be of appropriate duration and structured with focused content. Wherever possible, appointments should incorporate routine tests and investigations to minimise inconvenience to women.
- 18.6** A system of clear referral paths should be established so that pregnant women who require additional care are managed and treated by the appropriate specialist teams when problems are identified.

Related RANZCOG Statements

[Routine Intrapartum Care in the absence of Pregnancy Complications \(C-Obs 31\)](#)

Care During Pregnancy

19. Specific pregnancy-related conditions

The purpose of antenatal care is early detection of problems that require additional support. Providers of maternity care should be aware of what facilities and which practitioners can be accessed so as to ensure these complications are managed appropriately to ensure the best possible outcome for mother and baby.

Standards

- 19.1** A system of clear referral paths should be established so that pregnant women who require additional care are managed and treated by the appropriate specialist teams when problems are identified.
- 19.2** Multidisciplinary, high-quality teamwork is essential. Professionals should communicate with other professionals and colleagues and should be supported by identified care pathways for referral.
- 19.3** 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 part of good obstetric management and efforts must be made to ensure the patient's unique needs are met.
- 19.4** Women with complex pregnancies and those receiving care from a number of specialists or agencies should receive the support of a single medical practitioner throughout the pregnancy, either the woman's family doctor or an obstetrician.
- 19.5** The development and routine use of an obstetric 'early warning chart' which will help in the more timely recognition, treatment and referral of women who have, or are developing, a critical illness should be encouraged.
- 19.6** The consultant obstetrician on-call should be told about all sick pregnant or postnatal women in hospital, whether they have a medical or an obstetric problem.
- 19.7** 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 by telephone.
- 19.8** All maternity care providers should ensure that consultant-led services have adequate facilities, expertise, capacity and back-up for timely and comprehensive obstetric emergency care, including transfer to intensive care.

Related RANZCOG Statements

[Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care \(C-Obs 30\)](#)
[Evidence-based Medicine, Obstetrics and Gynaecology \(C-Gen 15\)](#)

Care During Birth

20. Intrapartum care

In a statistical sense, late pregnancy, labour and birth are associated with significant clinical risk to mother and baby. Fortunately, vigilant surveillance and timely intervention have made these times extraordinarily safe for most women. With appropriate antenatal education, the intrapartum experience will not be lessened by a false expectation of an absence of obstetric interventions.

Standards

- 20.1** The organisation has a robust and transparent clinical governance framework which is applicable to each birth setting with a defined clinical leader who carries ultimate responsibility for clinical decisions.
- 20.2** Effective multidisciplinary working is essential to the efficient delivery of the service.
- 20.3** Both intra- and inter-professional communication are keystones of good clinical practice.
- 20.4** Safe staffing levels of all professionals and support staff as recommended are maintained, reviewed and audited annually for each birth setting. This includes obstetric operating theatres, labour wards, ante and post natal wards.
- 20.5** Core responsibilities of obstetricians, midwives, anaesthetists and neonatal paediatricians are clearly defined.
- 20.6** Each birth setting has clinical protocols, procedures and guidelines to assist the health care providers in the delivery of clinical care.
- 20.7** Clinical protocols:
 - a) are based on clinical, organisational and system needs
 - b) guide clinical practice rather than obligate
 - c) restrict clinical practice where needed for the individual or organisation
 - d) allow a diversity of clinical practice where more than one reasonable option is present
 - e) do not preclude individualisation of patient care to best meet the unique needs of the mother
- 20.8** All professional staff must have the opportunity and support for continuing professional development, including agreed mandatory education and training sessions.
- 20.9** Facilities in birth settings should be at an appropriate standard.
- 20.10** All services delivering intrapartum care should have timely access to:
 - a) operative care
 - b) specialist services including anaesthesia, neonatal paediatrics and haematology

Where by virtue of remote location, such services are not immediately available, the woman should be appraised of any service limitations and an informed choice made regarding planned location of birth.

Related RANZCOG Statements

[Obstetricians and Childbirth: responsibilities \(C-Obs 1\)](#)

[Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care \(C-Obs 30\)](#)

[Maternity Services to Remote and Rural Communities in Australia \(C-Obs 34\)](#)

[Statement on Stand-alone Primary Childbirth Units \(WPI 15\)](#)

Care in the Puerperium and Neonatal Period

21. Neonatal care and assessment

Most babies are born, and remain, healthy. The newborn infant physical examination is a key element of the child health surveillance programme. Early recognition and treatment of some problems can have a significant impact on the health of the child.

Standards

- 21.1** The personal child health record should be given to all women as soon as possible and its use explained.
- 21.2** All consultant-led obstetric units should have ready access to paediatricians who have responsibility and a special interest in neonatology.
- 21.3** All examinations of the baby should be performed by a suitably qualified healthcare professional who has up-to-date training in neonatal examination techniques.
- 21.4** All newborn infants should have a complete clinical examination within 72 hours of birth.
- 21.5** Prompt referral for further medical investigation or treatment should be provided through agreed clinical care pathways.
- 21.6** Professionals should be skilled in sharing information, concerns and treatment choices with parents and other members of the maternity care team if any abnormal condition in the baby is diagnosed
- 21.7** Wherever possible, separation of mothers and babies should be avoided by nursing babies who require additional care with appropriately trained staff on the postnatal wards.
- 21.8** Babies at high risk of hypoglycaemia (e.g. small for dates or born to women with diabetes) should be closely monitored in the postnatal period. Clear agreed guidelines should be in place.
- 21.9** Guidelines should be in place to minimise the number of infants who require rewarming or avoidable admission to special care baby unit (SCBU).
- 21.10** The newborn blood spot screening (heel prick) tests for phenylketonuria, congenital hypothyroidism, cystic fibrosis, MCADD (medium chain acylCoA dehydrogenase deficiency) should be offered and discussed with all women and their partners following the birth of the baby.
- 21.11** Vitamin K is recommended for all newborns.
- 21.12** Women and their families should be offered newborn screening for hearing problems, and prophylactic vaccinations such as Hepatitis B in accordance with accepted protocols.

Related RANZCOG Statements

[Hepatitis B \(C-Gen 3\)](#)

[Joint Statement and Recommendations on Vitamin K Administration to New Born Infants to Prevent Vitamin K Deficiency and Bleeding in Infancy](#)

Care in the Puerperium and Neonatal Period

22. Postnatal assessment and care of the mother, including breastfeeding

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.

Standards

- 22.1** 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
 - ~ details of the healthcare professionals involved in her care and that of her baby, including roles and contact details
- 22.2** All women should be assessed immediately after giving birth by a suitably qualified member of the birth team (doctor or a midwife) and again prior to transfer to community care and/or within 24 hours of giving birth, by a midwife.
- 22.3** 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.
- 22.4** All professionals involved in the care of women immediately following childbirth 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.
- 22.5** 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.

Breastfeeding

- 22.6** Maternity services should adhere to the principles and work toward the recommendations of UNICEF/WHO Baby Friendly (vii) status.
- 22.7** Attention should be paid to facilitating an environment that supports skin-to-skin contact where possible. Skin-to-skin 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.
- 22.8** All healthcare providers (hospitals and community) should have a written breastfeeding policy that is communicated to all staff and parents.
- 22.9** Each maternity service should have a nominated person identified to implement the breast feeding policy.
- 22.10** 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.
- 22.11** 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 cleanse and sterilise feeding bottles and teats and how to store formula milk.
- 22.12** 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.
- 22.13** Mothers should have access to [nutritious] food and drink on demand.

- 22.14** Women who are taking medicines should receive specialist advice, based on best available evidence, in relation to breastfeeding.
- 22.15** 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.
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Care in the Puerperium and Neonatal Period

23. Care of babies requiring additional support, including babies born preterm

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.

Standards

- 23.1** All newborn infants 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.
- 23.2** Concerns expressed by the parents as to the wellbeing of the baby, or identified through clinical observations, should be assessed.
- 23.3** Health professionals should ensure that parents are offered newborn screening for their babies, and that appropriate follow-up care is arranged if necessary.
- 23.4** Particular support in breastfeeding should be provided for mothers who have had a multiple birth or have a premature or sick baby.
- 23.5** Care of the baby should ensure there is ongoing assessment, including recognition of group B streptococcal infection and jaundice.
- 23.6** 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.
- 23.7** 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.
- 23.8** Parents of babies with identifiable medical or physical problems should receive timely and appropriate care and support in an appropriate environment.
- 23.9** Because extremely premature births may take place rapidly when no senior members of the team are available, 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.
- 23.10** Special care baby unit facilities should be available on site in all units that deliver.
- 23.11** 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.
- 23.12** 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 the appropriate use of magnesium sulphate for neuroprotection.
- 23.13** The care of babies born at the threshold of viability will be partly determined by the available expertise and resources.

Related RANZCOG Statements

[Screening and Treatment for Group B Streptococcus in Pregnancy \(C-Obs 19\)](#)

Related RANZCOG Published Documents

[Magnesium sulphate in women at risk of preterm birth for neuroprotection of the fetus](#); A/Prof Susan Walker, O&G, 2010, Vol 12, No 2

Other Related Non College Statements

[Perinatal care at the borderlines of viability: a consensus statement based on a NSW and ACT consensus workshop](#); Kei Lui, Barbara Bajuk, Kirsty Foster, Arnolda Gaston, Alison Kent, John Sinn, Kaye Spence, Wendy Fischer and David Henderson-Smart; MJA 2006; 185 (9): 495-500

Care in the Puerperium and Neonatal Period

24. Promotion of 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 that inhibit the development of positive parent–infant relationships that require professional intervention.

Standards

- 24.1 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.
 - 24.2 Services responsible for postnatal care should be able to support parents in developing a basic understanding of attachment issues, infant mental health and their role in supporting their child's mental and emotional development.
 - 24.3 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 parent's condition on any dependants and young siblings.
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Care in the Puerperium and Neonatal Period

25. Transition to parenthood

Rationale

Health professionals 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.

Standards

- 25.1 Postnatal care should include provision of information to both mothers and fathers on infant care, parenting skills and accessing local community support groups.
 - 25.2 A coordinating healthcare professional should be identified for each woman. In ideal circumstances, this should be the family doctor or suitable general practitioner. Additional support can be obtained from maternal and child health nurses and clinics.
 - 25.3 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 post-natal visit by an obstetrician or general practitioner obstetrician, but other suitably qualified clinicians might also perform this function.
 - 25.4 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.
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Care in the Puerperium and Neonatal Period

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

Rationale

Bereavement can be extremely traumatic. Providers of maternity care need to ensure support and information for women and their families both during the acute time of the event and continuing through the weeks or months afterwards.

Standards

- 26.1 Maternity care providers should ensure there are comprehensive, culturally sensitive, multidisciplinary policies, services and facilities for the management and support of families (and staff) who have experienced an early or mid pregnancy loss, stillbirth or neonatal death.
 - 26.2 Consideration should be given to lactation suppression in losses beyond the mid trimester.
 - 26.3 Skilled staff should be available to support parents following a maternal or neonatal death, a stillbirth or miscarriage.
 - 26.4 Information [that includes details about investigations (including post-mortems), birth and death registration and options for disposal of the body] should be available in different languages with particular cultural beliefs or sensitivities appropriately reflected.
 - 26.5 Local guidelines must include clear communication pathways between secondary care and the primary care team with the woman's GP informed of any death within one working day.
 - 26.6 Parents of stillborn babies or babies with identifiable medical or physical problems should receive timely and appropriate care and support in an appropriate environment.
 - 26.7 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 (e.g. SANDS).
 - 26.8 Following the death of a baby, preliminary results of placental and post-mortem histology should be available within 6 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.
 - 26.9 There must be a clear and consistent local policy about the sensitive disposal of fetal tissues after early pregnancy loss.
 - 26.10 Post-mortem examination of a baby should be performed by a specialist perinatal pathologist where resources allow.
 - 26.11 Access to family planning/contraception should be available to parents following pregnancy loss stillbirth or neonatal loss.
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Related RANZCOG College Statements Summary

All Statements and Guidelines reference in this Standard are available on the RANZCOG website at: www.ranzcog.edu.au/publications/collegestatements.shtml

Organisation of Maternity Care

Provision of Choice for Women and their Families

[Obstetricians and Childbirth: responsibilities \(C-Obs 1\)](#)

[Maternity Services to Remote and Rural Communities in Australia \(C-Obs 34\)](#)

[Guidelines for consent and the provision of information regarding proposed treatment \(C-Gen 2\)](#)

Planning Appropriate Maternity Services for Local Communities

[Maternity Services to Remote and Rural Communities in Australia \(C-Obs 34\)](#)

[Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care \(C-Obs 30\)](#)

Appropriate Staffing for Maternity Services

[Policy Statement on Shared Maternity Care Obstetric Patients in Australia \(WPI 9\)](#)

[Antenatal care in Australian public hospitals \(WPI 10\)](#)

[Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care \(C-Obs 30\)](#)

[Maternity Services to Remote and Rural Communities in Australia \(C-Obs 34\)](#)

[Guidelines for the Assistance of Hospital Committees in the Delineation of Credentials and Scope of Clinical Practice for General Practitioner Obstetricians and Rural Non Specialist Obstetricians Practising Obstetrics in Australia \(WPI 6\)](#)

[RANZCOG / ANZCA / RACGP / ACCRM Position Statement on the provision of obstetric anaesthesia services \(WPI 14\)](#)

Provision of Care in Maternity Units with Service Limitations

[Maternity Services to Remote and Rural Communities in Australia \(C-Obs 34\)](#)

[Statement on Stand-alone Primary Childbirth Units \(WPI 15\)](#)

[Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care \(C-Obs 30\)](#)

Training and Maintenance of Professional Competence in Maternity Units

[Guidelines for the Assistance of Hospital Committees in the Delineation of Credentials and Scope of Clinical Practice for General Practitioner Obstetricians and Rural Non Specialist Obstetricians Practising Obstetrics in Australia \(WPI 6\)](#)

[Policy Statement on Shared Maternity Care Obstetric Patients in Australia \(WPI 9\)](#)

[Obstetrician's Competence and performance \(WPI 11\)](#)

[Re-entry guidelines following a prolonged period of absence from practice and retraining programs for Fellows \(WPI 13\)](#)

[Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care \(C-Obs 30\)](#)

Inter-Professional Communication

[Policy Statement on Shared Maternity Care Obstetric Patients in Australia \(WPI 9\)](#)

[Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care \(C-Obs 30\)](#)

Clinical Governance of Maternity Services

[Guidelines for consent and the provision of information regarding proposed treatment \(C-Gen 2\)](#)
[Evidence-based Medicine, Obstetrics and Gynaecology \(C-Gen 15\)](#)

Documentation and Confidentiality

[Maternal and Perinatal Data Collection \(C-Obs 40\)](#)
[Pre-pregnancy Counselling & Antenatal Screening Tests \(C-Obs 3\)](#)

Infection Prevention and Control

[Hepatitis B \(C-Gen 3\)](#)
[Hepatitis C \(C-Gen 4\)](#)
[Pre-pregnancy Counselling & Antenatal Screening Tests \(C-Obs 3\)](#)
[Screening and Treatment for Group B Streptococcus in Pregnancy \(C-Obs 19\)](#)

Pre-Pregnancy Care

Preparation for Pregnancy

[Pre-pregnancy Counselling & Antenatal Screening Tests \(C-Obs 3\)](#)
[RANZCOG / RACGP Statement on Pap Smears \(C-Gyn 19\)](#)
[Women and smoking \(C-Gen 5\)](#)
[Alcohol in pregnancy \(C-Gen 13\)](#)

Pre-Pregnancy Care for Women with Existing Medical Conditions, or Significant Family or Obstetric History

[Pre-pregnancy Counselling & Antenatal Screening Tests \(C-Obs 3\)](#)
[Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care \(C-Obs 30\)](#)

Care During Pregnancy

Access to Maternity Care

[Pre-pregnancy Counselling & Antenatal Screening Tests \(C-Obs 3\)](#)
[Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care \(C-Obs 30\)](#)

Early Pregnancy Services

[Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care \(C-Obs 30\)](#)
[Pre-pregnancy Counselling & Antenatal Screening Tests \(C-Obs 3\)](#)

Maternity Booking and Planning of Care

[Pre-pregnancy Counselling & Antenatal Screening Tests \(C-Obs 3\)](#)
[Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care \(C-Obs 30\)](#)
[Maternal and Perinatal Data Collection \(C-Obs 40\)](#)

Pre-Existing Medical Conditions in Pregnancy, Including Mental Health Issues

[Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care \(C-Obs 30\)](#)
[Maternal and Perinatal Data Collection \(C-Obs 40\)](#)

Women with Social Needs

[Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care \(C-Obs 30\)](#)

[Policy Statement on Shared Maternity Care Obstetric Patients in Australia \(WPI 9\)](#)

Antenatal Screening

[Pre-pregnancy Counselling & Antenatal Screening Tests \(C-Obs 3\)](#)

[Prenatal Screening tests for Trisomy 21 \(Down syndrome\), Trisomy 18 \(Edwards syndrome\) and Neural Tube defects \(C-Obs 4\)](#)

[Joint HGSA/RANZCOG Prenatal Diagnosis Policy \(C-Obs 5\)](#)

[Prenatal Screening for Fetal Abnormalities \(C-Obs 35\)](#)

Routine Antenatal Care

[Routine Intrapartum Care in the absence of Pregnancy Complications \(C-Obs 31\)](#)

Specific Pregnancy-Related Conditions

[Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care \(C-Obs 30\)](#)

[Evidence-based Medicine, Obstetrics and Gynaecology \(C-Gen 15\)](#)

Care During Birth

Intrapartum Care

[Obstetricians and Childbirth: responsibilities \(C-Obs 1\)](#)

[Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care \(C-Obs 30\)](#)

[Maternity Services to Remote and Rural Communities in Australia \(C-Obs 34\)](#)

[Statement on Stand-alone Primary Childbirth Units \(WPI 15\)](#)

Care in the Puerperium and Neonatal Period

Neonatal Care and Assessment

[Hepatitis B \(C-Gen 3\)](#)

[Joint Statement and Recommendations on Vitamin K Administration to New Born Infants to Prevent Vitamin K Deficiency and Bleeding in Infancy](#); NHMRC, RACP, RANZCOG, RACGP & ACM; Oct 2010

Care of Babies Requiring Additional Support, Including Babies Born Preterm

[Screening and Treatment for Group B Streptococcus in Pregnancy \(C-Obs 19\)](#)

Related RANZCOG Published Documents

[Magnesium sulphate in women at risk of preterm birth for neuroprotection of the fetus](#); A/Prof Susan Walker, O&G, 2010, Vol 12, No 2

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[Perinatal care at the borderlines of viability: a consensus statement based on a NSW and ACT consensus workshop](#); Kei Lui, Barbara Bajuk, Kirsty Foster, Arnolda Gaston, Alison Kent, John Sinn, Kaye Spence, Wendy Fischer and David Henderson-Smart; MJA 2006; 185 (9): 495-500

