

1 ANTEPARTUM CARE

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1.2 Adolescent Clinic
Section B
Clinical Guidelines
King Edward Memorial Hospital
Perth Western Australia

1.2 ADOLESCENT CLINIC

BACKGROUND INFORMATION

Teenage pregnancy in Australia ranks the third highest in the developed world.¹ While birth rates in the 15-19 year groups are declining in Australia in recent years the rate remains higher than numbers in comparable countries. However, this decline is not reflected in rural teenagers, indigenous and socially disadvantaged teen groups.² Teenagers have complex psychosocial issues and are more likely to live in unstable households or have no fixed address, have lower family incomes, are lacking social support networks, and are at higher risk for mental illness. Pregnancies are often unplanned or unwanted, and adolescents commonly face single parenthood.³

A study in Western Australia (WA) found that risk factors in pregnancy increase in teenagers, and that they are more likely to come from a low socioeconomic background, smoke, have anaemia, urinary tract infections, and pregnancy-induced hypertension in pregnancy.² The study also indicated that indigenous teenagers were more disadvantaged than non-Indigenous women^{2,4} with younger indigenous teenagers having increased risk factors leading to poor birth outcomes.⁴ Other reported pregnancy complications for teenagers include increased risk for preterm labour, intrauterine growth restriction (IUGR), and pre-eclampsia.⁵

A recent study in WA of 137 adolescents attending KEMH found that 47% of teenage mothers recommenced sexual activity within 6 weeks postpartum, 9% wanted to become pregnant again, and two of the teenagers became pregnant again prior to the 6 week postnatal check. This indicates the importance of contraception counselling throughout pregnancy with early postpartum follow-up and counselling, and that the appointment may be more beneficial for some teenagers if arranged prior to 6 weeks postpartum.⁶ Reducing risk for rapid-repeat pregnancies in teenagers can be facilitated by long-acting contraceptives, and by health workers gaining a clear understanding of their future intentions following birth so that the appropriate support and counselling can be provided.^{7,8}

REFERRALS

Referrals for the Adolescent Clinic are made by the 'bookings clerk' after the Patient Flow Co-ordinator liaises with the Co-ordinator for the Adolescent Clinic regarding the urgency/timing for the booking visit.

TIME OF THE ADOLESCENT CLINIC

The Adolescent Clinic is conducted on each Wednesday afternoon in the east wing clinic from 1300-1630.

ADOLESCENT TEAM MEMBERS

Staff attending the Adolescent Clinic include:

- Obstetric Consultant
- Obstetric registrar and resident

- Midwives
- Social Workers
- Parent Education Midwives
- Clinical Psychology
- Dietician (with referral)
- Adolescent Support Midwife

PROCEDURE	ADDITIONAL INFORMATION
<p>1 Routine antenatal care</p> <p>See Clinical Guidelines Section B Antepartum Clinic Visits – Initial visit</p> <p>See Clinical Guidelines Section B Antepartum Clinic Visits – Subsequent visit</p>	<p>Routine antenatal visits should be conducted, however frequency of visits and additional tests are required for the adolescent woman.</p>
<p>2 Initial visit</p> <p>At the initial visit women shall be assessed by the:</p> <ul style="list-style-type: none"> • Midwife or doctor and • Social worker <p>Additional referrals may be made depending on psychosocial and fetal/maternal needs.</p>	<p>Allows early interventions to link women with welfare assistance and social services.¹</p>
<p>2.1 Additional screening and blood tests</p> <ul style="list-style-type: none"> • Pap smear <p>See Clinical Guidelines Section A 5.2.3 Papanicolaou (Pap) Smear</p> <ul style="list-style-type: none"> • Screen for sexual transmitted infections (STI's) by taking the following swabs: <ul style="list-style-type: none"> ➢ Endocervical swab ➢ Low vaginal swab ➢ Additional endocervical swab for chlamydia/gonorrhoea <p><u>NOTE:</u> adolescents at high risk for STI's are re-screened at 36 weeks gestation.</p>	<p>Unless contra-indicated encourage collection of a pap smear at the booking visit if the adolescent presents with no current result. Pregnancy provides an opportunity to screen teenagers.</p> <p>If an STI is diagnosed:</p> <ul style="list-style-type: none"> • Complete the Health Department Notification form • Advise the partner they will need to be screened and treated as appropriate, and that the Health Department will be notified.

PROCEDURE	ADDITIONAL INFORMATION
<ul style="list-style-type: none"> Screen for iron and vitamin D levels if current results are unavailable. 	<p>Adolescents in industrialised countries often have micro-nutrient poor, energy-dense diets with deficiencies in iron and Vitamin D.⁹</p>
<p>2.2 Dental hygiene</p> <ul style="list-style-type: none"> Recommend a dental check in pregnancy. Refer to Perth Public Dental Clinics if financial restraints are present. 	<p>Adolescents who smoke are at increased risk for lower concentrations of folate which can be associated with fetal growth restriction in adolescents. They have a higher likelihood of anaemia which increases in the third trimester, and also may be at higher risk for Vitamin D deficiency especially in the darker skinned groups.⁹</p>
<p>3 Subsequent antenatal visits</p> <p>3.1 Frequency of antenatal visits</p> <p>Frequency of visits recommended are:</p> <ul style="list-style-type: none"> 2 weekly from 32 – 36 weeks gestation weekly from 36 weeks gestation <p>However, antenatal visits should be adjusted according to the individual maternal and fetal needs.</p> <p>3.2 Assessment each visit</p> <ul style="list-style-type: none"> Dietary habits/patterns 	<p>Undiagnosed dental infections and poor dental hygiene in teenagers may increase risk the risk of pre term birth.¹</p> <p>Urgent dental problems are given priority at the public dental clinics, and appointments for routine dental checks are placed on the 'waiting list'.</p>
<ul style="list-style-type: none"> Social Issues: <ul style="list-style-type: none"> ➢ Home environment/accommodation ➢ Financial issues ➢ Support network 	<p>Shared care with a consistent GP may be an option if the Adolescent team decide this is feasible (e.g. transport, distance issues)</p> <p>Adolescents are high risk for anaemia during pregnancy², therefore assessment of their dietary habits is essential at each visit. When anaemia is diagnosed and iron supplementation is instigated the health practitioner needs to confirm compliance with medication use at each visit.</p> <p>At each visit the midwife/doctor will assess the woman's psychosocial situation, and refer to the social worker or psychological services as required.</p>

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<ul style="list-style-type: none"> Psychological well-being Smoking habits /illicit drug use 	<p>Teenage mothers are at higher risk of mental health and related problems compared to other groups of antenatal women.³</p> <p>Pregnant teenagers have been found to be less likely to quit smoking during pregnancy than other antenatal women.² Adolescents who continue to smoke in the second half of pregnancy are more likely to have low birth weight neonates.¹⁰ Emphasis on this modifiable risk factor should be monitored and interventions offered at each visit to the woman and support group.</p>
<p>3.3 Blood</p> <p>Repeat full blood picture (FBP) at 36 weeks gestation as required.</p>	<p>Adolescents are at higher risk for anaemia.² If medication treatment for anaemia is initiated a follow-up FBP may indicate compliance with management or need for additional dosage.</p>
<p>4 Social work assessment</p> <p>The social worker will assess the adolescent at the:</p> <ul style="list-style-type: none"> Booking visit Follow up visits on an individual needs basis <p>The social worker liaises with the Adolescent Co-ordinator at each clinic and advises who they will review at the clinic that day.</p>	<p>The social worker will assess the adolescent's psychosocial situation, financial situation, support network, and the educational/work circumstances.</p> <p>Assistance with financial services, housing services, educational and community support groups is provided by the social work services.</p> <p>A plan of management is formulated and ongoing assessment is made during the pregnancy.</p>
<p>5 Diet and Nutrition</p> <ul style="list-style-type: none"> Provide pamphlets on diet and nutrition. Refer for Dietician Consultation as required. Monitor weight each visit. 	<p>Pamphlets written specifically for adolescents are available at the clinic.</p> <p>Adolescents may have poor knowledge of dietary nutrition and quality. Their skeletal maturity has not been reached yet and they are at risk of calcium deficiency. Iron requirements normally increase during adolescence, and pregnancy places them at an even higher risk for anaemia. Lack of folate may impair fetal development.¹¹</p> <p>Adolescents who fail to gain weight appropriately in pregnancy are at increased risk of preterm birth and delivering a low birth weight infant.¹²</p>

PROCEDURE	ADDITIONAL INFORMATION
<p>6 Parent education</p> <p>Parent education is provided on an individual basis.</p> <p>A hospital tour is arranged during the antenatal visit.</p>	
<p>7 Discharge Planning</p>	
<p>7.1 Contraception</p> <ul style="list-style-type: none"> Discuss contraception during the antenatal period and aim for a postnatal management plan prior to labour and birth. If an adolescent mother consents to contraception it is recommended to be prescribed prior to discharge. 	<p>Contraceptive implants and injectable contraceptives are the most successful methods at preventing repeat teenager pregnancy because they are long acting. Other forms may be used inconsistently or are easily discontinued.⁶</p> <p>The adolescent is less likely to attend GP follow-up.</p>
<p>7.2 Sexual Health Education</p> <p>Discuss risk factors and strategies to reduce risk of STIs.</p>	
<p>7.3 Postnatal Home Visits</p> <p>Inform the adolescent woman:</p> <ul style="list-style-type: none"> A midwife will visit the home at approximately 36 weeks gestation The hospital stay is based on individual needs. This may be from 24 hours to 5 days. A midwife will provide follow-up home visits for up to 6 months postnatally. 	<p>Assessing the home prior to delivery allows the midwife to evaluate the home environment, preparation for an infant, and to implement support plans as required.</p> <p>Postnatal visits can result in a reduction of adverse neonatal outcomes and the visits leads to teenagers having increased knowledge and use of contraception.¹³</p> <p>Frequency of visits are based on individual needs and the home situation.</p>
<p>7.4 Postnatal Check-up at KEMH</p> <p>Arrange a clinic follow-up appointment at the KEMH Adolescent clinic 4 weeks postpartum unless the Adolescent team has arranged a GP postnatal follow-up appointment.</p> <p>Ensure a pregnancy test is performed prior to commencing contraception at the postnatal follow-up visit.</p>	<p>Postnatal follow-up allows ongoing contraception counselling and commencement of contraception as appropriate. It provides the adolescent an opportunity to access staff that provides information and assistance with any physical or psychosocial issues.</p> <p>Some teenage mothers plan a rapid repeat pregnancy, and this may be planned as early as 6 weeks postpartum.⁶</p>

REFERENCES

1. Quinlivan J. Teenage pregnancy. **Obstetrics & Gynecology**. 2006;8(2):25-6.
2. Lewis LN, Hickey M, Doherty DA, et al. How do pregnancy outcomes differ in teenage mothers? A Western Australian study. **MJA**. 2009;190(10).
3. Laios L, Steele A, Judd F. What are we screening for? Development of a psychiatric referral tool for use with adolescent pregnant women. **Australasian Psychiatry**. 2010;18(3):256-59.
4. Skinner SR, Hickey M. Current priorities for adolescent sexual and reproductive health in Australia. **MJA**. 2003;179:158-61.
5. Royal College of Obstetricians and Gynaecologists. **Teenage Pregnancy and Reproductive Health. Summary Review**. 206. Baker P, Guthrie K, Hutchinson C, et al, editors. London: RCOG Press; 2007.
6. Lewis LN, Doherty DA, Hickey M, et al. Implanon as a contraceptive choice for teenage mothers: a comparison of contraceptive choices, acceptability and repeat pregnancy. **Contraception**. 2010;81:421-26.
7. Lewis LN, Doherty DA, Hickey M, et al. Predictors of sexual intercourse and rapid-repeat pregnancy among teenage mothers: an Australian prospective longitudinal study. **MJA**. 2010;193(6):338-42.
8. Baker P, Guthrie K, Hutchinson C, et al. **Teenage Pregnancy and Reproductive Health. Summary Review**. 214: RCOG; 2007.
9. Baker PN, Wheeler SJ, Sanders TA, et al. A prospective study of micronutrient status in adolescent pregnancy. **American Journal of Clinical Nutrition**. 2009;89:1114-24.
10. Chan DL, Sullivan EA. Teenage smoking in pregnancy and birthweight: a population study, 2001-2004. **MJA**. 2008;188(7):392-6.
11. Derbyshire E. Nutrition in pregnant teenagers: how can nurses help. **British Journal of Nursing**. 2007;16(3):144-5.
12. Stang J, Story M, Feldman S. Nutrition in Adolescent Pregnancy. **Journal of American Dietary Association**. 2007;20(2):4-11.
13. Quinlivan J, Box H, Evans SF. Postnatal home visits in teenage mothers: a randomised controlled trial. **The Lancet**. 2003;361:893-900.