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INTRODUCTION

These guidelines:

- provide guidance to midwives in situations where transfer from a planned birth at home into hospital is required during the intrapartum and immediate postpartum period and up to six weeks postpartum, for either the woman and/or her newborn;

- provide guidance to midwives if the woman declines transfer for herself and/or her newborn; and

- provide the template Transfer of Care Summary for use by the midwife transferring the woman and/or her newborn from home to hospital.

When applying the guidelines, the midwife:

- works in partnership with the woman and acknowledges the reciprocity that facilitates the woman-midwife relationship;

- works within their scope of practice;

- is considerate of institutional policies and procedures at their place of employment where applicable;

- works within the scope of the ACM National Midwifery Guidelines for Consultation and Referral (ACM Guidelines); and

Web version at:
http://issuu.com/austcollegemidwives/docs/guidelines2013/1

- works within the standards, codes, policies and guidelines issued by the Nursing and Midwifery Board of Australia (NMBA).

Registration Standards:

Professional Standards:

Codes, policies and guidelines:
ANTENATAL PREPARATION FOR TRANSFER

During pregnancy, the midwife:

- informs the woman of:
  - circumstances which may result in the need to transfer, and possible timing of that recommendation;
  - the *Transfer from Planned Birth at Home Guidelines* – it is recommended that the midwife provide the woman with a copy of this document;
  - their arrangements for accessing real-time consultation and hands-on clinical support throughout the continuum of care; and
  - their role and scope of practice at the hospital if transfer is required.

- documents this discussion and the fact that the *Transfer from Planned Birth at Home Guidelines* have been provided.

The midwife plans and facilitates a process of transfer, in consultation with the woman, by:

- recommending that the woman ‘book’ into a hospital that provides maternity care, preferably the closest hospital to her home;
- recommending that the woman obtain ambulance insurance to cover transport costs if needed;
- establishing a professional relationship with the hospital at which the woman is booked;
- recommending that the woman engage with the booking hospital and other maternity care providers for consultation, referral and/or transfer of care, if indicated;
- recommending that the woman take preparatory steps for a potential transfer. For example: organising support to assist with transport, having an appropriate child seat installed in the car, having a birth/postnatal bag packed and child care arranged for siblings;
- adjusting the plan for transfer should new circumstances arise; and
- documenting transfer planning and decision making in the woman’s clinical records.

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1 See the *ACM Birth at Home Midwifery Practice Standards*

2 See Appendix 3 for further guidance
PROCESS OF TRANSFER FOR THE WOMAN

Decision making about transferring from a planned birth at home to hospital should occur in consultation with the woman.

The midwife should discuss the rationale, urgency and safest approach to transfer with the woman.

The woman must provide informed consent before she is transferred except in the case of an emergency where the woman lacks the capacity to consent.

As represented in the Process of Transfer for the Woman Flow Chart (Figure 1), the midwife:

1. recommends transfer to the woman when indicated;
2. communicates the rationale and level of urgency of transfer to the woman;
3. obtains informed consent from the woman to transfer to hospital;

- If the woman consents to transfer, the midwife makes recommendations to the woman about the safest mode of transport;
  
  a. **In the event of an emergency or birth is imminent**, the midwife:
     
     o recommends transferring in an ambulance.
  
  b. **If transfer is not urgent**, the midwife:
     
     o recommends that the woman and her support team travel in their private car.

- If the woman declines to transfer to hospital, the midwife follows the process described in Appendix 1.

4. makes arrangements for transfer and explains these to the woman;
5. phones ahead to the receiving hospital to alert them to the woman’s arrival and circumstances;
6. elicits assistance from the woman’s support team if needed;
7. provides clinical care while awaiting transfer;
8. travels to the receiving hospital:
   
   a. **In the event of an emergency**, the midwife:
      
      o requests to travel in the ambulance to provide clinical care if required. It is recommended that the midwife also bring basic equipment not already available in the ambulance (i.e. obstetric Doppler, infant bag and mask, oxytocic medication); and
o requests that the woman and baby, if born, travel in the ambulance together, skin-to-skin\(^3\) unless the woman or baby need individualised clinical care.

*Note that these requests are reliant upon local policies and protocols, and authorisation of these requests is at the discretion of the ambulance officers.*

b. **If transfer is not urgent,** the midwife follows the woman’s private car.

9. documents the decision-making process and clinical care provided, and brings the woman’s clinical records to the hospital;

10. presents to the hospital with the woman to provide a handover to the receiving staff. This is done verbally and followed by a written handover\(^4\) for inclusion in the woman’s hospital records\(^5\); and

11. remains with the woman in hospital during the intrapartum and immediate postpartum period\(^6\), where possible.

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\(^3\) **Please note:** skin to skin care includes the woman holding the baby in her arms and near her chest with bedding or blankets covering them both, and is recognised as the best method of the stabilization of neonatal temperature and cardiac and respiratory effort (Moore, E. R., Anderson, G. C., Bergman, N., & Dowswell, T. (2012). Early skin-to-skin contact for mothers and their healthy newborn infants Cochrane Database of Systematic Reviews(5), CD003519. [http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003519.pub3/pdf](http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003519.pub3/pdf))

\(^4\) See Appendix 2


\(^6\) See Appendix 3
Figure 1: Process of Transfer for the Woman Flow Chart

Transfer indicated for the woman → Recommend transfer to woman and explain rationale and urgency

Emergency or birth imminent?

YES → Recommend transport in ambulance

NO → Recommend transport in private car

Woman declines transfer?

YES → Implement Recommended Process in the Event a Woman Declines Transfer (Appendix 1)

NO → Make arrangements for transfer and explain to woman

Phone receiving hospital ahead and provide care while awaiting transfer

Transport of woman in ambulance?

YES → Support team transport woman in private car

NO → Follow private car

Request skin-to-skin contact if possible

Allowed in ambulance?

YES → Provide Clinical care in ambulance

NO → Follow ambulance

Document decision-making process and care provided, and provide verbal handover and completed Transfer of Care Summary form (Appendix 2) to clinical staff

Remain with woman in hospital if possible
PROCESS OF TRANSFER FOR THE NEWBORN

As represented in the Transfer Process for the Newborn (Figure 2), in the circumstance where transfer is indicated for the newborn in the immediate postpartum period and up to 6 weeks after the birth, the midwife:

1. recommends transfer of the newborn to hospital;
2. communicates the rationale and urgency of transfer to the parents;
3. obtains informed consent to transfer the newborn from the parents:
   a. If the parents consent to transferring their baby, the midwife calls an ambulance for immediate transfer (a newborn must always be transferred by ambulance, regardless of urgency) and provides clinical care in the interim.
   b. If the parents decline transfer of their newborn, the midwife determines the urgency of the circumstance:
      ⇔ If the newborn requires emergency life-saving care, the midwife:
         • explains the urgency of the emergency and/or life-saving care required to the parents;
         • informs the parents of mandatory reporting requirements to government child protection services (it is a reportable circumstance for parents to decline emergency life-saving care for their newborn);
         • if the parents continue to decline emergency life-saving care for their newborn, the midwife is required to take immediate action in providing care to the newborn, call ‘000’ for police and ambulance assistance and report to their State government child protection services7 after the incident.
      ⇔ If the newborn does not require emergency life-saving care, the midwife observes the newborn for signs of deterioration and makes recommendations for ongoing care and indicators for transfer, prior to leaving the woman and her newborn.

   Note that a mandatory report is not always indicated in this circumstance.

4. phones ahead to the receiving hospital to alert them to the newborn’s arrival and circumstances;
5. provides clinical care while awaiting transfer;

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7 See information below for more details about mandatory reporting requirements in each Australian state or territory:

6. upon arrival of the ambulance, the midwife:

- requests to travel in the ambulance to provide clinical care if required. It is recommended that the midwife also bring basic equipment not already available in the ambulance (such as an infant bag and mask, a heat source, and suctioning equipment); and

- requests that the woman and newborn travel in the ambulance together, skin-to-skin contact unless the baby needs immediate clinical care

*These requests are reliant upon local policies and protocols, and authorisation of these requests is at the discretion of the ambulance officers.*

7. documents the decision-making process and clinical care provided, and brings the newborn’s clinical records to the hospital; and

8. provides a verbal and written handover to the receiving staff, and

9. provides ongoing support to the parents in hospital where possible.

It should be noted that if both the woman and the baby require transfer, two ambulances may be necessary.

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9 See Appendix 2
Figure 2: Transfer Process for the Newborn

Transfer indicated for the newborn

**Recommend transfer to parents and explain rationale and urgency**

Parents consent?

Emergency life-saving care required?

Continue to observe the newborn for signs of deterioration

Emergency life-saving care required?

Reriterate rationale and urgency and inform parents of mandatory reporting to child protection services

Parents consent?

Document decision-making process and clinical care provided

Report to government Child Protection Services if mandatory reporting applies

Take immediate action to facilitate emergency or life-saving care to the newborn and call '000' for police and ambulance assistance

Provide Clinical care in ambulance and bring newborn’s clinical records

Follow ambulance and bring newborn’s clinical records

Document decision-making process care provided, and provide verbal handover and completed Transfer of Care Summary Form (Appendix 2) to clinical staff

Provide support for parents where possible

Allowed to travel in ambulance?

Phone ahead the receiving hospital and provide care while awaiting transfer

Call ambulance
GUIDANCE FOR MATERNITY CARER COLLABORATION AT THE RECEIVING HOSPITAL

The transferring midwife and receiving maternity carers (midwives and medical practitioners):

- adopt the principles of the *National Collaborative Guidance for Maternity Care*, which can be found at: [https://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/CP124.pdf](https://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/CP124.pdf)
- implement the process of transfer outlined in this document;
- remain mindful of state and territory policies and regulatory bodies’ regulatory standards and codes;
- demonstrate collegial generosity, respect and courtesy throughout professional interactions;
- engage in constructive and professional communication to facilitate safe transfer and handover and when negotiating ongoing care, in consultation with the woman; and
- engage in discharge planning for the woman and baby and facilitate safe transfer back into the care of the woman’s midwife at the conclusion of hospital care, in consultation with the woman.

In some circumstances, the midwife may have arrangements with the hospital such that they could continue to provide midwifery care following transfer.
Throughout the course of intrapartum and immediate postpartum care at home, there may be circumstances where the woman declines transfer to hospital for herself. In this instance the woman’s decision must be respected and she cannot be forced to leave her home unless it is an emergency and she lacks the capacity to consent.

As described in the ACM guidelines:

‘...If issues arise during labour or in urgent circumstances, the midwife is obliged to attend the woman.

Where a woman has refused emergency transport or transfer of care during active labour, the midwife must remain in attendance as the primary care provider. He or she may be called upon to deal with an urgent situation, or one that is not within the midwife’s standards, scope or abilities to perform.

In the case of responding to an emergency outside the midwife’s scope of practice or competence, the midwife should:

1. If outside the hospital setting:

   a. Call an ambulance to facilitate the most timely transfer of care should the woman decide to change her decision

   b. With the woman’s consent, notify the hospital receiving transfer

...Continue to document all care provided, as well as discussions and decisions...’
Recommended Process in the Event a Woman Declines Transfer to Hospital for Herself

As represented in the Recommended Process in the Event a Woman Declines Transfer to Hospital for Herself flow chart (Figure 3), in the circumstance where transfer is indicated, the midwife:

1. recommends transfer of the woman to hospital;
2. communicates the rationale and urgency of transfer to the woman;
3. obtains informed consent to transfer from the woman:
   - If the woman consents to transfer, the midwife implements the Process of Transfer for the Woman described on page 6;
   - If the woman declines transfer for herself, the midwife determines the urgency of the circumstance:
     a. In the event of an emergency or birth is imminent, the midwife:
        - accesses real-time hands-on clinical support*;
        - calls an ambulance and requests that the personnel wait outside if possible;
        - continues to provide care; and
        - documents the decision-making process and care provided as soon as possible.
     b. If circumstances escalate, the midwife recommends transfer: if the woman continues to decline transfer, the midwife calls an ambulance, requests that the personnel wait outside if possible, continues to provide care and documents the decision-making process and care provided.
     
   b. If transfer is not urgent, the midwife:
      - accesses real-time advice, reports the advice to the woman, and documents it;
        ⇒ If the woman continues to decline transfer, the midwife:
           - accesses real-time hands-on clinical support*;
           - continues to provide care and documents the decision-making process and care provided;
     
     If circumstances escalate, the midwife recommends transfer: if the woman continues to decline transfer, the midwife calls an ambulance, requests that the personnel wait outside if possible, continues to provide care and documents the decision-making process and care provided.
If circumstances don't escalate, the midwife continues to provide care and documents the decision-making process and care provided.

It should be noted that if both the woman and the baby require transfer, two ambulances may be necessary.

* It is assumed that the ACM Birth at Home Midwifery Practice Standards have been followed and that plans have been made for hands-on clinical to be present during the birth with the informed consent of the woman. In the event the woman did not consent to the presence of a second maternity care provider, or hands-on clinical support is not available during birth due to unforeseen circumstances, please go directly to the next step and continue to follow the process as indicated.
Figure 3: Recommended Process in the Event a Woman Declines Transfer to Hospital for Herself Flow Chart

- **Transfer indicated for the woman**
  - **Recommend transfer to woman and explain rationale and urgency**
  - **Access real-time advice, report to woman, and document**
  - **Emergency or birth imminent?**
  - **Circumstances escalate?**
  - **Call ambulance, request they wait outside if possible, continue to provide care and document**
  - **Continue to provide care and document**
  - **Implement Process of Transfer for the Woman (Figure 1)**

- **Circumstances escalate?**
  - **YES**
  - **YES**
  - **YES**

- **NO**
  - **NO**
  - **NO**

* It is assumed that the ACM Birth at Home Midwifery Practice Standards have been followed and that plans have been made for hands-on clinical to be present during the birth with the informed consent of the woman. In the event the woman did not consent to the presence of a second maternity care provider, or hands-on clinical support is not available during birth due to unforeseen circumstances, please go directly to the next box and continue to follow the process as indicated in this diagram.
APPENDIX 2: TEMPLATE FOR ‘TRANSFER OF CARE SUMMARY’

The purpose of this template is for the transferring midwife to provide a written record of the handover given to hospital staff. It can be used for the woman and/or newborn transfer. It is not designed to be an extensive summary of antenatal, intrapartum or postnatal care. This information can be provided to the transferring hospital from the clinical records or antenatal care card if needed. The midwife should retain a copy of this transfer of care summary.

<table>
<thead>
<tr>
<th>Transfer of Care Summary</th>
<th>Woman being transferred/NA</th>
<th>Newborn being transferred/NA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Name:</td>
<td>D.O.B:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Time of birth:</td>
</tr>
<tr>
<td></td>
<td>D.O.B:</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>MRN (if applicable):</td>
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</table>

**SITUATION**

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<th>Booking hospital</th>
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<tbody>
<tr>
<td>Transferring Midwife</td>
<td>Phone</td>
</tr>
<tr>
<td>Primary Midwife</td>
<td>Phone</td>
</tr>
<tr>
<td>Mode of transfer</td>
<td>Ambulance</td>
</tr>
<tr>
<td></td>
<td>Private Car</td>
</tr>
<tr>
<td></td>
<td>Date/time of arrival</td>
</tr>
<tr>
<td>Summary of reason for transfer &amp; recommendation(s)</td>
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</tr>
</tbody>
</table>

**OBSERVATION**

<table>
<thead>
<tr>
<th>Summary of woman’s most recent clinical observations</th>
<th>Time/date of Obs</th>
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**Labour**

<table>
<thead>
<tr>
<th>BP</th>
<th>SROM/ARM time/date</th>
<th>Liquor colour</th>
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</thead>
<tbody>
<tr>
<td>Temp</td>
<td>Pulse</td>
<td></td>
</tr>
<tr>
<td>Contraction pattern/timing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal exam findings (if checked)</td>
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<td></td>
</tr>
<tr>
<td>Third stage:</td>
<td>Complete</td>
<td>Incomplete</td>
</tr>
<tr>
<td>Medications used</td>
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</tbody>
</table>

17 of 24
### Other clinical notes/observations


### OR

**Postpartum**

<table>
<thead>
<tr>
<th>Blood loss (mL)</th>
<th>OR Actively bleeding (choose one)</th>
<th>BP</th>
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</table>

<table>
<thead>
<tr>
<th>Pulse</th>
<th>Fundus (position/tone)</th>
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<tr>
<th>Temp</th>
<th>Perineal assessment/repair</th>
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<th>Medications used</th>
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<th>Other clinical notes/observations</th>
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### Summary of newborns most recent clinical observations

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<table>
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<tr>
<th>Apgar 1 min</th>
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<table>
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<th>Heart rate at birth</th>
<th>Heart rate during transfer</th>
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<table>
<thead>
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<th>Resp. rate at birth</th>
<th>Resp. rate during transfer</th>
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<table>
<thead>
<tr>
<th>Abnormalities noted at birth</th>
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<table>
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<tr>
<th>Other clinical notes/observations</th>
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### Woman's antenatal clinical record

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<th>G</th>
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<table>
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<table>
<thead>
<tr>
<th>Complicating factors/ relevant medical history</th>
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## BACKGROUND

<table>
<thead>
<tr>
<th>Date/time of call to hospital to notify arrival</th>
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<tbody>
<tr>
<td>Person spoken to</td>
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<tr>
<td>Summary of communication with hospital</td>
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## ASSESSMENT & ACTIONS


## RESPONSIBILITY FOR TRANSFER

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<th>Midwife providing written handover</th>
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<tbody>
<tr>
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<tr>
<td>Date</td>
</tr>
<tr>
<td>Signature</td>
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</table>

<table>
<thead>
<tr>
<th>Staff receiving handover</th>
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<tbody>
<tr>
<td>Full Name</td>
</tr>
<tr>
<td>Date</td>
</tr>
<tr>
<td>Signature</td>
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</tbody>
</table>
APPENDIX 3: MIDWIFE’S ROLE AND SCOPE WHEN CARING FOR A WOMAN AFTER TRANSFER IN HOSPITAL

Upon transfer into hospital, the midwife works within their scope of practice and professional boundaries. Each midwife’s scope and boundaries are different depending on their individual context and circumstances. It is the responsibility of the midwife to know and work within their own professional boundaries when entering the hospital with a woman.

When deciding if a role, function, responsibility or activity is within their scope of practice, the midwife must comply with the NMBA’s Decision-Making Framework\(^\text{10}\); that is, a midwife may carry out a particular activity if they:
- have received appropriate education and experience to carry out the activity safely;
- have been deemed to be competent by a supervisor;
- are confident in their ability to carry out the activity; and
- have appropriate authorisation, for example, from an employer.

The midwife’s role within a hospital setting is determined by:
- the scope of their professional indemnity insurance ;
- whether they are credentialed with the receiving hospital;
- the conditions of their employment at the receiving hospital;
- the policies and procedures of the receiving hospital;
- the policies, codes and guidelines of the NMBA\(^\text{11}\); 
- their level of fatigue and self-care needs;
- their scope of practice; and
- the specific needs of the woman and/or baby.

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DEFINITIONS

Australian College of Midwives (ACM):
The Australian College of Midwives (ACM) is a national, not-for-profit organisation that serves as the peak professional body for midwives in Australia (www.midwives.org.au)

Commencement of intrapartum period:
The commencement of the intrapartum period is when the woman makes initial contact with the midwife and is believed to at least be in the latent stage of labour. It is at this stage that the midwife assumes responsibility for the intrapartum care of the woman

Emergency:
A serious circumstance in which the woman and/or her baby are at high risk of immediate or long term morbidity and/or death

Evidence-informed information:
The best available evidence from research, context and experience (http://www.nccmt.ca/eiph/index-eng.html)

Immediate postpartum period:
The immediate postpartum period commences from the complete birth of the placenta up until the time the midwife leaves the woman and family and/or the woman has been transferred from the birth unit to postnatal ward after requiring transfer to hospital

Maternity care provider:
A qualified registered health professional, appropriately trained to provide maternal and/or newborn care

Midwife:
A midwife is a person who has successfully completed a midwifery education programme that is duly recognised in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title ‘midwife’; and who demonstrates competency in the practice of midwifery (http://internationalmidwives.org/assets/uploads/documents/Definition%20of%20the%20Midwife%20-%202011.pdf)

Nursing and Midwifery Board of Australia (NMBA):
The NMBA is the national regulator for the nursing and midwifery professions in Australia. It is established under the Health Practitioner Regulation National Law (the National Law), as in force in each state and territory. Its primary roles are to protect the public by registering suitably qualified and competent persons and set standards that all nurses and midwives registered within Australia must meet (www.nursingmidwiferyboard.gov.au)

Planned birth at home:
Describes when the woman plans to birth at home under the care of a public or private midwife
Skin-to-skin:
Describes the practice of placing the baby bare skinned onto the bare chest of the woman and covered with warm blankets. Skin-to-skin can be facilitated during transfer by the use of an infant carrier that allows uninterrupted skin-to-skin contact between the woman and baby.

Transfer:
Denotes the occurrence of transfer from a planned birth at home, with a registered midwife in attendance, into a hospital.
RESOURCES

- National Health and Medical Research Council (2010). National guidance on collaborative maternity care, Canberra NHMRC.
- Nurses and Midwives Board of Australia (2015). Policy: Midwives in private practice, role of the midwife in private practice when the woman is admitted to a health service as a public patient
- South Australia Department of Health (2007). Policy for Planned birth at home in South Australia