

GP Antenatal Shared Care Protocol

The Antenatal Shared Care Protocol was produced by Sutherland Division of General Practice and St George Division of General Practice (now Central and Eastern Sydney PHN) in collaboration with the South Eastern Sydney Local Health District. (Revised August 2015)

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CONTENTS

1. AIM.....	3
2. OBJECTIVES.....	3
3. REGISTRATION, EDUCATION AND GP REQUIREMENTS.....	3
4. ANTENATAL SHARED CARE OPTIONS.....	4
5. SUITABILITY FOR ANTENATAL SHARED CARE AND BOOKING PROCEDURES	5
5.1 INITIAL VISIT WITH GP	5
5.2 FREQUENCY OF VISITS	6
6. MANAGING COMMON PROBLEMS.....	6
7. ANTENATAL RECORD CARD.....	8
8. RECOMMENDED ROUTINE ANTENATAL INVESTIGATIONS	9
9. DETERMINATION OF ESTIMATED DATE OF BIRTH (EDB)	10
10. ANTENATAL EXAMINATIONS.....	10
11. POSTNATAL CHECK.....	10
12. REFERENCES AND RESOURCES	11

GET IN TOUCH

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1. 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.

2. OBJECTIVES

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

3. REGISTRATION, EDUCATION AND GP REQUIREMENTS

To be eligible as a member of the Antenatal Shared Care Program in South Eastern Sydney Local Health District (SESLHD) the GP should:

- Fulfil the requirements for Registration

Registration

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

- Current Medical Registration.
- Current membership of a Medical Defence Association.
- Attendance at a Central and Eastern Sydney PHN registration course.
- 12 points of Central and Eastern Sydney PHN -delivered / endorsed Antenatal Shared Care educational activities for each triennium. The CESP HN will monitor the number of points achieved by each GP. Each PHN will record the names of the GPs attending the activities they run. If GPs attend an activity conducted by another PHN, they must inform their own PHN so the points may be recorded.
- Royal Hospital for Women (RHW) requires GPs to have a police check and annually re submit their medical registration details for affiliation to the Hospital.
- An optional placement with the obstetrician in the Antenatal Clinic (St George and Sutherland Hospital)

Quality Management

Quality management activities will be conducted periodically by the PHN

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4. ANTENATAL SHARED CARE OPTIONS

(a) Women wishing to have Antenatal Shared Care with their GP and the SESLHD 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	Not available	√	
Home Birth	Not available	√	Not available
Community Program	Aboriginal Maternal & Infant Health Service	Midwifery Group Practice <ul style="list-style-type: none"> ▪ South Hurstville Child and Family Health Centre ▪ Kingsgrove Health Centre Aboriginal Maternal & Infant Health Service	Antenatal Community Clinic Menai Aboriginal Maternal & Infant Health Service

(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, for women who choose this option.

2. Aboriginal Maternal & Infant Health Service

Available at the RHW contact 9382 6783 for further details, St George and Sutherland contact 9543 1111.

3. Midwifery Group Practice

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

5. Home Birth

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

6. Menai Community Clinic

Antenatal Clinic at Menai with delivery at the Sutherland Hospital

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5. SUITABILITY FOR ANTENATAL SHARED CARE AND BOOKING PROCEDURES

5.1 INITIAL VISIT WITH GP

1. Assess suitability for Antenatal Shared Care (see below)
 - Women who may not be suitable for Antenatal Shared Care include:
 - a. Serious medical condition
 - b. Pre-existing hypertensive disorders
 - c. Previous significant obstetric complications (severe hypertensive disorder, preterm birth etc.)
 - d. Twin pregnancies
 - e. Drug addictions

Suitability may be individualised and can be discussed with the Obstetrician involved at booking.

2. Arrange initial screening investigations
 - 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
 - HIV antibody & Hep C antibody screening (*with appropriate counselling*) and is offered routinely at RHW.
 - Vitamin D
 - MSU for M/C/S (plus Chlamydia PCR if <25 or high risk e.g. sexworker)
 - 75g 2 hour OGTT (based on GDM high risk factors)
 - Pap smear if due
3. Discuss options for genetic screening and testing, which may include:
 - First trimester screen (Nuchal Translucency USS and PAPP-A + free B-hCG), performed between 11-13 weeks
 - Non Invasive Prenatal Diagnosis (NIPT) from 10 weeks gestation
 - Invasive testing (Chorionic Villus Sampling (CVS) 10-12 weeks or Amniocentesis (15 weeks)

Women over 35 yrs age or with a history of genetic conditions should be referred for genetic counselling.
4. Issue woman with her Antenatal Record Card.
5. Follow booking process for relevant Hospital (RHW, St George or Sutherland) per the referral form
6. Perform physical examination
7. Discuss frequency of visits
8. Discuss nutrition, advise folate 500mcg and iodine 150mcg daily supplementation
9. Discuss strategies to reduce or cease smoking (as required)
10. Discuss antenatal education/antenatal classes

5.2 FREQUENCY OF VISITS

St George and Sutherland Hospitals	The Royal Hospital for Women
First visit as soon as pregnancy suspected (with GP)	First visit as soon as pregnancy suspected (with GP)
Booking visit 10-14 weeks gestation (at Antenatal Clinic)	Booking visit 10-14 weeks gestation (at Antenatal Clinic)
4 weekly to 26 weeks (with GP)	4 weekly to 20 weeks (with GP)
30 weeks (at Antenatal Clinic)	20 week visit (at Antenatal Clinic)
2 weekly to 34 weeks (with GP)	4 weekly to 30 weeks (with GP)
36 weeks (at Antenatal Clinic – with VMO/Registrar)	30 weeks (at Antenatal Clinic)
37-39 weeks, weekly (with GP)	2 weekly- 34 weeks (with GP)
40 weeks onwards, weekly (at Antenatal Clinic)	36 weeks (at Antenatal Clinic-with VMO/Registrar or Midwife)
Rh-negative women attend at 28 & 34 weeks for anti-D injections.	37-39 weeks, weekly (with GP)
	40 weeks onwards, weekly (at Antenatal Clinic)

More or less 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 Antenatal Shared Care is unable to see his/her patient (i.e. during holidays or sickness), she should be referred back to the Antenatal Clinic or to another colleague who is also accredited with the Antenatal Shared Care Program.

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

6. MANAGING COMMON PROBLEMS

First trimester bleeding/ pain

Women with pain or bleeding in the first 12 weeks of the pregnancy should be referred to the first available appointment at the Early Pregnancy Assessment Service (EPAS). Women with excessive pain or bleeding should be referred to the nearest Emergency Department.

- Royal Hospital for Women: Early Pregnancy Assessment Service (EPAS) phone for appointments Monday – Friday - Phone 9382 6701
- St George Hospital: Early Pregnancy Assessment Service (EPAS) is a drop in service, patients are asked to arrive at the Women's and Children's Health Clinic (1 West Gynaecology Ward) at 8am (takes women from Sutherland area also).
- The Sutherland Hospital: Contact the O&G Registrar 9540-7111 page 125

GET IN TOUCH

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

- 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 (return to delivery suite or pregnancy day stay at the RHW)
- Placenta Previa detected
- Recommended scan at 34 weeks to check placental location (RHW specifically)
- Foetal abnormality is suspected/detected
- Generalised pruritus
- Hb <95g/l
- Rhesus D allow immunisation.
- Mal-presentation 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.

Managing hypertensive disorders

Women should be referred to the delivery suite urgently for assessment if:

- SBP \geq 170bpm or DBP \geq 110bpm
- If SBP 140-170bpm or DBP 90-110bpm, perform urinalysis, if proteinuria and/or symptomatic, refer to Delivery Suite urgently. If no proteinuria and asymptomatic, refer to earliest Day Assessment Unit.

Advice should be sought from the on-call Obstetric Registrar if uncertain.

Women should also be referred for immediate assessment if:

- Intractable vomiting with dehydration and ketosis.
- Preterm rupture of membranes.
- Threatened preterm delivery.
- Undiagnosed severe abdominal pain.
- Antepartum haemorrhage.
- Decreased foetal movements.
- Suspicion of death in-utero.
- Unusual headaches or visual disturbances.
- Seizures or "faints" in which seizure activity may have occurred.
- Dyspnoea on mild-moderate exertion, orthopnoea or nocturnal dyspnoea
- Symptoms or signs suggestive of deep vein thrombosis.
- Pyelonephritis.
- Symptoms or signs of pre-eclampsia

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Patients referred back to the Hospital will 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 this 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 would not be appropriate in the GP rooms.

7. ANTENATAL RECORD CARD

Medical records are the key to good communication and good communication is the essence of successful Antenatal Shared Care.

For the sake of uniformity the Antenatal Record Card will be the only form used. These cards will be issued to the woman in the Antenatal Shared Care information pack 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 Card should be written legibly and signed.

GPs should stamp their details on the bottom right-hand corner of the Antenatal Record Card so their contact details are easily visible.

Women involved in Antenatal Shared Care will be given this Antenatal Record Card and this should be carried by her at all times. Since this Antenatal Record Card 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, it can be completed at the next visit or filled in as soon as possible.

Pathology tests and ultrasound results are to be recorded on the Antenatal Record Card. First visit tests are entered on the front page, 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 card.

When any investigations are performed by the GP, the results are entered into the Antenatal Record Card. 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).

GET IN TOUCH

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8. RECOMMENDED ROUTINE ANTENATAL INVESTIGATIONS

(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 (<i>as per hospital guidelines</i>) • Blood Group and Antibody Screen • Rubella Serology • Varicella VZ IgG (<i>if not sure of previous exposure</i>) • Syphilis Screening (ELISA) • HBs Ag (<i>for high risk patients only at RHW</i>) • HIV antibody & Hep C antibody screening (<i>with appropriate counselling</i>) and is routinely offered at RHW • Vitamin D (<i>for high risk patients only at RHW</i>) • MSU for M/C/S (plus Chlamydia PCR if <25 or high risk e.g. sexworker) • Pap smear if due • Gestational Diabetes (<i>based on GDM high risk factors</i>)
<p>GP to counsel women about options for genetic screening and testing.</p>	<p>Test available are:</p> <ul style="list-style-type: none"> • First Trimester Screen Nuchal Translucency Plus test+/- PAPP-A & free B-hCG • Non Invasive Prenatal Testing (NIPT), note: this is billed privately • Invasive testing Chorionic Villus Sampling (CVS) (10-12 weeks): Amniocentesis (15 weeks) • Genetic Counselling • Diabetes management
<p>18-20 weeks</p>	<p>Morphology Ultrasound</p>
<p>26-28 weeks</p>	<ul style="list-style-type: none"> • Antibody Screen – Rh negative women • FBC • Diabetes screening: <ul style="list-style-type: none"> ○ 75g 2 hour OGTT (all women)

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9. DETERMINATION OF ESTIMATED DATE OF BIRTH (EDB)

To determine the EDB:

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 EDB.
 - a) Using the USS(s) note: The earlier the USS, the more accurate in terms of dating however the foetal 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.

10. ANTENATAL EXAMINATIONS

It is suggested that the antenatal visits include the following:

- History - foetal movements, etc.

Examination:

- BP
- Urinalysis (where indicated)
- Evidence of oedema
- The foetal 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

Guidelines:

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.

11. POSTNATAL CHECK

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

History

- Psychological state (e.g. 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)

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- Physical sequela of confinement. (E.g. backache/urinary symptoms etc.)
- Enquire about intercourse and any associated problems.
- Contraception

Examination

- BP (re-check again at 3/12 if high during pregnancy)
- Breast check
- 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)
- 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:

- Vaccination 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 guidelines¹

12. REFERENCES AND RESOURCES

You can access this protocol on the Central and Eastern Sydney PHN website:

www.cesphn.org.au

The NHMRC guidelines can be accessed here:

[http://www.health.gov.au/internet/main/publishing.nsf/content/015FBFDD266795DBCA257BF0001A0547/\\$File/ANC_Guidelines_Mod1_v32.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/015FBFDD266795DBCA257BF0001A0547/$File/ANC_Guidelines_Mod1_v32.pdf)

SESLHD Gestational Diabetes Guidelines (Dec 2014)

http://www.seslhd.health.nsw.gov.au/Policies_Procedures_Guidelines/Clinical/Women_Babies_Health/Documents/SESLHDPD282FINALPolicyGestationalDiabetesMellitusGDMManagem.pdf

¹ 2 NHMRC Immunisation 10th edition 2012 guidelines

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