



St George and Sutherland Hospitals GP Antenatal Shared Care Protocol

The GP 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.

Last updated June 2020



phn
CENTRAL AND
EASTERN SYDNEY
An Australian Government Initiative

Contents

Contents	2
Aim	3
Objectives	3
Registration, education and GP requirements	3
Booking into hospital process	3
Initial GP visit	4
Subsequent antenatal visits and investigations	8
Antenatal record card	9
Postnatal check	9
Managing common problems	10
References and resources	12

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 (GP).

Objectives

- To provide choice, continuity of care and greater accessibility for women by seeing their GP during pregnancy.
- To enable registered 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 hospital outpatient services.

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 needs to fulfil the requirements for registration:

Registration

Registration for Antenatal Shared Care requires:

- Current medical registration.
- Current membership of a Medical Defence Association.
- Attendance at an orientation, conducted by the GP Liaison Midwife.
- 12 points of Central and Eastern Sydney PHN (CESPHN)-delivered or endorsed Antenatal Shared Care educational activities for each triennium. CESPHN will monitor the number of points achieved by each GP. If GPs attend an activity conducted by a party other than CESPHN, they must inform CESPHN by email (ansc@cesphn.com.au) so the points may be approved and recorded.

Quality management

Quality management activities will be conducted periodically by the Women's Health and Antenatal Care Advisory Committee.

Booking into hospital process

Women should contact their preferred hospital when they become pregnant, by calling

9113 2162

or completing the **online antenatal appointment** form for [St George](#) or [Sutherland](#)

to arrange their antenatal booking appointment with the hospital. The woman will receive a booking in package which includes a GP referral form to take to their initial GP visit.

If women present prior to this, the GP can organise the initial investigations, check they are on the correct supplements and direct them to contact the hospital for booking ASAP. A review appointment can be arranged to complete the paperwork and less urgent aspects of the initial visit.

Initial GP visit

Assess suitability for Antenatal Shared Care

Not suitable for GP shared care	Generally suitable for GP shared care
Serious medical conditions	Low risk pregnancies
Pre-existing hypertension	Well mothers
Previous significant obstetric complications (preeclampsia, preterm birth etc)	IVF conception
Twin pregnancies	
Drug addictions	
BMI > 35	

- If a woman is not suitable for GP shared care, then arrange investigations as below and refer to the hospital antenatal clinic.
- Suitability may be individualised and can be discussed with the Obstetrician involved at booking.
- An interpreter service is available by phoning 131 450 (free call).

Arrange initial screening investigations

Routine investigations (all women)	Optional investigations (per clinical circumstance)
FBC	Chlamydia PCR (urine) if < 25 years or risks
Blood group and antibody screen	TSH (if past or family history)
Rubella IgG	HbEPG (if at risk of thalassaemia e.g. MCV<86 and certain ethnic groups, refer to flowchart in Resources section)
Syphilis serology	75gGTT (if risk factors for diabetes mellitus) at 15 weeks gestation
Hep B surface antigen	Cervical screening test (if > 25 years and due; safe at any time during pregnancy; click here for clinical guidelines)
Hep C and HIV (with counselling and consent)	Varicella screening (if unknown)
MSU for M/C/S	CMV (for high risk groups)
Vitamin D	

- Please forward a copy of all results to the antenatal clinic and the relevant hospital

Estimate the date of birth (EDB)

- To determine the estimation of EDB:

Certain LMP	Add 9 months and 7 days (280days) to first day of LMP If cycle shorter or longer than 28 days, subtract or add that number of days from the EDB as required
Uncertain LMP	Arrange US scan. The earliest scan after 6 weeks gestation is the most accurate for dating
IVF pregnancy	Use the EDB provided by the fertility centre

- Only change menstrually determined dates if:
 - The USS at less than 12 weeks gestation is more than 5 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.
- Inform the woman that the hospital *eMaternity* program algorithm may slightly alter the EDB.

Discuss options for genetic screening and testing

- Offer women either:

A First trimester Screen (nuchal translucency ultrasound with biochemical markers- PAPP-A and HCG) at 11-13 weeks gestation
or
Non-invasive prenatal testing (NIPS) from 10 weeks gestation with an early fetal anatomy scan at 12-14 weeks gestation
or
Invasive (diagnostic) testing: CVS at 10-12 weeks or Amniocentesis (15 weeks) Refer to genetic counsellor if these tests are considered.

- The increased risks of aneuploidy for women over 35 years should be considered.
- Women with a history of genetic conditions should be referred for genetic counselling. Ph 9113 3636 and complete referral form available on CESPHN website.

Perform physical examination.

- A general physical exam including a breast check should be performed.



Discuss frequency of visits and options of care

Options of shared care	St George Hospital	The Sutherland Hospital
Antenatal clinic	Available	Available, including midwifery group practice
	New Directions program for Aboriginal and Torres Strait Islander women (liaison from TSH service)	
Active Birth team	Available	Available
Community	Midwifery group practice at local early childhood centres	New Directions program for Aboriginal and Torres Strait Islander women (with extension to SGH)

- **Antenatal Clinic-** is a hospital based mixed-risk antenatal clinic service with care by midwives and obstetric doctors, with intrapartum and postnatal care by Birth Unit and postnatal ward midwives. Early discharge program available.
- **Aboriginal Maternal and Infant Health Service-** contact the New Directions team on 0439 391 192. The program has a full-time midwife and Aboriginal Health Worker who is available Monday – Friday 0830-1700.
- **Midwifery Group Practice-** a nominated midwife, with antenatal, intrapartum and postnatal care delivered by a small team of midwives. Should a woman choose the Maternity Support Program (early discharge), one of the MGP midwives will visit her at home (as long as she lives within the area covered). GP ANSC is available; visits alternate between GP and midwife.
- **Active Birth team-** care for low risk women by a team of midwives during pregnancy, labour, birth and postnatally with a natural low-intervention birth focus. GP ANSC is available; visits alternate between GP and midwife.

Frequency of visits for GP Antenatal Shared Care clients	
Standard shared care	Additional hospital visits that may be required
Initial visit with GP	
Hospital booking-in visit (10-14 weeks)	20 weeks at SGH for NBAC women
4 weekly with GP till 28 weeks	Anti D at hospital for Rh neg women at 28 weeks
Hospital visit at 30 weeks	
33 weeks with GP	Anti D at hospital for Rh neg women at 34 weeks
	NBAC at SGH at 34 weeks
Hospital visit at 36 weeks	
37, 38 and 39 weeks with GP	
Hospital visit at 40 and 41 weeks (if required)	

- 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 registered 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.

Nutritional advice and good health

- Discuss nutrition, advise folate 500mcg and iodine 150mcg daily supplementation.
- Discuss weight management and exercise, complete [referral](#) to Get Healthy in Pregnancy if required.
- Discuss strategies to reduce or cease smoking (as required).
- Encourage antenatal education/antenatal classes available at both hospitals.
- Discuss alcohol cessation and smoking reduction/cessation.

Assess whether a woman may need low-dose aspirin treatment

- Low dose aspirin (150mg) should be commenced as early as possible for women who meet the following criteria:

History of pre-eclampsia in a previous pregnancy
Pre-existing diabetes (Type 1 or 2)
Antiphospholipid syndrome
Chronic kidney disease
At least 2 other risk factors such as nulliparity, multiple pregnancy, family history of preeclampsia, obesity, age ≥ 40
Chronic (pre-existing) hypertension
12 week ultrasound shows high risk for pre-eclampsia

- If in doubt, err on the side of commencing aspirin as it is safe and associated with few side effects, and early commencement is important.
- These women will often be seen in the high risk clinic and may be excluded from the ANSC program.



Subsequent antenatal visits and investigations

Antenatal history and examination

- It is suggested that the antenatal visits include the following:

History	Examination
Fetal movements	Blood pressure
Presence of uterine activity	Urinalysis (where indicated)
Shortness of breath or palpitations	Evidence of oedema
Calf pain and or oedema	Fetal heart rate (after 16 weeks)
Vaginal bleeding and or discharge	Symphysial- fundal height (after 20 weeks)
Mood and emotional wellbeing	Fetal presentation (after 26 weeks)
	Engagement of fetal head (after 37 weeks)

- 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.

Subsequent investigations

Timing	Routine investigations (all women)	Optional investigations (per clinical circumstance)
At any time		Flu vaccine (as per season)
18-20 weeks	Morphology ultrasound	
20 weeks		Boostrix for women at high risk of premature birth
26-28 weeks	Antibody Screen FBC 75g 2 hour OGTT (if GDM not already present)	Vitamin D (if low at booking) Ferritin (if iron deficiency suspected)
28-32 weeks	Boostrix	
36 weeks	Low vaginal swab	FBC (if anaemic)

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 Booking pack.
- 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. GPs should print a copy of their notes to give to the woman if they forget their card at a visit.
- All pathology tests, vaccinations and ultrasound results are to be recorded on the front side of the Antenatal Record 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 cc'd to the Antenatal Clinic as soon as possible (by post or fax).

Postnatal check

- Arrange routine postnatal check 6 weeks after birth.
- The discharge summary will be electronically transmitted or sent with the woman to the GP.
- Some women may attend the hospital clinic for postnatal review if they suffered complications e.g. the Pelvic Floor Unit for 3rd and 4th degree perineal tears.

History

- Assess:
 - a. Psychological state (e.g. Postnatal Depression).
 - b. Feeding/settling problems.
 - c. Lochia (usually stopped by 6 weeks, first period may occur at 6 weeks. Lochia is usually clear of blood by 2 weeks).
 - d. Physical sequela of confinement. (e.g. backache/urinary symptoms etc.).
 - e. Enquire about intercourse and any associated problems.
- Discuss Contraception.

Examination

- BP (re-check again at 3/12 if high during pregnancy).
- Breast check.
- Abdominal examination to check for fundal height.
- Vaginal examination:
 - a. Check episiotomy/tears, cauterise granulomas,
 - b. Check for prolapse



- c. Assess pelvic floor muscle strength.
- d. Cervical screening test (if due).

Follow-up investigations

- Hb (if significant PPH or previously anaemic).
- 75g OGTT for gestational diabetes follow-up.
- Any medical problems if diagnosed during pregnancy.

Offer

- Vaccination of new parents for Pertussis as per NHMRC guidelines if not given previously or during pregnancy.
- 2nd MMR to mother who had low immunity and given the first MMR vaccine in hospital as per NHMRC guidelines¹.

Managing common problems

First trimester bleeding/ pain

- St George: Women with pain or bleeding in the first 12 weeks of the pregnancy should be referred to the Early Pregnancy Assessment Service (EPAS). EPAS is a drop in service; patients are asked to arrive at the 1 West Gynaecology Ward/Ward Tower Block at 7.30-8.30am Monday-Friday (takes women from Sutherland area also).
- The Sutherland Hospital: Ask the woman to attend the Emergency Department.
- Women with excessive pain or bleeding should be referred to the nearest Emergency Department.

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

- Gestational diabetes requiring oral medication or insulin or further complications.
- 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 (attend Birth Unit).
- Placenta Previa detected (if placenta less than 2cm from cervix at 34 weeks scan).
- Foetal abnormality is suspected/detected.
- Generalised pruritus.
- Hb <95g/l.
- Rhesus D allo immunisation.
- Mal-presentation after 36 weeks. Formal ultrasound to be arranged asap and appointment at ANC.
- Necessity for support services such as Social Worker or Drug and 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 Birth Unit urgently for assessment if:

- SBP \geq 160bpm or DBP \geq 110bpm
- If SBP 140-160bpm or DBP 90-110bpm, perform urinalysis, if proteinuria and/or symptomatic, refer to Birth Unit urgently. If no proteinuria and asymptomatic, contact Day Assessment Unit to arrange referral.
- Advice should be sought from the on-call Obstetric Registrar if uncertain.
- Women who have a relative increase in blood pressure of > 30 systolic or > 15 diastolic from booking who do not reach 140 systolic or 90 diastolic may require referral for further assessment at hospital in the presence of proteinuria, a small for gestational age baby or hyperuricaemia.

Anaemia in pregnancy

The St George and Sutherland Hospitals protocol for management of anaemia outlines that the first line of treatment is with oral supplementation and an increase dietary iron and vitamin C. A follow-up blood

¹ NHMRC Immunisation 10th edition 2012 guidelines

review of FBC and ferritin levels after 4-6 weeks should then be reviewed. The use of an iron infusion should only be considered if the woman does not tolerate the medication or there has not been an increase in the blood results. The infusion process needs to be closely monitored within the hospital setting (usually the Ambulatory Care unit) followed by fetal surveillance in the Birth Unit. Due to the risk of an adverse reaction, it is recommended that it is not performed in the community setting.

Cholestasis

Women who have unexplained persistent and generalised itch (involving palms and soles of feet is particularly suggestive) require bile acids and liver function tests (LFT). Blood tests may be fasting or non fasting.

The diagnosis is made with:

- Serum bile acids >10 and/or deranged LFT.
- May also have an unexplained persistent generalised itch in the absence of a visible rash.

If results are abnormal, refer woman to the Birth Unit for antenatal assessment as soon as possible.

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.

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 Birth Unit assessment or an earlier clinic appointment, phone Birth Unit to discuss 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.



References and resources

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

www.cesphn.org.au

NHMRC Pregnancy Care Guidelines:

<http://www.health.gov.au/internet/main/publishing.nsf/Content/pregnancycareguidelines>

SESLHD Gestational Diabetes Guidelines (Dec 2014) and flowchart:

<https://www.cesphn.org.au/documents/hierarchical-document-list/antenatal-shared-care-1/gp-resources/560-gdm-screening-diagnosing-referral-flowchart>

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

Haemoglobin EPG screening flowchart 2015:

https://www.cesphn.org.au/images/181101_Thalassaemia_screening_flowchart_2015_1.pdf