OBSTETRICS AND GYNAECOLOGY
CLINICAL PRACTICE GUIDELINE

Partnering with the woman who declines recommended maternity care

Scope (Staff):	WNHS Obstetrics and Gynaecology Directorate staff
Scope (Area):	Obstetrics and Gynaecology Directorate clinical areas at KEMH, OPH and home visiting (e.g. Visiting Midwifery Services, Community Midwifery Program and Midwifery Group Practice)

This document should be read in conjunction with this Disclaimer

Contents

Acknowledgments

WNHS would like to acknowledge the State of Queensland (Queensland Health) for the use, replication and adaptation of their resources in the development of this document, including ‘Clinical Excellence Queensland, Guideline: Partnering with the woman who declines recommended maternity care, V1.0, 2020, Queensland Health: Brisbane’.

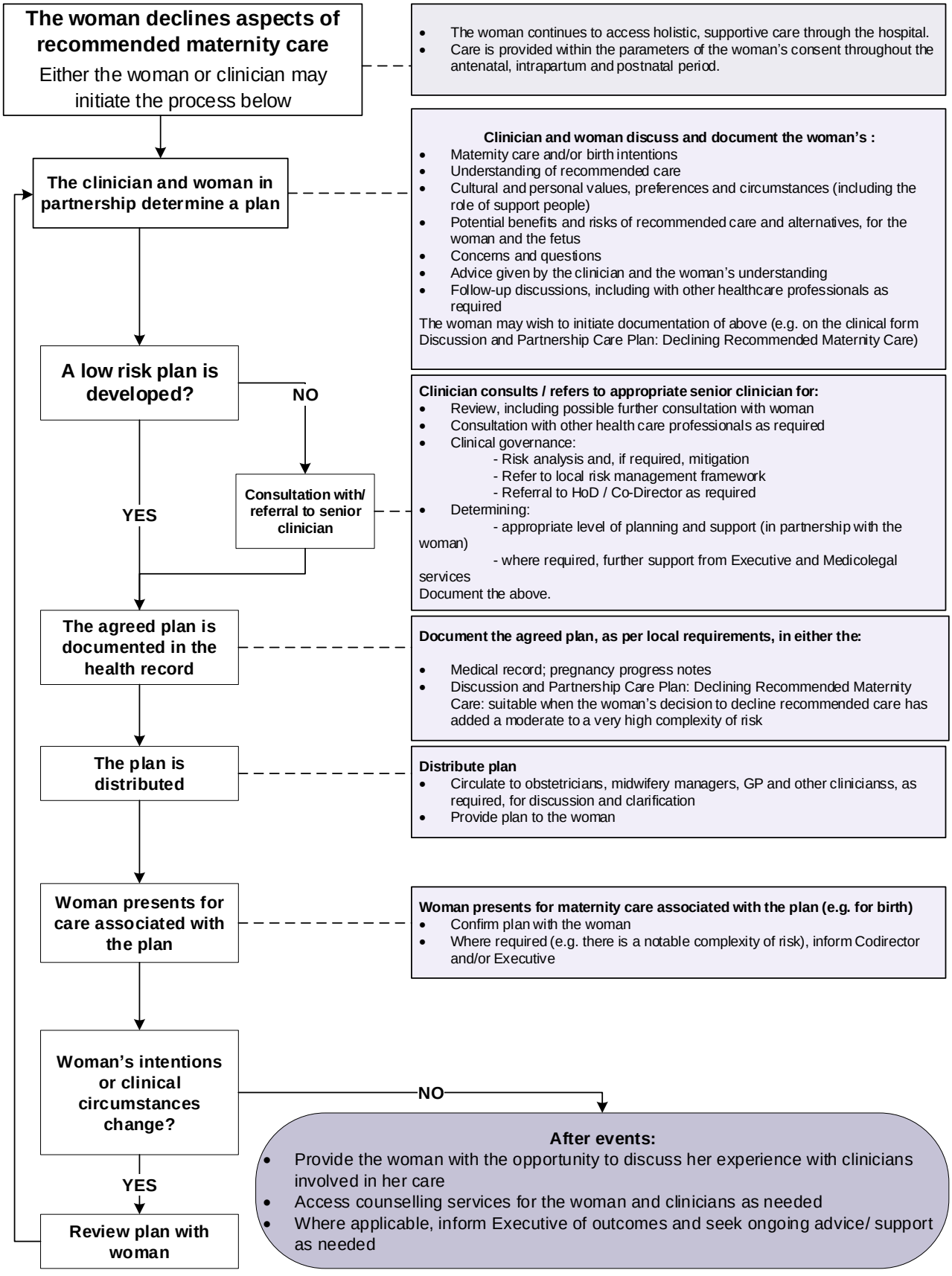
WNHS would like to also acknowledge the consumers, Community Advisory Council and working group members who contributed to adapting resources for WNHS.

Cultural acknowledgment

We acknowledge the Noongar people as the traditional owners and custodians of the land on which we work, and pay respect to their elders both past and present.

North Metropolitan Health Service recognises, respects and values Aboriginal cultures as we walk a new path together.

Flowchart: Partnering with the woman who declines recommended maternity care: Antenatal preparation



If the woman declines recommended care for the first time in labour and/ or where there is an emergent situation: Refer to Flowchart: Partnering with the woman who declines recommended maternity care in an emergent situation and/ or labour and is declining care that has not previously been discussed.

Acknowledgment: QLD Health [1]

Key points

Principles and actions for clinicians
1. Consumers have the right to decline recommended maternity care[3, 4]
1.1. Encourage the woman to make fully informed decisions by discussing available care and treatment options, including expected outcomes, risks and benefits 1.1.1. Identify, where applicable, benefits and risks, including any limitations, of the woman's preferred birth setting 1.1.2. Provide women with information and support that is evidence-based, culturally appropriate and tailored to their needs 1.2. Inform the woman of their right to decline treatment or withdraw consent at any time[3] 1.2.1. Provide information to the woman on the right to decline recommended maternity care (e.g. consumer information, how to access this guideline) 1.3. Avoid all forms of coercion during the informed decision-making process 1.4. If the woman declines recommended maternity care: 1.4.1. Ensure the woman continues to feel safe and supported 1.4.2. Discuss alternate care options
2. Women must not be denied access to maternity care because of their decision to decline recommended care[4]
2.1 When the woman declines recommended maternity care, continue to: 2.1.1 Provide holistic, culturally supportive care and informed choice for the woman 2.1.2 Risk assess evolving clinical situations, clearly informing the woman about how changing circumstances, and where applicable the planned place of birth, may impact her or her baby's health 2.2 Respect the woman's decision regarding place of birth, including declining transfer to another facility 2.3 The woman's decision to decline recommended maternity care informs the clinician's clinical decision- making 2.4 The healthcare service will support the clinician's clinical decision-making with regard to the woman's decision to decline recommended maternity care
3. Good communication with women and between clinicians and the health care facility underpins high quality care in situations where women decline recommended care.
3.1 Provide information to the woman on the process of declining recommended maternity care, including how to access this guideline 3.2 Contemporaneously document discussions and outcomes of the discussions 3.3 Inform the woman of the role of the Consumer Liaison Officer (CLO) 3.4 Follow the clinical communication process, or implement a process, to effectively communicate, including documenting, alerting and distributing, to the necessary clinical staff and the woman, the care plan which is developed after a woman declines recommended maternity care

Introduction

> "Shared decision making involves discussion and collaboration between a consumer and their healthcare provider. It is about bringing together the consumer's values, goals and preferences with the best available evidence about benefits, risks and uncertainties of treatment, in order to reach the most appropriate healthcare decisions for that person." (ACSQHC)[2]

Aim

To prepare in advance of admission/birth by opening up the conversation between the patient and the clinician(s) to provide respectful maternity care. To support partnership and shared decicion making and jointly plan maternity care when the woman is planning, or considering, declining recommended maternity care.

It is intended to support safe and high-quality maternity care through:

- strategies for communicating with the woman, including discussing:
  - her perspective and understandings
  - evidence-based advice on care choices, along with their benefits and risks
- supporting clinicians to continue to provide holistic, supportive care to the woman
- assisting with the ongoing informed decision-making process after the woman declines recommended care
- understanding of the respective roles, responsibilities and accountabilities of the woman, clinicians, and the health service
- communication, including clinical handover, and consultation between clinicians, regarding the woman's ongoing maternity care
- developing a plan with the woman for her ongoing maternity care

Background

Essential to this, is ensuring the woman is placed at the centre of her own care and including the other established principles of collaborative maternity care such as, but not limited to:

- respect, safety, choice and access
- clinicians providing the best evidence to aid the woman's informed decision-making
- informed consent

Please note that whilst 'baby' may be used in communication with the woman, this guideline uses the term 'fetus', not 'baby', to highlight the differing legal status of a born and unborn baby.

Scope (patients)

This guideline is intended for use in the following situations:

- A woman:
  - declines one or more aspects of recommended care at any point in her pregnancy, birth or postnatal period.
  - recognises that her intended (desired) care may be different from routine or recommended practice and wishes to secure support for an alternative approach.
- A clinician is concerned that a woman's decision or intention to decline recommended care may:
  - limit their capacity to provide safe clinical care and may potentially contribute to poor outcomes for the woman and/or her fetus.
  - require them to provide care that is outside their scope of practice or health service guidelines.

This guideline **does not** include or cover the following situations:

- The woman requesting intervention that is not clinically indicated
- The informed decision-making process which may precede the woman declining aspects of recommended maternity care
- Where the woman lacks capacity to make decisions about her healthcare
  - It should not be assumed that the woman lacks capacity to make a decision solely because she declines recommended care. Refer to WA Health Consent to Treatment Policy for guidance on capacity.
- Where, following birth, a parent declines care recommended for their baby
- If declining:
  - blood products- refer instead to Obstetrics and Gynaecology guideline: Refusal of Blood Products
  - vitamin k- see Declining Vitamin K neonatal form (MR216.01 (KEMH) / MR216.2 (OPH))

What is declining recommended care

Declining recommended care, in the context of this guideline, refers to a range of situations where the woman does not consent to recommended care. Every woman has the right to decline care. This may include care that is:

- recommended in the antenatal, intrapartum or postnatal period
- recommended for the benefit of herself and/or her fetus
- against her cultural needs or religious/spiritual beliefs (refer to section Cultural Safety)

When it is not possible to reach an agreement, the woman must continue to receive respectful, supportive maternity care that is within the parameters of her consent.

Cultural considerations

Cultural safety

When caring for the woman:

- consider risk and safety in the social, emotional, cultural and financial context, as well as the bio- medical context
  - the woman may want the support of a cultural support person/worker
- recognise that being separated from land, language, culture and families, especially older children, during birth may signify an intolerable threat to the woman's and her family's safety.

Where the woman declines recommended care, discuss other ways healthcare may be provided, including when transfer is declined. Fully inform the woman of the risks and benefits so they may make an informed choice about where to birth; The woman's right to choose should be respected[5]. For further information, consider:

- Australian Health Ministers' Advisory Council (AHMAC): The characteristics of culturally competent maternity care for Aboriginal and Torres Strait Islander Women[5]

Interpreters

Refer to the WNHS Language Services Policy

Ethical and legal considerations

Valid consent

Refer to Department of Health WA Consent to Treatment policy.

The woman's right to decline recommended care

Any patient who has capacity to consent may also decline any or all healthcare at any time, even when this is contrary to medical recommendations and in circumstances where such a decision to decline healthcare may result in death.

Adverse outcomes and material risks

Many circumstances where recommended care is declined will not have adverse outcomes. However, perinatal outcomes may be significantly poorer where the woman:

- declines or delays Caesarean Section (CS), including emergency CS for abnormal fetal heart rate patterns with likely fetal compromise
- declines blood products (this may also include Anti D immunoglobulin)

- discharges herself against medical advice during the antenatal or postnatal period (refer to section Keeping the woman engaged in maternity care)
- homebirths with identified obstetric risk factors (e.g. after 42 weeks gestation, with twins, breech presenting baby, vaginal birth after two caesarean sections) that are associated with higher rates of neonatal mortality.

Clinicians owe a duty of care to ensure women are appropriately informed about care and treatment options being recommended for them and their fetus. If a fully informed woman experiences an adverse outcome as a result of declining recommended care and treatment, and where there is no evidence that the outcome was the result of any clinical negligence, the clinician will not be held liable for the woman's decision.

To be fully informed, the woman must have been informed about the material risks of her intended course of action.

Refer to WA Health Consent to Treatment policy.

Additional advice

If required, health professionals may seek advice from the relevant Codirector who may recommend WNHS medicolegal advice.

Roles and responsibilities

Each participant in maternity care has important responsibilities and accountabilities when a woman declines recommended care.

The woman's role and responsibilities

When declining recommended care, the woman is responsible for:

- making decisions that reflect her physical, social, emotional, psychological, spiritual and cultural needs
- the physical, social, emotional, psychological, spiritual and cultural outcomes that arise from her decisions, as well as her baby's outcomes
- being clear about planning "if, then" scenarios with the maternity care provider
    - in an emergency situation where there is a lack of capacity (refer to section- Definitions) and where the declined care may prevent usual emergency rescue efforts, the situation may be irretrievable and result in long term injuries or death.

To the extent that the woman wishes to do so, the woman may:

- actively participate in discussions regarding care options, risks, and benefits
- amend a previous decision/plan
- seek support (e.g. partner) in her decision-making process
- document within the 'Discussion and Partnership Care Plan: Declining Recommended Maternity Care' form (MR213 (KEMH) / MR221.1 (OPH)).

Clinicians' roles and responsibilities

Clinicians partnering with the woman are not necessarily endorsing the woman's choices, they are respecting the woman's right to decline care.

Communication

The clinician is responsible and accountable for:

- informing the woman about changes in clinical circumstances and explicitly communicating to the woman how these changing circumstances may, or are likely to, impact her or her baby's health
    - the woman may subsequently agree to review her previous decision/plan
- providing clear, unbiased, accurate, applicable, evidence-based, culturally appropriate and timely advice and answers to questions asked by the woman, including:
    - informing the woman she has the right to refuse treatment and withdraw consent at any time
    - seeking further professional support (e.g. Codirector and legal where there are significant risks to declining- see previous section 'Ethical and legal considerations')
    - recognising that the woman may decline to participate in discussions about the risks and benefits of declining recommended care:
        - try to ensure the woman has sufficient information and understanding
        - offer the woman the opportunity to:
            - seek a second opinion or to discuss with another healthcare professional known to the woman
            - involve her family or other nominated support people in discussions
- referring to national and professional best practice clinical guidelines, such as:
    - WNHS Obstetrics and Gynaecology guidelines
    - Australian Government Pregnancy Care Guidelines and Maternity Services and Stillbirth Prevention publications
    - The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
    - ACM National Guidelines for Consultation and Referral
- cultural safety and the use of interpreters (links to sections in this guideline)
- thorough **documentation**, including:
    - the information provided to the woman, including resources given
    - the woman's decision to proceed with the care plan

- inviting the woman to commence the 'Discussion and Partnership Care Plan: Declining Recommended Maternity Care' form (MR213 (KEMH) / MR221.1 (OPH)) and clinician completing relevant sections
- documenting and signing by a clinical witness, where applicable.
- Within the medical record, National Woman-Held Pregnancy Record (NWHPR), and highlighted on the Obstetric Special Instructions Sheet (MR004), and Australian College of Midwives' (ACM) Record of Understanding (where applicable e.g. EPPM)
- The MR213(KEMH) / MR221.1(OPH) form goes into the woman's medical record once the clinician has initiated documentation and a copy is provided to the woman, whenever the plan is amended.

Further information on communication and documentation is provided in Initial discussions.

Providing care

Providing care for the woman includes:

- demonstrating respect for the woman's decisions:
- declining to perform a requested procedure that they believe is unsafe, unnecessary and/or will do more harm than good

Consultation and referral

Consultation and referral considerations include:

- where required and available, arranging to hand over care to, or seeking a second opinion
- assessing risk, escalating and implementing appropriate risk mitigation strategies
- practicing according to scope of credentialed and clinical practice, professional guidelines and codes, such as:
  - RANZCOG statement: Suitability criteria for models of care and indications for referral within and between models of care (C-Obs 30) (external website, PDF, 153KB)
  - Medical Board of Australia: Good medical practice: A code of conduct for doctors in Australia (external website)
  - ACM: National midwifery guidelines for consultation and referral (external website)
  - Nursing and Midwifery Board of Australia: Code of conduct for midwives (external website)

Initial discussions- Antenatal preparation

The woman is most likely to be interested in alternatives to recommended care and is not declining all care. Also refer to sections in this document The woman's role and responsibilities and Clinicians' roles and responsibilities.

Supporting communication

To support effective woman-centred communication and decision-making:

- Provide a safe respectful place for the woman to discuss her concerns and needs.
- Seek resources and engage services where needed, including but not limited to:
  - Aboriginal Liaison Officer (ALO)
  - interpreter services
- Provide patient information, where available
- The woman should be offered:
  - a second opinion
  - inclusion of family members or cultural support person of her choice in consultations.
- The clinician may wish to include another colleague in the discussions.
- Provide the woman with the 'Discussion and Partnership Care Plan: Declining Recommended Maternity Care' form (MR213 (KEMH) / MR221.1 (OPH))– see page one which includes the questions she may like to consider.

Reasons for declining recommended care

Discuss and document the woman's reasons for declining recommended care. The purpose of these discussions is not to judge the validity of the reasons, rather it:

- is a key component of supportive care interactions
- may reveal ways to make aspects of recommended care acceptable to the woman
- may help clinicians to maintain respectful care practices
- may help clinicians find out which risks may be material to the woman, and thus tailor discussions accordingly
- may reassure clinicians that the woman has capacity to understand and make healthcare decisions

Communicating benefits and risks

Discuss and document the benefits and risks to the woman and fetus of recommended care and alternatives (including the woman's intended care and the alternative of no treatment):

- Provide information to the woman in a way that they can understand
- Present evidence using absolute risk and benefit numbers in preference to relative risk and benefit numbers (refer to section- Definitions) and percentages; for example, it is preferable to express risk as:
  - increasing from a 1 in 1000 risk to a 2 in 1000 risk, rather than:
    - × doubling the risk
    - × increasing the risk from 0.1% to 0.2%
    - × increasing the risk by 100%
    - × comparing 1 in 1000 to 1 in 500 risk.

- Consider framing effects of how evidence is presented, as this may influence the woman's decision, and present in balanced (e.g. both gain and loss) and neutral terms where possible, for example, risk may be expressed as:
  - 20 in 100 women experience complications, then also say that 80 in 100 have no complications.
- Develop 'if, then' scenarios and plans for emergencies so that the woman's wishes are known.

Maternity care planning

Care plan review

Review plans whenever the woman's intentions, clinical indications or circumstances change, and reconfirm upon admission for birth.

Documentation

See 'Communication': Documentation section above.

Antenatal subsequent discussions

After initial discussions between the woman and clinician, all parties will have a better understanding of the woman's pregnancy and/or birth intentions and the reasons for them. All follow-up discussions and resulting changes are to be documented appropriately.

- An agreed way forward may have been identified.

- If not, an appropriate senior clinician can review documentation of the initial discussions to inform risk analysis and mitigation. To do this, the senior clinician may consult:
  - further with the woman
  - with colleagues (e.g. midwifery, obstetrics, ALO, anaesthetics, neonatology/paediatrics, maternal fetal medicine, social work, perinatal mental health, GP, Codirector and/or legal services)

Keeping the woman engaged in maternity care

When agreement between the woman and the clinician is not agreed

Where the results of the planning discussions with the clinicians have not been acceptable to the woman:

The next steps may include:

1. Discuss with the relevant midwifery manager or Head of Department (Obstetrics) / Codirector as required. If the concerns are not resolved in a timely manner, proceed to the next step.
2. Ensure the woman is provided with information on the WNHS feedback procedure. Follow Consumer Liaison Service processes. See also WA Health Compliments and Complaints.

During labour and birth

Admission

When the woman presents in labour, reconfirm the plan with the woman:

- Discuss and understand any new clinical or operational circumstances.
- Document the woman's intention to continue as planned or revise the plan.
- Inform relevant clinicians, and, as required, the hospital executive that the woman has been admitted.
- Maintain communication and seek support from other clinicians and the hospital executive, as required.

Emergent situation

Care declined for the first time

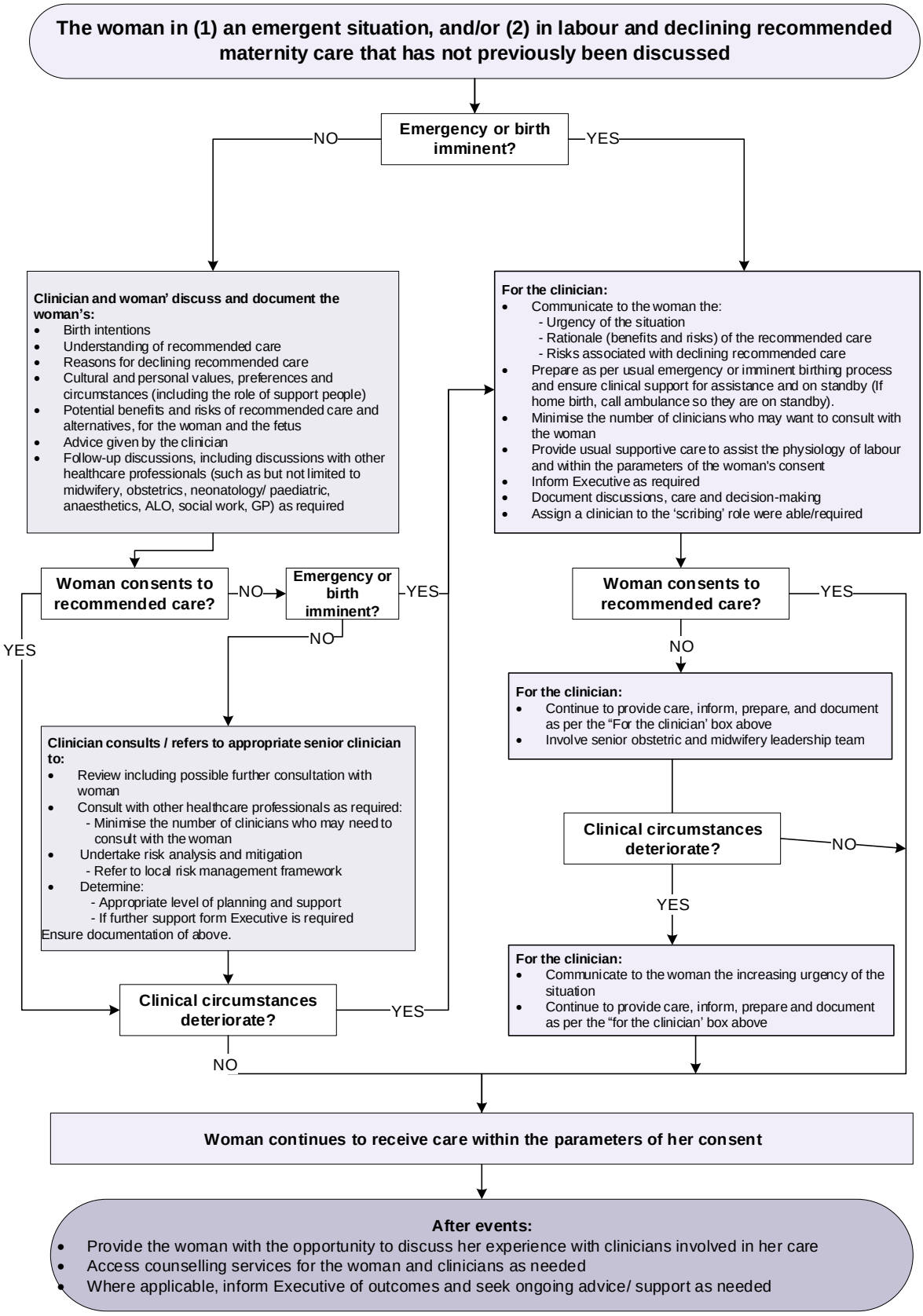
The woman may decline care for the first time after labour has commenced:

- A condensed planning approach may be necessary to elicit the woman's perspective.

Refer to next page: Flow chart: Partnering with the woman who declines recommended maternity care in an **emergent situation and/or in labour** and is declining care that has not previously been discussed.

- clearly inform the woman about the changing clinical circumstances including:
  - the urgency of the situation
  - how these changing circumstances may or are likely to impact her or her baby's health and wellbeing, including the risks of declining recommended care
  - the rationale of recommended care
- respectfully ensuring the woman understands that while clinicians will always do their best to provide life-saving care to her and her fetus, if that is delayed too long then permanent harm to the woman and/or fetus may not be avoidable
- providing, wherever possible, continuity of carer for the woman to feel safe and confident in her care, and to promote an environment of partnership and shared dialogue
- where possible, reducing the number of clinicians in the birth room, or where the woman may be, as this may reduce tension and support more effective and calm communication with the woman and the physiology of labour
- offering to contact an ALO for cultural appropriate advocacy services
- being prepared to act immediately should the woman change her mind and wish to review alternative care options that may further minimise risk, or have more information to make choices which may or may not be in line with recommended care
- informing and seeking support from colleagues as required (e.g. notifying neonatologist / paediatrician, Executive)
- involving the senior leadership team for obstetrics and midwifery

Flowchart: Partnering with the woman who declines recommended maternity care in an emergent situation and/or in labour and is declining care that has not previously been discussed



Abbreviations: GP: General Practitioner; ALO: Aboriginal Liaison Officer

Acknowledgment: QLD Health [1]

Follow-up care

- Offer debrief, preferably with the clinician(s) involved
- Offer open disclosure processes (where required)
- Inform the woman about WNHS resources available to her (e.g. Psychological Medicine, Social Work, ALO, Pastoral Care)

Supporting clinicians

Employee support is available- refer to NMHS Employee Wellbeing website for critical incident debrief processes and support resources.

References and resources

Abbreviations

ACM	Australian College of Midwives
ACSQHC	Australian Commission on Safety and Quality in Health Care
ALO	Aboriginal Liaison Officer
CLO	Consumer Liaison Officer
CS	Caesarean section
GP	General Practitioner
NSQHSS	National Safety and Quality Health Service Standards
NWHPR	National Woman-Held Pregnancy Record (MR220)
RANZCOG	The Royal Australian College of Obstetricians and Gynaecologists
VBAC	Vaginal birth after Caesarean

Definitions

Term	Definition
Absolute risk	The likelihood of an event or health outcome occurring in a group of people under specific conditions. Means the same as 'incidence' and 'actual risk'.
Best practice guidelines	A set of recommended actions that are developed using the best available evidence. They provide clinicians with evidence-informed recommendations that support clinical practice, and guide practitioner and patient decisions about appropriate health care in specific clinical practice settings and circumstances. The above definition is also used by the ACSQHC's NSQHSS.
Clinician	A health practitioner, trained as a health professional, providing direct clinical care, and health care students who provide health care under supervision.
Capacity	"In the context of medical treatment, a patient has capacity if he/she is capable of understanding the nature, purpose and consequences of the proposed treatment. Capacity must always be assessed in the context of the decision that is to be made. The Mental Health Act 2014 (s15) defines a person as having capacity when they: • understand any information or advice about the decision that is required • understand the matters involved in the decision • understand the effect of the decision • weigh up the above factors for the purpose of making the treatment decision • communicate the decision in some way." WA Health Consent to Treatment Policy 2016. Perth: Department of Health WA. [6]
Informed consent	For consent to be informed, the patient needs to be fully aware and have an understanding of the condition, the nature and purpose of the available and proposed health care, and the potential consequences of each option. Furthermore, the patient should be aware of what is likely to occur should they choose not to receive the health care. This results from the provision of information in a manner appropriate to the needs of an individual woman, in the absence of coercion by any party, that reflects self-determination, autonomy and control.

Material risk	Information about the risks of healthcare that: • a reasonable person in the patient's position would, in the circumstances, require to enable the person to make a reasonably informed decision about whether to receive the healthcare or follow the advice; and • the health practitioner knows or ought reasonably to know the patient wants to be given before making the decision about whether to receive the healthcare.
Maternity care	Antenatal, intrapartum and postnatal care for pregnant women and babies up to six weeks after birth.
Open disclosure	Describes the way clinicians communicate with and support patients, their family and carers, who have experienced harm during health care
Relative risk	Also known as a risk ratio. The probability of an event (risk) occurring in the exposed (study) group compared to the probability of the same event occurring in the non-exposed (control) group. The risk is expressed as a ratio. To understand the implications of relative risk and the woman's likelihood of developing a health condition, absolute risk numbers are required.
Residual risk	The risk that is left over following completion of actions to modify the initial risk. Often referred to as retained risk.
Safe and high quality care	Care is consumer-centred, driven by information, and organised for safety.
Senior clinician	Refers to at minimum a senior medical officer with specialist training in obstetrics.
Treatment	The provision of a service or a procedure to diagnose, maintain or treat a physical or mental condition and carried out by, or under the direction or supervision of, a health provider.
Woman-centred care	Care that is focused on the woman's individual, unique needs, expectations and aspirations, rather than the needs of institutions or maternity service professionals. This type of care recognises the woman's right to self determination in terms of choice, control, and continuity of care.

Examples

Declined care	Additional resources
Blood products	Not included in this guideline- refer instead to • 'Blood Products Refusal' and • Transfusion Medicine Blood Products (Adults): 'Refusal'
Caesarean section	• Birth After Previous Caesarean • Caesarean Birth
CMP specific	• See Non-compliance of Client with the CMP Midwifery Standard of Practice
Discharge Against Medical Advice (DAMA)	• See 'Emergent situation' chapter • Obstetrics and Gynaecology: Patient Movement: Discharge of a Patient: DAMA • WNHS Discharge Against Medical Advice policy [*under development*]
Epidural when medically indicated	• Neuraxial Analgesia (epidural, intrathecal) • Cardiac Disease • Other guideline conditions as relevant
General	• Department of Health WA Consent to Treatment
Home birth	• Department of Health WA Home Birth policy
IOL	• WNHS Induction of Labour guideline
IVC	• Relevant guidelines indicating IVC e.g. anaesthetic, neuraxial analgesia, resuscitation, acute deterioration, Caesarean section, IOL, Birth after CS • Department of Health WA: Insertion and Management of PIVC policy and guideline
Maternal antibiotics	See Obstetrics and Gynaecology guidelines: • 'Infections' including antibiotic prophylaxis by conditions • Group B Streptococcal Disease • Preterm Labour • Rupture of Membranes- Spontaneous (Previable, Preterm, Term)
Medications	• Medication Administration pharmacy guideline – section 'Medication Refusal'
Neonatal	• See CAHS neonatology guidelines by conditions • Declining Vitamin K form (MR216.01 (KEMH) / MR216.2 (OPH))

Standardised care (e.g. antenatal swabs / blood tests) recommended in guidelines	• Antenatal Care Schedule • Birth After Previous Caesarean • Bladder Management • Induction of Labour • Other guidelines relevant to care type • NWHPR (MR220)- 'Suggested schedule of routine antenatal care' • WNHS Pregnancy Birth and Your Baby consumer information book
VBAC, requirements associated with	• Birth after Previous Caesarean Section • Fetal Heart Rate Monitoring

Note: The above table provides examples only and is not intended to be an exhaustive list of conditions or related guidelines. Care should be individualised.

References

1. Clinical Excellence Queensland. Guideline: Partnering with the woman who declines recommended maternity care (V1.0). Brisbane: Queensland Health; 2020. Available from: https://www.health.qld.gov.au/__data/assets/pdf_file/0022/736213/maternity-decline-guide.pdf
2. Australian Commission on Safety and Quality in Health Care. Shared decision making: ACSQHC; 2019. Available from: https://www.safetyandquality.gov.au/our-work/partnering-consumers/shared-decision-making
3. Department of Health. Clinical practice guidelines: Pregnancy care. Canberra: Australian Government Department of Health; 2020 (last updated March 2021). Available from: https://beta.health.gov.au/resources/publications/pregnancy-care-guidelines
4. Australian Medical Association [AMA]. AMA position statement: Maternal decision-making. 2013. Available from: https://ama.com.au/articles/maternal-decision-making-2013
5. Kruske S, on behalf of the Maternity Services Inter-Jurisdictional Committee. Culturally Competent Maternity Care for Aboriginal and Torres Strait Women Report. **Australian Health Ministers' Advisory Council**. 2013. Available from: https://www1.health.gov.au/internet/main/publishing.nsf/content/77F5B09BC281577ACA257D2A001EE8CD/%24File/cultur.pdf
6. WA Health Consent to Treatment Policy. Perth: Department of Health WA; 2016.

Related external policies, legislation and standards

- Australian Government Pregnancy Care Guidelines and Maternity Services and Stillbirth Prevention publications (external website)
- ACM National Guidelines for Consultation and Referral (external website)
- The Royal Australian and New Zealand College of Obstetricians and Gynaecologists guidelines (RANZCOG) (external website)

Related WNHS and NMHS policies, guidelines and procedures

NMHS Clinical Documentation Policy

Anaesthetics: Intraoperative Cell Salvage

CMP:

- Inclusion Criteria at Booking: Protocol and Procedure
- Non-Compliance of Client with the CMP Midwifery Standard of Practice

Obstetrics and Gynaecology:

- Blood Products and Transfusion: Refusal
- Exclusion Criteria for Midwifery Group Practice birthing in the Family Birth Centre

Transfusion Medicine: Blood Products (Adults) (Refusal)

Useful resources and related forms

e-learning ACSQHC Helping patients make informed decisions: Communicating risks and benefits (external site)

Forms	
MR004	Obstetric Special Instructions Sheet
MR213 (KEMH) / MR221.1 (OPH)	Discussion and Partnership Care Plan: Declining Recommended Maternity Care
MR213.01 (KEMH) / MR221.2 (OPH)	Discussion and Partnership Care Plan: Declining Recommended Maternity Care (Continuation)
MR216.01 (KEMH) / MR216.2 (OPH)	Declining Vitamin K [neonatal]
MR220	National Woman-Held Pregnancy Record
MR340	Discharge Against Medical Advice

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Version history

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1	Oct 2022	First version

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