Armadale Kalamunda Group

Antenatal Clinical Guideline

1. Purpose

- To establish a collaborative relationship between the woman and the health care professionals involved in her care.
- To inform the women about the models of care available for pregnancy and birth
- To provide baseline recordings of the woman's physical and psychosocial condition for comparison at subsequent visits,
- To identify risk factors in pregnancy and make appropriate referrals where necessary
- To provide support, provide health education and promote healthy lifestyle habits
- Provide providers of Antenatal services the process required to provide efficient and safe care.

2. Guidelines

Attending regular antenatal appointments during pregnancy is a key component of a healthy pregnancy. Appointments provide an opportunity to receive information, support and advice about pregnancy that suit a woman's individual needs. Regular antenatal care helps to identify and treat complications and improves pregnancy outcomes mother and baby. During antenatal appointments, the doctor or midwife will discuss available screening tests and arrange these as required.

2.1 First visit

Commence documentation in the 'Woman held Record' at the initial booking visit. Pregnancy Health Record MR70 is the National Woman Held Record to ensure the pregnancy record is formatted in line with Australian Standards improves visibility for the most relevant clinical information and now includes the newborn consents, Edinburgh Postnatal Depression Scale (EPDS), alcohol and tobacco screening, safe sleeping information for parents and a birth plan.

An accredited interpreter or the Telephone Interpreting Service (TIS) must be used if communication is limited due to language barriers. Avoid use of known persons and relations while addressing to the woman's needs Interpreter and Translator Guidelines (AKG-GUI-0212-00)

Clinical, legal and ethnic consequences are avoided by use of the interpreting services.

- Complete MR20 form
- Obtain consent to share Medical Records with GP ANC AKMR30.14
- Complete FDV AK
- Check for Latex allergy

- Complete Breastfeeding Checklist.
- Commence Thromboembolic risk assessment.
- Commence Neonatal History AKMR 78.1
- Generate Customised Growth Charts
- Complete Obstetric Risk Assessment form

A photocopy of the medical/surgical/obstetric history from the MR20 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. If at the time of booking visit the midwife does not have complete set of documents to complete woman's HHR, the booking midwife inform the Clinic coordinator about the need to get all information from the woman's GP and/or health care facility. If the records are unavailable, then tests will be reordered in conjunction with assessment of the woman's risk factors. Appointment in either midwifery clinic or GP Obstetric clinic will depend on the assessed risk factors. Regardless of when woman has her first appointment at AHS, she must be seen by a GPO nearest to 28 weeks.

2.2 High risk woman requiring referral to specialist clinic should have the following minimum information on the MR20 form:

- Reason for referral,
- woman's age, BMI,
- spontaneous or IVF pregnancy,
- Parity,
- EDD,
- past and current medical, surgical, social history,
- Interpreter service required, CaLD group patient.
- abnormal test results, (attach result reports)

Explain the purpose and use of the MR70 'Pregnancy Health Record'. Advise the woman to take the record:

- To all antenatal appointments
- To appointments with her GP
- On holiday if travelling away

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[2].

2.3 Health history:

Record the woman's health history including:

- Surgical history
- Gynaecological history
- Obstetric history
- Family history
- Psychosocial history
- Medications / drugs
- Complementary therapies

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

2.4 Physical assessment / examination:

Women attending a midwifery clinic may be referred back to the community 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'.

All refugee women who have been in Australia less than 12 months should have a full physical examination performed by a doctor.

2.4.1 Weight and height

- Measure the height and weight of the woman and calculate their body mass index (BMI).
- Check woman's weight at each visit. Initiate ultrasound scan at 28 and 34 weeks if BMI >35 or BMI<20
- With high BMI, the fetus is at increased risk of congenital abnormalities, small-for-gestational age, macrosomia, pre-term birth and morbidity. Long term consequences include childhood obesity, diabetes, cardiovascular disease and fatty liver disease.

NOTE: Ideally BMI should be calculated from a pre-pregnancy weight and height, or at first opportunity during pregnancy.

Formula for Calculating a BMI

[Weight in Kilograms / Height in cm / Height in cm] x 10,000

For example (16.9kg / 105.4cm / 105.4cm) x 10,000 – 15.2

2.4.2 Blood Pressure

Record the woman's blood pressure (BP) at each visit[13]

- 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
- If abnormal recheck post consultation if concerned refer woman to Antenatal Assessment unit for review. Instigate blood screening prior to attending if indicated

2.4.3 Breasts

- Observe and discuss:
- Previous breast surgery or abnormalities

- Breast changes in pregnancy
- Breast self-examination. Provide verbal and written instruction as required.

2.4.4 Cardiovascular system

- Refer women attending with a cardiac anomaly, arrhythmia, or cardiac disease to the specialist obstetric and Anaesthetist clinic for review. If a GP has arranged previous cardiac tests request a copy of the results.

2.4.5 Pelvic assessment / examination

- The PAP screen has been replaced with the new Cervical Screening Test every five years.
- Screening is undertaken using a speculum as for PAP screening, the sample medium is liquid based and testing will involve testing of Human Papilloma virus (HPV) Cervical Screening Program DoH.
- 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.
- Women with **Grade 2-3 FGM** are referred to the specialist obstetric clinic for review and counselling.

2.4.6 Urine analysis

Document the reagent urinalysis test result at each visit for:

- Protein
- Glucose

Testing may indicate pre-eclampsia, urinary tract infection, renal abnormalities, or diabetes in pregnancy. Collect a MSU for asymptomatic bacteriuria in early pregnancy.

The current (2018) Clinical Practice Guidelines Antenatal Care Module 2 2018 does not support routine urinalysis at each antenatal visit. However, the expert opinion at Armadale Health Service is that the practice of routine urinalysis will continue.

2.4.7 Blood tests

Blood tests are performed by Community GP on initial visit prior to referral.

- Blood tests are recommended for all antenatal patients.
- All bloods tests are ordered following counselling and verbal consent. Women should be advised of all results and post-counselling given[6].

2.4.8 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.

All Rh (D) negative women are recommended to have prophylactic Rh Immunoglobulin at 28-30 weeks and 34-36 weeks gestation.

AKG Rhesus Negative Women Guideline (OBS-PRO-0399-15)

- Full blood picture (FBP)

Repeat FBP and serum iron studies at:

- 28 weeks gestation.
- 36 weeks gestation as required.

All women with anaemia treated for anaemia, with low ferritin levels or at an increased risk of bleeding should have a FBP repeated at 36 weeks.

- **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
- **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.
- **Syphilis serology** should be performed using specific Treponema Pallidum assay e.g. TPHA or TPPT.Screening to be repeated at 28-32 weeks for women at increased risk of infection. Syphilis | Australian Government Department of Health
- **Rubella.**
- **Thyroid Function.** Do not routinely test pregnant women for thyroid dysfunction. Recommend for women who are at high risk
- **Haemoglobinopathy studies (If indicated by MCV or family history or ethnicity)**
- **Vitamin D serology.** Do not routinely recommend testing for vitamin D status to pregnant women in the absence of a specific indication. If testing is performed, only recommend vitamin D for women with levels lower than 50nmol/L
- **Iron studies**
- **Vitamin B12 levels For at risk women (Vegetarian diet/Bariatric surgery)**
- **Varicella**
- **Cytomegalovirus.** Screening offered to women working within child care centres due to a high risk of infection for sero-negative women. Discussions should be made regarding reducing risk through hygiene precautions especially if exposed to saliva or urine.. Offer testing to women to pregnant women if they have suggestive symptoms not attributable to another specific infection or if imaging findings suggest fetal infection.
- **Diabetic screening** is recommended for all pregnant women[6].Gestational Diabetes Mellitus (GDM)(OBS-GUI-0180-15)
    - All woman with risk factors for developing GDM should have early OGTT, if negative to repeat OGTT at 24-28 weeks
    - Woman with no risk factors should have OGTT between 24-28 weeks
    - Consider repeating OGTT between 32-34 weeks if any symptoms or signs of evolving GDM
    - Woman on Metformin should have the drug stopped at least a week before OGTT is done.

2.5 Chlamydia screening

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

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

2.6 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

Repeat screening is recommended for women at high risk for blood-borne viruses and STIs in the third trimester

2.7 Group B streptococcus screening

- Screening for GBS is recommended for women between 35-36 weeks.
- Group B Streptococcus Guideline (OBS-GUI-0184-16)

2.8 Methicillin Resistance Staphylococcus Aureus (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.

2.9 Ultrasound screening

All women 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)
- KEMH - Non Invasive pregnancy Testing NIPT Prenatal Testing For Fetal Aneuploidy

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

Review PAPP-A results.

If a woman returns a low PAPP-A result (<0.4MoM), a referral should be made to the GP Obstetric service by 20-24 weeks gestation for assessment regarding the need for closer maternal and fetal surveillance.

2.10 Fetal morphology ultrasound

- Offer a fetal morphology ultrasound to all women. Ultrasound screening for fetal anomalies should be routinely offered between 18 weeks 0 days and 20 weeks 6 days[3]. Anatomy scans are to be arranged by the GP within the metropolitan area. Advise the woman to arrange to bring a copy of the report to her next antenatal appointment, or arrange a copy to be faxed to AKH.
- Review Anatomy scan and refer as per Triage referral Guidelines if any concerns.
- Review cervical length and follow pathway Preterm Birth Prevention: Management
- **Document Results within Hand Held Record**
- **Serial scan will be required in high risk pregnancies e.g.**
    - Previous still birth
    - Previous SGA, IUGR babies
    - Low PAPP-A
    - Obese woman
    - Low BMI woman
    - Medical disorders warranting serial scan
    - GDM pregnancies
    - Previous macrosomic babies

Arrange a repeat ultrasound for placental location if a woman has a low lying placenta (LLP) earlier in pregnancy or at anatomy scan

2.11 Psychological assessment

Perform Edinburgh Post Natal Depression Scale (EPDS) assessment at the booking visit.

- Refer the woman (with their permission) to the mental health Liaison Nurse if the EPDS score is 13 or above.
- If the 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 from clinic co-ordinator. Refer to EDPS flowchart
- 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 at risk of harming herself (or others) due to psychiatric disturbances.
- If the woman is at immediate risk contact MLN or Social work and escort safely to ED for assessment.
- **Repeat the Edinburgh Postnatal Depression Scale after 32 weeks.**

2.12 Genetic services

- Offer genetic counselling to all women with risk factors.

2.13 Family and domestic violence (FDV) screening:

Pregnancy Care Guidelines | Australian Government Department of Health

- 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'.
- **Repeat the FDV screening tool in the third trimester if the woman is alone.**

2.14 Diet

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

- Advice women that taking vitamins A, C or E supplements are not of benefit in pregnancy and may cause harm.
- Advice women to take 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.

2.15 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.

2.16 Tobacco smoking assessment

Assess smoking habits each visit for women who smoke or have ceased in pregnancy. KEMHS Nicotine Dependence assessment and Intervention Clinical Guideline

2.17 Discuss Antenatal Models of Care

Explain the options of antenatal care:

- ANC
- MGP
- GP OWN
- GP Public
- Specialist Obstetric Clinic
- STAR
- NBAC

2.18 Initiate parent education

- Provide information at the booking visit: 13
- When to phone or come to hospital
- Discuss Parent education classes
- Provide dietary advice

- 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 Commence Breast feeding Checklist and sign
- 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.

2.19 Subsequent Antenatal visits (At Each Apt)

The frequency of the antenatal visits is adjusted according to fetal and maternal wellbeing. Refer to individualised guidelines for specialised clinics and their schedule for antenatal visits

- **All antenatal visits to be documented on HHR**

2.20 Assess maternal health and well-being:

- Assess for abnormal symptoms
- Assess if the woman has any abnormal health symptoms e.g. headaches, epigastric pain, vomiting, visual disturbances.
- These symptoms may be associated with pre-eclampsia and further investigations or evaluation may be required
  - BP
  - Urinalysis screen for proteinuria and glycosuria, educate woman to self-screen
  - Oedema assessment. Identify and document oedema including the site and degree. 50-80% of women experience oedema in pregnancy which is due to increased tissue fluid. If the BP and urinalysis is normal, reassure the woman.
- Vaginal discharge, note at each visit:
  - If any vaginal bleeding has occurred since the last visit
  - Signs of vaginal infection
  - Signs of premature rupture of membranes

Women should be informed that increased vaginal discharge is a normal physiological change in pregnancy, however if they experience an itch, soreness, offensive smell or pain with voiding they should inform the midwife or doctor.

2.21 Assess fetal growth and well-being:

- Note fetal movements
- Assess fundal height / growth estimate presence of adequate amniotic fluid as appropriate
- Enquire regarding presence of abnormal vaginal discharge

- Auscultate fetal heart rate.
- **At each visit perform abdominal palpation:**

2.21.1 Assess fetal growth at each visit by:

- Measuring fundal to symphysis-pubis height. This should always be documented in cm Fundal Height Measurement. Symphysis fundal Height (SFH) should be measured and documented on the Customised Growth Charts chart every 2-3 weeks. The Charts must be generated for women at the time of booking and stapled to the front page of HHR.
- Women who are recognised as **low risk** should have serial fundal height measurements undertaken as a primary screening test for fetal wellbeing. These should commence from 26-28 weeks gestation.
- Not all pregnancies are suitable for primary surveillance by fundal height measurement, and require ultrasound biometry instead. In most instances, these pregnancies fall into the following categories:-
- Fundal height measurement unsuitable/inaccurate e.g. large fibroids, BMI ≥ 35, multiple pregnancy.
- Pregnancy considered increased risk requiring serial ultrasound e.g. Pre-existing diabetes.

2.22 Referral to Ultrasound

Indications for a growth scan are:

- First FH measurement below 10th centile (preferably between 26-28 weeks)
- Static growth: no increase in sequential measurements
- Slow growth: based on sequential measurements, the pattern of growth is not following the slope of the curve.
- Excessive growth: curve linking up plots crossing centiles in an upward direction

Note that a first measurement above the 90th centile is NOT an indication for a growth scan. A scan would however be indicated if there was clinical suspicion of polyhydramnios or there was excessive growth on subsequent measurements

Serial growth scans for those at increased risk of growth restriction

Some women will be at increased risk of developing fetal growth restriction because of risk factors in the current pregnancy, past medical history or past obstetric history. All women should be assessed at booking for risk factors to identify those who need increased surveillance. Women who fall into these categories will need referral to a consultant. The consultant-led team will arrange for serial scans at least every two to three weeks from 26-28 weeks until delivery (earlier gestation or higher frequency if required in individual cases). These women will ***not*** require plotting of fundal height measurements while such a serial scanning protocol is being followed.

2.23 Growth scan requests related to obstetric history:

- Previous birthweight(s) <10th customised centile
- Previous stillbirth

2.23.1 Growth scan requests related to maternal medical history include:

- Chronic hypertension

- Diabetes
- Renal impairment
- Antiphospholipid syndrome
- Local variances

2.23.2 Growth scan requests related to current pregnancy

- Maternal age >40 years
- Maternal smoking
- Drug misuse
- PAPP-A <0.415MoM
- Fetal echogenic bowel
- Large fibroids
- BMI > 35
- Multiple pregnancy *
- Severe pregnancy induced hypertension
- Pre-eclampsia
- Unexplained APH
- Concerns related to growth measurements, as listed above

All ultrasound reports must be acknowledged and actions taken documented either on the Ultrasound report directly, which is then kept in the woman's case file or actions taken from the scan report are to be documented directly in the case notes.

Palpate for presentation from 36 weeks gestation. Abnormal presentation is discussed with the Obstetric Team and a management plan is formulated.

2.24 At 40 weeks in either Midwifery or GP clinic:

- Discuss IOL
- Book CTG in AAU at 41 weeks and bi weekly till IOL booked or alternate days if ≥ 42 weeks POG
- Organise 41 weeks scan for fetal wellbeing (AFI and Doppler)

2.25 At 41 weeks AAU assessment:

- Review CTG
- Review scan report
- Assess Bishop Score
- Plan date and time of IOL

2.26 Fetal assessment

- Monitor the history of fetal activity at each visit[7].
    - Provide information leaflet Pregnancy :Pregnancy and your baby's movements
- Refer to AAU for Fetal monitoring and obstetric review if the woman notices a change in pattern or frequency of fetal movements
- Fetal heart rate (FHR) auscultation. Perform FHR auscultation at each visit.

- Routine listening of the FHR provides confirmation of a live fetus, but does not give a predictive value. However, if the woman would like auscultation of the FHR it may provide reassurance.
- The current (2018) National Antenatal Guidelines Clinical Practice Guidelines – Antenatal Care Module 2 states that fetal heart auscultation may be undertaken with either a Doptone (from 12 weeks) or a Pinnard's from 28 weeks. AKH recommends that a Doptone be used for all antenatal visits.

2.27 Membrane sweeping

- A Cochrane review concluded there is little justification for performing routine sweeping of membranes for women near term (37 to 40 weeks of gestation) in an uncomplicated pregnancy.

Membrane sweeping should be discussed with women from 40+0 and offered from 41+0 weeks gestation. It can be repeated regularly (based on individual clinical need and local protocols) until spontaneous labour occurs, or induction of labour is indicated.

- Where a woman requests membrane sweeping earlier than 41+0 weeks, she should be advised of the risks and benefits and the reason for the procedure documented in the woman's clinical record by her care provider.

2.28 Increased surveillance for women age 40 years or over

All women who are age 40 years or over require increased surveillance from 38 weeks gestation.

- At 38 weeks gestation these women require a twice weekly CTG and one ultrasound scan.
- At 39 weeks gestation they require twice weekly CTG.
- At 40 weeks gestation they require a CTG, ultrasound scan and a discussion regarding induction of labour.
- Induction of labour is recommended from 40-41 weeks gestation

2.29 Increased surveillance of woman from culturally and linguistically diverse background:

- Risks related to changed environment, psychological aspects, dietary changes need to be assessed and kept in mind,. Use of interpreter services should be done all the time if English is not the first language and woman has difficulty understanding. Avoid use of relatives or friends for interpreter purposes. Research to date is limited by variation in methodology and in classification of ethnicity, making it difficult to generalise. Therefore, there is not sufficient evidence at this time to recommend IOL timing based on maternal country of birth as an isolated risk factor. Book an ultrasound scan for fetal wellbeing and estimated fetal weight at 38 weeks. Plot estimated fetal weight on customised GROW Chart and review the growth and wellbeing. Refer to AAU if any deviation from normal.
- **Increased surveillance in IVF pregnancies and consideration of IOL between 39-40 weeks.** There is increased risk of perinatal morbidity and mortality, prematurity, IUGR and PET in IVF pregnancies. Consider increased surveillance for fetal well-being.

2.30 Parent Education

Provide ongoing pregnancy education including:

- Offering interventions/strategies to cease smoking or prevent resumption of smoking
- Discharge planning.
- Visiting hours
- Pain relief options.
- Birth plan.
- Neonatal auditory screening.
- Newborn Screening Test.
- Consent for Vitamin K & Hepatitis B vaccination.
- Visiting Midwifery Service.
- Child Health Services.
- Breastfeeding- incl. community resources.
- Family Planning.
- Sudden Infant Death Syndrome and Co-Sleeping.
- Use of capsules & car seats.
- Community resources. GP follow-up &Post-partum screening tests e.g. PAP smears.
- Health issues e.g. hepatitis, vitamin D deficiency.
- Education may include both verbal and available written brochures

3. Legislative context

The following documents are required to give effect to this policy:

- Health Department of Western Australia (HDWA) Mandatory Clinical Handover Policy (MP 0095)
- HDWA Recognising and Responding to Acute Deterioration Policy (MP 0086/18)
- East Metropolitan Health Service (EMHS) Patient Identification and Procedure Matching (EMHS: 21)

4. Supporting information

The following documents support the implementation of this policy:

- Antenatal: Triage of Referral Guidelines (OBS-GUI-0037-18)

5. Compliance, monitoring and evaluation

Compliance against this guideline will be evaluated and monitored by the Obstetrics and Gynaecology Department Safety and Quality departmental meeting.

6. Relevant standards

National Safety and Quality Health Service (NSQHS) Standards (second edition):

- Standard 1 – Action 1.5 The health service organisation considers the safety and quality of health care for patients in its business decision-making

- Standard 2 – Action 2.10 The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that:
    - a. Information is provided in a way that meets the needs of patients, carers, families and consumers
    - b. Information provided is easy to understand and use
    - c. The clinical needs of patients are addressed while they are in the health service organisation
    - d. Information needs for ongoing care are provided on discharge
- Standard 5 – Action 5.3 Partnering with consumers
- Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to:
    - a. Actively involve patients in their own care
    - b. Meet the patient's information needs
    - c. Share decision-making
- Standard 6 – Action 6.5 Correct identification and procedure matching
- The health service organisation:
    - a. Defines approved identifiers for patients according to best-practice guidelines
    - b. Requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated
- Standard 6 – Action 6.7 Clinical Handover
- The health service organisation, in collaboration with clinicians, defines the:
    - a. Minimum information content to be communicated at clinical handover, based on best-practice guidelines
    - b. Risks relevant to the service context and the particular needs of patients, carers and families
    - c. Clinicians who are involved in the clinical handover

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8. Glossary

The following definitions are relevant to this policy.

Term	Definition
NWHPR	National Woman –Held Pregnancy Record, it is a comprehensive record of woman's journey throughout her pregnancy
Antenatal Care	It is the care provided to the pregnant woman throughout her pregnancy
Booking Visit	A booking visit refers to an appointment whereby the woman has her first appointment in the AHS antenatal clinic with a midwife and is subsequently booked to the hospital, regardless of whether she has had care elsewhere or her gestation (i.e. all women need a booking appointment). It is the booking appointment that ensures that the woman can birth at AHS following assessment by the midwife at this appointment, referrals to other health care professionals e.g. specialist obstetrician or GP Obstetrician will be made following this appointment. Most booking appointments occur between 16 to 20 weeks gestation.
Late Booking	Any booking after 20 weeks of gestation
Late Referral	'Late referral' indicates that the woman for whatever reason has had her first appointment at AHS after >26 weeks

Term	Definition
	gestation. The woman may have had care with her GP (not GPO), not had any or limited antenatal care, or moved in pregnancy to the AHS catchment area. The woman's first appointment at AHS antenatal clinic is called her booking visit but she is considered a late referral.

9. Document owner

Enquiries relating to this guideline may be directed to:

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10. Review

This guideline will be reviewed and evaluated as required to ensure relevance and currency. At a minimum it will be reviewed within one (1) year after first issue and at least every three (3) years thereafter.

Version	Effective from	Effective to	Amendment(s)
Version 5.2	03/02/2020	03/02/2024	Clinical incident recommendation – major review

11. Authorisation

This guideline has been authorised and issued by the Director Nursing and Midwifery.

Authorised by	Louise Keyes – A/Director Nursing and Midwifery
Authorisation date	03/02/2020
Published date	03/03/2023

Appendices

Appendix 1: Minimum Schedule for visits for Antenatal Care

Appendix 2: Antenatal Attendance Pathway

Appendix 1: Minimum Schedule for visits for Antenatal Care

Wks	ANC Clinic / MGP Risk: Low	ANC Clinic / MGP Risk Medium:	ANC Clinic/MGP Risk: High		Star/ MGP BY Risk: High	NBAC	Private Pts/GPO Risk: Low/Med/High	GDM
			Midwife	Spec Obs v1				
14	Referral received							
18	Midwife	Midwife	Midwife			Midwife	GP Own	As per existing stream
20	Midwife	GP Obs		Spec Obs	Midwife	Midwife	GP Own	
24	Midwife	Midwife		GP Obs or Spec Obs	Midwife	Midwife	Midwife	
28	GP Obs	GP Obs		Spec Obs	GP Obs	GP Obs	GP Own	GP Obs
30				Spec Obs				Midwife
32	Midwife	Midwife	Midwife		Midwife	Midwife	GP Own	GP Obs
34	Midwife	Midwife		Spec Obs	Midwife			Midwife
36	GP Obs	GP Obs		GP Obs or Spec Obs	GP Obs	GP Obs	GP Own	GP Obs
38	Midwife	Midwife	Midwife	Spec Obs	Midwife	Midwife	Midwife	Midwife
40	Midwife	GP Obs/ Midwife		*Spec Obs if req'd*	GP Obs	GPObs	GP Own	GP Obs
41	AAU	AAU		*Spec Obs if req'd*	AAU	AAU	AAU	AAU

Appendix 2: Antenatal Attendance Pathway (in Conjunction with Guidelines)

BOOKING VISIT 12-16 Weeks

Review Previous notes.

- Complete HHR.
- Enter all results.
- Obtain Maternal history.
- Screen DV/Latex
- **Information** Pensanz)
- Discuss fetal movements.
- Pertussis/Flu vaccination.
- Complete MR20
- Medical release.
- STORK/GROW chart.
- Refer SW/MLN
- Earl GTT if high Risk

Review Obstetric risk

20 weeks.
Review Anatomy scan
Document results in HHR.
Arrange Early GTT if high risk.
Record Maternal fetal observations
Review Risk and Refer if indicated.

24-26 Weeks
Document results from Anatomy Scan
Information for GTT.
Form for FBC Fe studies/GTT/Group and antibodies if Rhesus neg
Plot fundal height on GROW chart
Arrange USS 28/40 if risk factors.
Review risk /follow pathway/Refer

28 Weeks
GP OBS Review
Follow up Blood results
Administer Anti D/Pertussis/Flu vaccine.
Review GTT
Plot fundal height on GROW chart
Review BMI
Discuss fetal movements: document
Review risk document on MR (Risk Management)

30-32 Weeks

Document Results
Arrange follow up Scan if LLP
Follow up USS and plot on GROW chart
Discuss fetal movements. Document
Reassess EPDS/DV assessment
Review Risk management

34 weeks.
Discuss fetal movements
Discuss birth Plan
Consents for Konakion
Hepatitis B.
Information on SIDS
Information for GBS screening
Update results on HHR
Review risk and refer

36 Weeks GP Obs
Obtain GBS with consent
Administer Anti D.
Blood form for FBC/Fe studies
Review GROW Chart/Discuss fetal movements
Arrange USS if risk factors.
Update Risk management

38 weeks

Discuss fetal movements document
Review all results and document
Complete birth plan/consents
Review USS results and plot
Update Neonatal records
Review risk management plan

40 Weeks midwife clinic and GP Obs clinic
Update results
Discuss fetal movements and document
Discuss IOL.
Book an AAU appointment for biweekly CTG commencing 41 weeks onwards and alternate day CTG commencing 42 weeks

41 weeks AAU appointment:
Review fetal movements, book biweekly CTG
Book alternate day CTG if ≥42 weeks POG
Book IOL from 41 week onwards depending on Bishop score, CTG and scan findings
Discuss/ inform re IOL and obtain Consents