

GP Antenatal Shared Care Protocol

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2. AIM

The Antenatal Shared Care Program aims to provide a high standard of antenatal care for women who have a low risk pregnancy. The women are cared for by the Antenatal Services at the Hospital in conjunction with their General Practitioner.

3. OBJECTIVES

The objectives of the General Practitioners' Antenatal Shared Program are:

- To provide choice, continuity of care and greater accessibility for women by seeing their General Practitioner during pregnancy.
- To enable registered General Practitioners (GP's) to provide a high standard of antenatal care to women who are considered suitable for Antenatal Shared Care.
- To provide GP's with a recommended 'Best Practice' standard of antenatal care.
- To reduce demands on the Hospital outpatient services.

4. REGISTRATION, EDUCATION AND GP REQUIREMENTS

Eligibility

To be eligible to be a member of the Antenatal Shared Care Program in South-East Area Health the GP must:

- Be a member or an associate member of a Division of General Practice.
- Fulfil the requirements for Registration

Registration

GPs wishing to practice Antenatal Shared Care need to be registered in the program. Registration for ANSC requires:

- Current medical registration.
- Current membership of a medical defence association.

- Attendance at a Division of General Practice Antenatal Shared Care Program registration course.
- **12 POINTS** of Division-delivered / endorsed Antenatal Shared Care educational activities for each triennium. The Division (s) will monitor the number points achieved by each GP. Each Division will record the names of the GPs attending the activities they run, but if GPs attend an activity run by another Division, GPs must inform their own Division so the points can be recorded.
- RHW requires GPs to have a police check and annually re submit their medical registration details for affiliation to the Hospital.

Quality Assurance

Quality assurance activities will be conducted periodically by the Divisions of General Practice

5. SHARED CARE OPTIONS

(a) Women wishing to have Shared Antenatal Care with their GP and the South East Area Hospitals may have the option of sharing the care with their GP and:

	Royal Hospital for Women	St George Hospital	Sutherland Hospital
Antenatal Clinic/Delivery Suite	✓	✓	✓
Birth Centre	✓	✓	
Home Birth	Not available	✓	Not available
Outreach Program	Aboriginal Maternal & Infant Health Service	STOMP: <ul style="list-style-type: none"> ▪ South Hurstville Child and Family Health Centre ▪ Rockdale Child and Family Health Centre 	Antenatal Outreach clinic Menai

(b) These options involve the following birthing choices:

1. **Antenatal Clinic/Delivery Suite**

The Hospital Antenatal Clinic, Delivery Suite and Postnatal Ward/Early Discharge Program, care for women who choose this option.

2. **Aboriginal Maternal & Infant Health Service**

Available at the RHW contact 9382 6783 for further details

3. **St George Outreach Maternity Project (STOMP)** at either

South Hurstville or Rockdale Early Childhood Centres –

Women who choose this option will be looked after by the same team of midwives during pregnancy, labour and birth at the hospital Delivery Suite and afterwards on the Postnatal Ward. Should a woman choose the Maternity Support Program (early discharge), these same midwives will visit her at home (as long as she lives within the area covered).

4. Birth Centres

Women who choose this option will be looked after by the same team of midwives during pregnancy, labour, birth and postnatally in the hospital Birth Centre.

5. Home Birth

St George Birth Centre now can offer home birth for low risk women; GP ANSC may also be available.

6. Menai Outreach Antenatal Clinic

Antenatal Clinic at Menai with delivery at the Sutherland Hospital

6. BOOKING FOR SHARED CARE

Booking with the Hospital should be early, preferably by 10-14 weeks gestation.

Late diagnosis of pregnancy

If the woman presents too late to offer the "Nuchal translucency plus" genetic screening test they should be counselled according to their age – related risk, and offered referral to genetic counselling or amniocentesis depending on their age, risk and wishes

For RHW – If a woman presents late, perform routine screening and arrange an antenatal appointment ASAP and also notify the GP Liaison midwife on 9382-6016.

Earlier presentations to the Antenatal Clinic should occur if:

- There is a history of recurrent miscarriage; or
- If vaginal bleeding occurs. Any vaginal bleeding should be referred to the Early Pregnancy Problems Clinics.

Royal Hospital for Women

Early Pregnancy Clinic (EPC) phone for appointments Monday – Friday -

Phone 9382 6701

St George Hospital

Early Pregnancy Problem Service (EPPS) is a drop in service, patients are asked to arrive at the Women's and Children's Health Clinic at **8.00 am**

The Sutherland Hospital

Contact the O&G registrar

Booking Procedure at the Royal Hospital for Women:

- The woman presents to the GP where pregnancy is confirmed.
- GP to discuss and offer appropriate antenatal testing to all women and to organise investigations as per protocol.
- GP to discuss with patients all options of antenatal care.
- GP to provide patient with information brochure explaining ANSC program.
- GP to discuss and offer appropriate antenatal testing to all women and to organise investigations as per protocol.
- Patient to phone Antenatal Clinic RHW - for appointment.
- Patient to bring to GP the envelope from RHW when received.
- GP to complete details on "yellow" antenatal card including GP's contact details including phone number and fax details name and address at bottom right hand corner.
- The "yellow" antenatal card is to be given to the patient to take to hospital clinic and is to be carried at all times.
- **Please give original copy of pathology results to patient to bring to hospital for the booking in visit and subsequent visits** as well as recording the results on the yellow patient record card.
- GP to complete the Antenatal Booking Referral form. This is to be given to the patient to take to hospital clinic. The form takes the place of a letter of referral.
- GP to inform patient of Childbirth and Parenting Classes & breast feeding antenatal classes. For RHW phone Health Education bookings line on 9382 6541 or for enquiries 9382 6700. Patients should be encouraged to book antenatal classes early in pregnancy.

Booking the initial hospital appointment at St George Hospital & Sutherland:

- The woman presents to the GP where pregnancy is confirmed. GP to discuss with patients all options of antenatal care.
- GP to provide patient with information brochure explaining ANSC program

- GP to discuss and offer appropriate antenatal testing to all women and to organise investigations as per protocol.
- GP commences 'yellow' antenatal card (to be carried by the woman at all times).
- GP completes the 'GP sections' of the Antenatal Booking Referral form
(then gives the form to the woman)

The woman then:

- Completes the 'patient section' of the Antenatal Booking Referral Form.
- Forwards the form to: The Antenatal Booking Clerks at the address on the Referral form.
- The women will be notified of their first hospital appointments by mail.

7. FREQUENCY OF VISITS

Routine antenatal visits are scheduled as follows:

- First visit as soon as pregnancy suspected (with GP)
- Booking visit 10-14 weeks gestation (at Antenatal Clinic)
- 4 weekly to 26 weeks (with GP)
- 28 weeks (with GP)
- 30 weeks (at Antenatal Clinic)
- 2 weekly to 34 weeks (with GP)
- 36 weeks (at Antenatal Clinic – with VMO/Registrar)
- 37-40 weeks, weekly (with GP)
- 41 weeks onwards (at Antenatal Clinic)

More frequent visits or referrals back to the Antenatal Clinic may be needed if complications arise. If the patient has significant complications, they may be asked to visit the Antenatal Clinic for the remainder of their pregnancy.

If a GP participating in shared antenatal care is unable to see his/her patient (ie. during holidays or sickness), she should be referred back to the antenatal clinic or to another colleague who is also accredited with the shared care programme.

If a woman is not returning to the family doctor for shared antenatal care, a letter should be sent to explain the reason, similarly if a GP feels a woman is unsuitable for shared care a letter should be sent to the clinic.

8. SUITABILITY FOR SHARED CARE

Women *usually unsuitable* for shared antenatal care include:

- Those with a major medical condition e.g.
 - diabetes
 - hypertension
 - cardiac disease
 - renal disease
 - thyroid disease
 - significant anaemia
 - haemoglobinopathy
 - epilepsy
- Drug addiction
- Rhesus allo immunisation or other abnormal serology

- Previous stillbirth, neonatal death
- Multiple pregnancy
- History of preterm delivery/preterm rupture of membranes <32/40
- Uterine abnormalities
- *Suitability can be discussed with the Obstetrician involved at booking.*

9. CRITERIA FOR REFERRAL BACK TO THE FIRST AVAILABLE CLINIC

The GP is encouraged to return the woman to the first available Antenatal Clinic if any of the following problems arise:

- Multiple pregnancy
- Significant hypertension is detected i.e. BP > 140/90.
- Gestational Diabetes
- Uterine growth is unusually small or large, i.e. Symphysial-fundal height (cm) <3 or >3 Gestation (weeks).
- Increased uterine activity is noted or reported (i.e. ? preterm labour).
- Rupture of membranes and antepartum haemorrhage (should go immediately to the Delivery Suite for assessment).
- Placenta praevia detected.
- Foetal abnormality is suspected/detected
- Generalised pruritis
- Hb <95g/l
- Rhesus allo immunisation.
- Malpresentation after 36 weeks.
- Necessity for support services such as social worker or drug & alcohol services.
- Any other problem which represents a significant departure from a
- Normal Antenatal course and which will require attention before a routine clinic.

10. CRITERIA FOR IMMEDIATE ASSESSMENT AT HOSPITAL IS REQUIRED WHENEVER THE FOLLOWING OCCURS:

1. Intractable vomiting with dehydration and ketosis.
 2. Preterm rupture of membranes.
 3. Threatened preterm delivery.
 4. Undiagnosed severe abdominal pain.
 5. Antepartum haemorrhage.
 6. Decreased foetal movements.
 7. Suspicion of death in-utero.
 8. Unusual headaches or visual disturbances.
 9. Seizures or "faints" in which seizure activity may have occurred.
 10. Dyspnoea on mild-moderate exertion, orthopnoea or nocturnal dyspnoea
 11. Symptoms or signs suggestive of deep vein thrombosis.
 12. Pyelonephritis.
- Patients referred back to the Hospital should be assessed by either the obstetric registrar or a specialist. To help ensure this they should be accompanied by a letterhead referral. It is also advisable to notify the registrar of the referral.
 - If unsure whether the situation requires urgent Delivery Suite assessment or an earlier clinic appointment it should be discussed with the registrar.
 - Complications arising that may not need hospital assessment should be discussed with the registrar.
 - Please note that for women in these urgent categories, vaginal speculum examinations are not appropriate in the GP rooms.

11. ANTENATAL RECORD CARD

Medical records are the key to good communications and good communication is the essence of successful shared care.

For the sake of uniformity the yellow antenatal record will be the only form used. These cards will be issued to the woman by her GP or at her initial visit to the Antenatal Clinic.

The record should be completed in a uniform manner using only standard and widely accepted abbreviations. Entries in the antenatal record should be written legibly and signed. GP's should stamp their details on the bottom right-hand corner of the yellow card so that their contact details are easily accessible.

Women involved in shared care will be given this yellow antenatal record and this should be carried by her at all times. Since this antenatal record becomes the official hospital record (and sometimes the only one available at the time the woman is admitted) it is important that it be as complete as possible.

Should the woman forget her card at a visit, the relevant details should be copied onto a letterhead and given to her to keep with the card.

Pathology tests and ultrasound results are to be recorded on the yellow antenatal record. First visit tests are entered on the front page, but for subsequent tests leave a space for the results to be added later or use the space provided at the bottom of the reverse side of the sheet.

When any investigations are performed by the GP, the results are entered into the yellow antenatal record. If the results are not available at the time the patient is given her record, then write down the name of the service used and the date ordered. It is recommended that a copy of pathology results and ultrasound reports are forwarded to the Antenatal Clinic as soon as possible (by post or fax).

12. RECOMMENDED ROUTINE ANTENATAL INVESTIGATION

(Arranged by GP with copies of results to Antenatal Clinic)

<p>GP to discuss and offer appropriate antenatal testing to all women and to organise investigations as per protocol, on confirmation of pregnancy</p>	<ul style="list-style-type: none"> • FBC • Haemoglobin EPG (as per hospital guidelines) • Blood Group and Antibody Screen • Rubella Serology • Varicella VZ IgG (if not sure of previous exposure) • Syphilis Screening (ELISA) • HBs Ag • <u>Offer</u> HIV antibody & Hep C antibody screening (with appropriate counselling) • Multistix urine analysis (MSU if indicated) • Pap smear if due
<p>Optional antenatal tests</p> <p>Special Antenatal tests to be offered to all women and arranged if requested before or at the first Antenatal Clinic visit.</p>	<p>Test available are:</p> <ul style="list-style-type: none"> • 10 – 12 weeks: Chorionic Villus Sampling (CVS) • 11 – 14 weeks: Nuchal Translucency Plus test +/- PAPP-A & free B-hCG • 14 – 16 weeks: Amniocentesis <p>Women to be counselled prior to the test that results are not 100% accurate and will incur cost to the patient.</p>
<p>18 weeks</p>	<p>Morphology Ultrasound</p>
<p>28 weeks</p>	<ul style="list-style-type: none"> • Antibody Screen – Rh negative women • FBC • Diabetes Screening as per hospital policy: • Sutherland Hospital – All women to have 50gm Glucose Challenge • St George Hospital – Selective with 50gm Glucose Challenge • Royal Hospital for Women – All women to have 50gm Glucose Challenge

13. ADDITIONAL COMMENTS:

1) Iron & Folic Acid

Folic Acid 500mcg should be recommended for all patients up to 12 weeks. The dose increased to 5mg if patient is taking antiepileptic drugs.

The dose may also alter if she is known to have elevated homocysteine levels.

Iron for those with a booking Hb of <10.5 and investigate as appropriate.

2) Ultrasound

First trimester dating scan is required for those with uncertain dates, Ultrasound should also be performed for relevant complications (e.g. vaginal bleeding).

Offer the option of a NT Plus scan at 11.5 – 14 weeks; please check that U/S provider is fully accredited to perform NT Plus scans

At 18-20 weeks foetal morphology is assessed.

Please note abnormalities (e.g. low placenta) on the yellow card, the date the test was performed as well as gestational age.

Dating of the pregnancy by ultrasound becomes increasingly unreliable after 20 weeks gestation.

Please fax the report and ensure the woman takes the ultrasound report and film to the Antenatal Clinic at the next visit. After review, the films will usually be returned to the woman.

3) Antenatal Colposcopy

Women with Cervical Intra-epithelial Neoplasia (CIN) diagnosed on the antenatal smear or just prior to the pregnancy should be referred for Colposcopy - this can be done through the clinic or alternative facilities according to woman's choice.

4) Prophylactic Anti-d

Given to all **Rhesus negative** women at 28 – 30 and 34 – 36 weeks in hospital clinics

5) Thalassaemia Screening

St George Hospital recommends that all pregnant women from the following risk groups be offered haemoglobin EPG as an initial investigation together with a full blood count and a manual film.

- South East Asian, Asian (including Indian, Pakistan, Bangladesh)
- Mediterranean, Arabic, or Black African women

If a known carrier the father's status needs to be ascertained, if father is a carrier refer to genetics counsellor

6) Varicella

This screening test to be offered all women who do not have a strong history of having had the disease

7) Influenza

Vaccination¹ is recommended by NHMRC for pregnant women in the 2nd and 3rd trimester during the winter months as it has been shown to reduce hospitalisation and morbidity.

14. DETERMINATION OF ESTIMATED DATE OF CONFINEMENT

To determine the EDC:

1. If the last menstrual period (LMP) is certain and the menstrual cycle regular, add 7 days and 9 months or add 280 days to the first day. If the cycle length is greater than or less than 28 days then add or subtract the difference respectively. For example, for a 35 day cycle add 14 days and 9 months or 287 days.
2. In cases where the LMP is unknown or uncertain an ultrasound scan (USS) should be used to determine the EDC.

¹ NHMRC immunisation 8th edition 2004 guidelines
Ref Red Book 2000 American Academy of Pediatrics

a) **Using the USS(s) note:** The earlier the USS, the more accurate in terms of dating however the fetal heart beat needs to be seen. In choosing between multiple scans always use the earliest USS.

b) **Only change menstrually determined dates if:**

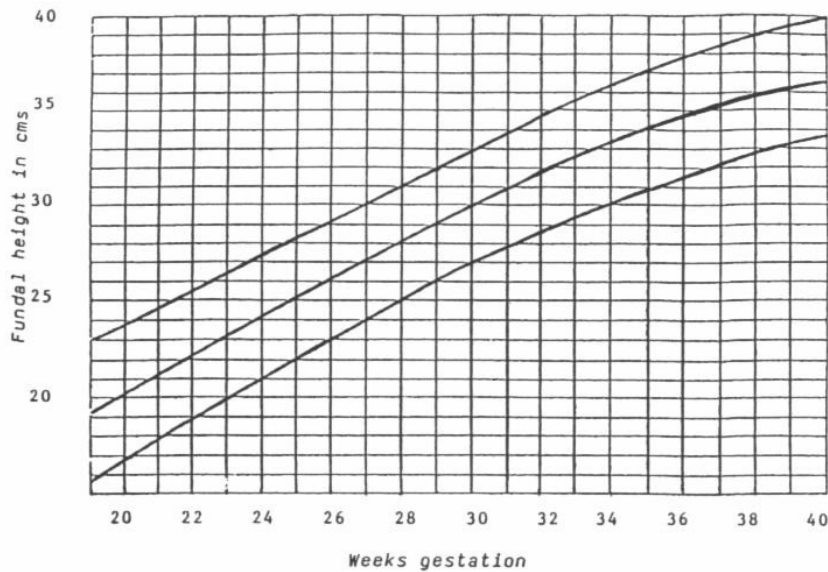
- The USS at less than 12 weeks gestation is more than 6 days different.
- The USS at 12 to 20 weeks is more than 10 days different.
- Dates should not be changed by a third trimester ultrasound scan.

15. ANTENATAL EXAMINATIONS

It is suggested that the antenatal visits include the following:

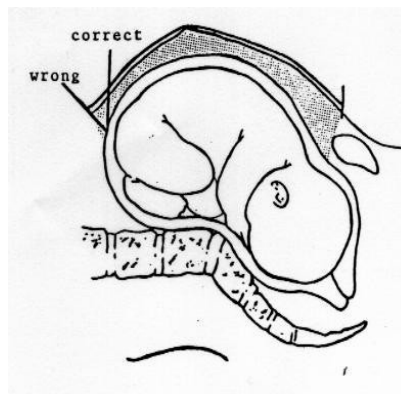
- History - foetal movements, etc
- Examination:
 - BP
 - Urinalysis
 - Evidence of oedema
 - The fetal presentation after 26 weeks.
 - The engagement of the head after 37 weeks.
- Foetal Heart Rate - Doppler after 16 weeks
 - Auscultation after 26 weeks.
- Estimation of fundal height – Symphysial-Fundal Height to be measured after 20 weeks

SYMPHYSIAL-FUNDAL HEIGHT CHART:



The curves represent the 10th, 50th and 90th percentiles for normal pregnancy. Readings below the 10th percentile, between 28 and 34 weeks' gestation are most likely to predict intra-uterine growth retardation.

Fundal height should be measured from the fundus of the uterus to the top of the symphysis pubis, with the tape measure lying in contact with the skin of the abdominal wall. The measurement at the fundus should be made by palpation vertically downward.



CORRECT METHOD

The top of the uterine fundus should be detected by palpation vertically downwards.

16. POSTNATAL CHECK

- As early as required generally between 4-6 weeks after confinement
- Details of confinement available on Midwife Discharge Data Sheet which should be routinely posted to GP's or urgently faxed if complications have occurred.

History

- Psychological state (eg. Postnatal Depression)
- Feeding/settling problems
- Lochia (usually stopped by 6 weeks, first period may occur at 6 weeks. Lochia is usually clear of blood by 2 weeks)
- Physical sequela of confinement. (eg. backache/urinary symptoms etc)
- Enquire about intercourse and any associated problems.
- Contraception (may fit diaphragm at this stage, avoid combined O.C.P. if breast feeding)

Examination

- BP (re-check again at 3/12 if high during pregnancy)
- Breasts
- Abdominal examination to check for fundal height
- P.V. - check episiotomy/tears, cauterise granulomas, etc
 - check for prolapse (pelvic floor tone)
- PAP (if due)
- Hb (if significant PPH or previously anaemic)
- Check for goitre (post-natal thyroiditis)
- Some women may be asked to attend the hospital clinic for review if they suffered complications.

Follow up any medical problems if diagnosed during pregnancy

Offer:

- Vaccination² of new parents for pertussis as per NHMRC guidelines
- 2nd MMR to mother who had low immunity and given the first MMR vaccine in hospital as per NHMRC guidelines

² NHMRC immunisation 8th edition 2004 guidelines