# INITIAL VISIT TO HOSPITAL CLINIC

**PURPOSE**

1. To establish a collaborative relationship between the woman and the health care professionals involved in her care.
2. To inform the woman about the models of care available for pregnancy and birth allowing her to make an informed choice.
3. To assess the woman's level of social support, and her physical, psychological and emotional well-being.
4. To provide baseline recordings of the woman's physical and psychosocial condition for later comparison.
5. To identify risk factors for the pregnancy.
6. To provide support and make appropriate referrals where necessary.
7. To provide health education promoting and reinforcing healthy lifestyle habits in pregnancy.

## PROCEDURE

<table>
<thead>
<tr>
<th>1</th>
<th>Pregnancy Health Record MR 220</th>
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<tbody>
<tr>
<td><strong>PROCEDURE</strong></td>
<td>Commence documentation in the ‘Pregnancy Health Record’ at the initial visit.</td>
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<tr>
<td><strong>ADDITIONAL INFORMATION</strong></td>
<td>A photocopy of the medical/surgical/obstetric history from the MR220 is filed in the woman’s medical record. This copy will be discarded following postnatal discharge. The original copy is then filed in the woman’s medical records.</td>
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- Explain the purpose and use of the MR220 ‘Pregnancy Health Record’.

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<td>Carrying her own health record improves the woman’s sense of control and satisfaction, and the availability of the notes. There is insufficient evidence of additional benefits on health behaviours and clinical outcomes.</td>
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<tr>
<td>PROCEDURE</td>
<td>ADDITIONAL INFORMATION</td>
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<tr>
<td>Advise the women to take the record: to all antenatal and hospital visits to appointments with her general practitioner on holidays or if travelling away.</td>
<td>Do not put information into the handheld record that the woman does not wish to be known by her partner / family.</td>
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2 Health History

2.1 Record the woman’s health history including: medical history surgical history gynaecological history obstetric history family history psychosocial history medications / drugs complementary therapies |
| Enables assessment of the level of general, medical, obstetric, psychological, and emotional health and wellbeing. Problems and risk factors are identified allowing early referral to appropriate specialist care. |

2.2 Calculate/confirm the expected date of delivery (EDD). |
| A first trimester ultrasound EDD should be used in preference to the last menstrual period (LMP) if there is a difference of more than 5 days. When there is a difference of more than 7 days from the LMP and the second trimester ultrasound, the EDD should be adjusted to the second trimester ultrasound EDD. When there is a first trimester and second trimester ultrasound available the EDD is determined from the first trimester scan. |

2.3 An accredited interpreter or the Telephone Interpreting Service (TIS) must be used if communication is limited due to language barriers. |
| Clinical, legal and ethnic consequences are avoided by use of the interpreting services. See WNHS policy [WO37 Language Services](#) |

3 Physical Assessment/Examination

3.1 Women requiring a full physical examination. All refugee women who have been in Australia less than 12 months should have a full physical examination performed by a doctor. |
| Women attending a midwifery clinic may be referred back to the GP for the full physical examination. However, confirmation of a normal physical examination by the GP should be documented in the woman’s ‘Pregnancy Health Record’. Inform the woman of this management. |
### 3.2 Breasts

Observe and discuss:
- previous breast surgery or abnormalities
- breast changes in pregnancy
- breast self-examination. Provide verbal and written instruction as required.

### 3.3 Skin

Note any rashes, scars, skin conditions or varicose veins.

Varicose veins are common in pregnancy. Compression stockings can improve the symptoms but will not prevent varicose veins from forming.

### 3.4 Pelvic assessment / Examination

- **Offer a Papanicolaou (PAP) smear** prior to 24 weeks gestation as required.
  - If a woman is due for a PAP smear but declines prior to 24 weeks gestation, it should be noted on the MR 004 ‘Obstetric Special Instruction Sheet’ for follow-up post-partum.
- Note any abnormal vaginal discharge and obtain swabs as required.
- Determine if a woman has had female genital mutilation (FGM) performed. Identify the type, provide counselling, and discuss intrapartum management.

There is no evidence to suggest a PAP smear in pregnancy is harmful. See Clinical Guideline Papanicolaou (Pap) Smear.

### 3.5 Cardiovascular system

Refer women attending the low risk midwives clinic with a cardiac anomaly, arrhythmia, or cardiac disease to the medical obstetric clinic for review.

If a GP has arranged previous cardiac tests request a copy of the results. Obstetric physician review may be required. See Clinical Guideline Cardiac Disease in Pregnancy.

### 4 Record Height and Weight

Measure the height and weight of the woman and calculate their body mass index (BMI).
NOTE: Ideally BMI should be calculated from a pre-pregnancy weight and height, or at first opportunity during pregnancy.

**Formula for calculating a BMI**

\[
\text{BMI} = \frac{\text{Weight in kilograms}}{\text{Height in metres} \times \text{Height in metres}}
\]

All women with a BMI of 35 or more in the first trimester are referred to the KEMH dietician.

6 **Blood Pressure**

Record the woman’s blood pressure (BP)

See Clinical Guideline, Measuring Blood Pressure

Baseline recording of BP enables comparison and monitoring of BP changes in pregnancy. Early baseline measurement will differentiate chronic hypertension in the pregnant woman from gestational hypertension and pre-eclampsia. Correct cuff size allows a more accurate BP measurements.

7 **Urinalysis**

7.1 Instruct women how to perform a urine regent strip testing for:

- proteinuria

Dipstick testing is useful for assessing for pre-eclampsia, urinary tract infection, and renal disease.

Clinical signs may warrant more detailed regent strip testing, or collection of a mid-stream urine (MSU) collection.

7.2 Collect a MSU for asymptomatic bacteriuria in early pregnancy.

Risk of ascending urinary infection increases during pregnancy. Identification of asymptomatic bacteriuria reduces the risk of pylonephritis.

Persistent proteinuria and haematuria may indicate renal disease and further investigations may be warranted.
8 Blood tests

Blood tests are recommended for all antenatal patients:

- Blood group and antibody screen. Where the blood group has already been performed it does not need to be repeated, but the antibody screen should be repeated at the beginning of each pregnancy.
  
  See Clinical Guideline, Blood Grouping and Antibody Screening during pregnancy for significance and management of different antibodies in pregnancy.

- Full blood picture (FBP)

  Hepatitis B.

  Women found to be chronic carriers of Hepatitis B should have an assessment of their antigen and viral replicative status with liver functions performed and be referred for specialist support.

  Note: if a laboratory report or historical group suggests the woman is Du, D variant, Partial D, Weak D or any other anomaly, it should be repeated at the PathWest KEMH site to determine the woman’s correct blood group and whether RhD Immunoglobulin is appropriate.

- Syphilis serology should be performed using a specific treponema pallidum assay e.g.TPHA or TPPT.

- Rubella

Hepatitis C

HIV screening. The woman must be provided with appropriate counselling as to the limitations of screening for viral infections in pregnancy and the implications of both positive and negative results.

Hepatitis C
Additional blood tests according to individual clinical situations:

- Vitamin D serology
- Iron studies
- Haemoglobinopathy studies
- Vitamin B₁₂ levels
- Varicella: consider this where there is no history or uncertain history or previous illness.
- Liver function tests

Vitamin B₁₂ indications include significant alcohol use and clinically undernourished.

9 Chlamydia Screening

Offer Chlamydia screening to all women at the first antenatal visit, however screening is recommended for women with increased risk of sexually transmitted infection (STI).

Women from STI endemic areas of Western Australia (WA) are recommended to be also tested concurrently for gonorrhoea.

See Clinical Guideline Chlamydia.

Women at risk of STIs include:

- those less than 25 years
- women who have had a recent partner change
- women with more than one partner in the last 12 months
- women from STI endemic areas of WA such as the Kimberley, Pilbara and Goldfield areas.

10 Gonorrhoea Screening

Women with increased risk factors are recommended to be screened in early pregnancy.

All women living in STI endemic regions in WA i.e. the Kimberley, Pilbara and Goldfields should be offered screening. Other risk factors include women who have unprotected sexual activity with an infected partner or a partner with known high risk factors, women with previous known infection with an STI, or women from countries with a high prevalence.

11 Ultrasound screening

11.1 Screening for Fetal Abnormalities

All women attending KEMH early in pregnancy should be informed of the availability of screening tests and offered prenatal screening for fetal abnormalities

Written and verbal information should be provided including advantages and disadvantages, limitations and consequences of screening.
Screening tests include:

- first trimester screening (FTS)
- maternal serum screening (MSS)

The FTS includes blood collection at 9-13 weeks gestation (ideally 9-12 weeks) for biochemical analysis combined with ultrasound measurement of fetal nuchal translucency (between 11 to 13 weeks gestation).

Blood collected for MSS is obtained at 14 to 20 weeks gestation (ideally between 15-17 weeks) for biochemical analysis.

11.2 Fetal morphology ultrasound

Offer a fetal morphology ultrasound to all women.

Anatomy scans may be booked at the KEMH Diagnostic Imaging Department, however whenever practical refer the woman to her GP to arrange an ultrasound at another metropolitan service. Advise the woman to arrange to bring a copy to her next antenatal appointment, or arrange a copy to be faxed to KEMH.

12 Genetic Services

Offer genetic counselling to all women with risk factors.

An Examination of the Genetic services of WA.

13 Psychological assessment

Edinburgh Post Natal Depression Scale (EPDS)

13.1 Perform the EPDS at the booking visit.  

See Clinical Guideline Psychological Medicine.

13.2 Refer women with their permission to the Department of Psychological Medicine if:

- the EPDS score is 13 or above
- a woman scores 1,2 or 3 of EPDS question 10, assess her current safety and the safety of other children in her care and, acting according to clinical judgement, seek advice and / or refer immediately for mental health assessment
- the anxiety scale is more than 6 (Q3+Q4+Q5 = 6)
- there are current mental health disorders or significant symptoms
- a personal history of diagnosed mental disorder is present
- the woman is currently taking psychiatric medications
- the woman is at risk of harming herself (or others) due to psychiatric disturbances.

The guideline provides information including management for urgent, out-of-hours, and routine referrals.
14 **Family and Domestic Violence (FDV) Screening**

Explain to all women that asking about domestic violence is a routine part of antenatal care and enquire about all women’s exposure to domestic violence.

Screen the woman when she is alone, tailoring the approach to her individual situation.

Document and file the result in the Medical Records, not in the woman's ‘Pregnancy Health Record’.

See [Clinical Guideline, Screening for Family and Domestic Violence](#).

15 **Diabetes Screening**

Assess gestation to determine if diabetes screening is due.

Screening for diabetes is recommended for all pregnant women.17

See [Clinical Guideline Screening for Diabetes in Pregnancy](#).

16 **Methicillin Resistance Staphylococcus Aureaus (MRSA) screening**

Screen women for MRSA who have been:

- hospitalised or worked in a hospital outside WA in the previous 12 months
- a room-mate of an active epidemic MRSA carrier during an outbreak occurring in the last 12 months, but were not screened prior to discharge.

Although MRSA strains are endemic in eastern Australia, WA has been able to prevent spread by it's geographical isolation, and the state wide policy to screen all patients and staff who have been in a hospital or nursing home outside the state in the previous 12 months.

See [Infection Control Policy 4.3 Methicillin Resistance Staphylococcus Aureaus](#).

17 **Dietary practices**

Record and provide advice about any dietary practices which may impact the pregnancy.

Advise women that taking vitamins A,C or E supplements is not of benefit in pregnancy and may cause harm.

Advise women to take an iodine supplement of 150 micrograms each day. Women with pre existing thyroid conditions should seek advice from their medical practitioner before taking a supplement.

Women having a vegetarian diet or with barriers for gastric absorption may require additional nutritional supplements in pregnancy.

18 **Oral Health**

Advise women to have oral health checks and treatment, if required, as good oral health protects a woman’s health and treatment can be safely provided during pregnancy.

19 **Allocate an antenatal model of care**
Explain the options of antenatal care and allocate accordingly:

- Family Birth Centre
- Low risk midwives clinics
- Team midwifery
- Shared Care with the GP
- Medical team obstetric clinic

Inform the woman when medical management/consultation is required if she is attending low risk midwifery care.

See Clinical Guidelines:

- [Low risk midwifery clinic](#)
- [Exclusion criteria to low risk midwives clinic](#)
- [Low risk midwives clinic with medical consultation](#)
## PROCEDURE

### 19 Special circumstances

See Clinical Guideline Women who refuse blood transfusion and blood products.

### 20 Antenatal Assessment

Assess maternal health and well-being:
- BP
- check for abnormal vaginal discharge
- note and provide information on health concerns/abnormalities in pregnancy

Assess fetal growth and well-being:
- note fetal movements
- assess fundal height / growth
- estimate presence of adequate amniotic fluid as appropriate
- auscultation of the fetal heart rate should be offered.

### 21 Initiate Parent Education

Provide information at the booking visit:
- when to phone or come to hospital
- parent education classes
- healthy dietary advice and dietitian services
- minor discomforts in pregnancy
- exercise in pregnancy
- smoking and alcohol in pregnancy
- illicit drug use in pregnancy
- risk of food-acquired infections e.g. listeria, salmonella
- dental health
- breast feeding policy recommendations and breast care
- frequency of antenatal visits
- health services available including physiotherapy, psychological services, aboriginal liaison service, social worker services
- prevention of ligament/muscle strains
- life-style issues e.g. air travel, working, sexual intercourse, seat-belt safety.

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**PREGNANCY EDUCATIONAL INFORMATION**
| **Seat Belts** | A seat belt reduces abdominal pressure and prevents contact with the steering wheel during low-impact collisions. Inform women the shoulder belt should be worn over the shoulder, across the chest between the breasts, and the lap belt is fastened as low as possible under the abdomen. |
| **Air Travel** | Women should be advised to check with individual carriers for their travel restrictions, however in the absence of medical or obstetric complications women can use the same precautions as all other passengers e.g. wearing of seat belts, hydration, support stockings, loose clothing, leg exercises, and ambulation when possible. |
| **Travelling** | Women travelling aboard should discuss vaccinations with the midwife or doctor. Travel insurance is recommended. Inform women to take their ‘Pregnancy Health Record’ with them. |
| **Exercise** | See written information in the ‘Pregnancy Health Record’. |
| **Hair Products** | No tetratogenic effects have been noted for occupational workers using products, but they are encouraged to wear gloves, avoid long standing times, and work in a well-ventilated room. There is minimal systemic absorption of hair products, therefore use by pregnant women 3-4 times in pregnancy is not considered harmful. |
| **Alcohol consumption** | Avoiding alcohol in pregnancy and while breastfeeding is the safest option. Harm to the fetus is highest with frequent high alcohol consumption. The risk to the fetus is low if a woman has consumed small amounts of alcohol before she knew she was pregnant, or during pregnancy. The level of risk influenced by maternal and fetal characteristics is hard to predict. |
| **Sexual Intercourse** | Sexual intercourse in a pregnancy without risk factors is not known to be associated with any adverse outcomes. |
| **Working during pregnancy** | A woman without risk factors may safely work in pregnancy. Discussion should include risk factors relating to manual handling activities, occupational hazards, and occupational health and safety strategies e.g. rest breaks, ventilation, avoidance of heavy physical exertion. |
| **Prevention of infection from foods** | Discuss risk for listeria infection in pregnancy. Provide women with written information. Prevent risk of salmonella by avoiding raw/partially cooked eggs (including egg-based mayonnaise) and raw/partially cooked meat. |
| **Complementary therapies** | Limited complementary therapies have been established as safe and effective. KEMH pharmacy can be contacted for advice. Staff should be aware of WNHS Policy W107 ‘Use of Complementary Therapies’. |
REFERENCES

Brown HC, Smith HJ. Giving women their own case notes to carry during pregnancy. The Cochrane Database of Systematic reviews. 2011.


Society of Obstetricians and Gynaecologist of Canada. Guidelines for the Management of Pregnancy at 41+0 to 42+0 Weeks. JOGC. 2008;September(9):800-10.


The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Hepatitis C. College Statement C-Obs 51. 2014.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Hepatitis B. College Statement C-Obs 50. 2014.


National Health and Medical Research Council AG. Australian Guidelines To Reduce Health Risks from Drinking Alcohol 324. Canberra: Commonwealth of Australia; 2009.


REFERENCES (STANDARDS)

National Standards – 1 Clinical Care is Guided by Current Best Practice Legislation - Nil

Related Guidelines – Identified within the Document

Other related documents – Nil

RESPONSIBILITY

Policy Sponsor Head of Obstetrics / Nursing & Midwifery Director OGCCU

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