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SOUTH AUSTRALIAN GP OBSTETRIC SHARED CARE PROTOCOLS - CLINICAL DIRECTIVE

A STATEWIDE MODEL

April 2020

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Policy Statement

The South Australian GP Obstetric Shared Care Protocols - Clinical Directive will guide General Practitioners, Registered Midwives and health practitioners working within the South Australian public health system when caring for the woman who makes an informed choice to have her antenatal care provided within a shared care arrangement.

‘Shared Maternity Care represents an opportunity to practice collaborative holistic obstetric care by combining the varied skills of Midwife, General Practitioner and Obstetrician to the benefit of the community and mutual understanding between colleagues’¹.

Women wishing to attend a South Australian public hospital (in metropolitan Adelaide, and Gawler) for childbirth have the option of GP obstetric shared care if they meet the designated criteria. In this model, the General Practitioner (GP) provides most of the antenatal and postnatal care, while the public hospital staff provides the inpatient, intrapartum and some outpatient maternity care.

It upholds the SA Health Strategic Plan 2017 - 2020 themes of Lead, Partner and Deliver through the use of evidence, translating research into practice and involving consumers in its development, ensuring safe and effective care for women planning shared antenatal care².

These protocols have been developed in accordance with contemporary professional standards of care and outline the minimum standards of clinical practice required by General Practitioners providing maternity services in South Australia. The SA Perinatal Practice Guidelines underpin the SA GP Obstetric Shared Care Protocols outlined within.

Roles and Responsibility

External Contract Provider

SA Health has contracted GP Partners Australia as the co-ordinating body for the statewide GP OSC SA. GP Partners Australia is managing the statewide framework for the GP OSC SA. Contact details are listed below.

GP Partners Australia manages the Statewide GP Obstetric Shared Care Program (GP OSC SA) in liaison with SA Health, within a governance framework that includes:

- > Clinical Governance Committee
- > GP Advisors
- > GP Obstetric Shared Care Program Manager
- > GP OSC Midwife Coordinators

GP Partners Australia
Postal | PO Box 7293 Hutt St Adelaide SA 5000
Phone: (08) 8112 1100
Fax: (08) 8227 2220
Program Manager: 0418 803 844
E-mail: info@gppaustralia.org.au
Website: www.gppaustralia.org.au

A database of accredited GPs across South Australia is maintained by GP Partners Australia and is available to the GP OSC SA Midwife Coordinators

Executive Officer

The Executive Officer of the hospital providing access to the GP OSC SA must comply with the statutory obligations and guidance provided by the GP OSC SA Clinical Governance Committee.

Hospital Managers

Hospital managers at units providing access to a GPOSC SA will ensure that health practitioners involved in the program:

- > have an understanding of the South Australian GP Obstetric Shared Care Protocols - Clinical Directive
- > recognises that the timely referral for support and assistance in the management of complex maternity care and psychosocial problems is entirely appropriate.
- > ensures the availability of a referral system that allows a the appointment of the pregnant woman who requires an antenatal appointment because her GPOSHC GP is on leave.

General Practitioners

A GP who is accredited for GP OSC SA can provide antenatal care in collaboration with the 'booking' public hospital throughout the pregnancy in accordance with these protocols and the enclosed visit schedule. A shared care arrangement requires additional effort to be given to communication between all parties involved in the shared care arrangement, this should include the pregnant woman.

The GP should ensure, the pregnant woman opting for GP OSC SA secures a reference number from the **Pregnancy SA Referral Line (Ph: 1300 368 820)** so she can be scheduled her first antenatal visit at 'booking' public hospital.

A GP who is accredited for GP OSC SA:

- > ensures the follow up of the pregnant woman they are managing who does not attend an antenatal appointment.
- > ensures the pregnant woman they are managing is referred to the 'booking' hospital for any antenatal appointment that cannot be scheduled at his/her practice because of their leave
- > is aware that a pregnant woman who develops complications can be referred to the 'booking' hospital for assessment at any time.

It is essential that the GP accredited for GP OSC SA ensures that their current details are accurate and any changes are communicated to GP Partners Australia, www.gppaustralia.org.au/osc and are updated on the SA Health Provider Registry <http://www.generalpracticesa.org.au/pages/hpry.html>

Registered Midwives

The SA Health units providing access to the GP OSC SA will have a Registered Midwife work force (i.e. GP OSC SA Midwife Coordinator) allocated to support the GP OSC SA.

The GP OSC SA Midwife Coordinator will facilitate and liaise with a range of health workers to support antenatal/postnatal activities for women and staff involved in the GP OSC SA, ensuring that relevant professional standards and appropriate documentation are maintained.

The GP OSC SA Midwife Coordinator acts as an advocate, both for women and the GP involved in the GP OSHC SA and will assist with general maternal care information; this is not reliant upon the woman giving birth at a metropolitan hospital.

The following units support their antenatal clinics with a GP OSC SA Midwife Coordinator:

- Women's and Children's Hospital
- Flinders Medical Centre
- Lyell McEwin Hospital
- Modbury Hospital
- Gawler Health Service

The Registered Midwife involved in the GP OSC SA will support and guide the timely referral of the pregnant woman requiring more complex care to a 'booking' hospital in accordance with the National Midwifery Guidelines for Consultation and Referral⁴.

Contact details for the:

GP OSC SA MIDWIFE CO-ORDINATORS

Women's and Children's Hospital

72 King William Road NORTH ADELAIDE SA 5006

Ph: (08) 8161 7000 pager 4259

Fax: (08) 8161 8189

Email: healthCYWHSSharedCare@sa.gov.au

Lyell McEwin Hospital

Haydown Road

ELIZABETH VALE SA 5112

PH: (08) 8182 9000 pager 6470 or 0417 840 062 (SMS only)

Fax: (08) 8282 1612

Email: Health.NALHNSharedcare@sa.gov.au

Modbury Hospital

Smart Road

Modbury SA 5092

PH: 81612593

Fax: 81612227

Email: NALHN.Sharedcare@sa.gov.au

Flinders Medical Centre

Flinders Drive BEDFORD PARK SA 5042

Ph: (08) 8204 4650/ 8204 6894

Fax: (08) 8204 5210

Email: Health.FMCsharedcare@sa.gov.au

Gawler Health Service

21 Hutchinson Road

GAWLER EAST SA 5118

Ph: (08) 8521 2060

Fax: (08) 8521 2069

Email: Health: HEALTHCHSAGHSCCommunityMidwives@sa.gov.au

Background

The GP OSC SA was established in 2002 as a result of an initiative by SA Health, facilitated by the Healthy Start Clinical Reference Group (now known as the SA Maternity Neonatal Gynaecology Community of Practice - Clinical Reference Work Group).

This document outlines the clinical protocols that support the GP OSC SA.

These protocols have been developed in accordance with contemporary professional standards of care and outline the minimum standards of clinical practice required by General Practitioners providing maternity services in South Australia.

The GP OSC SA protocols are updated every 5 years (or as required) and the clinical practices outlined in these protocols have been developed in accordance with the **SA Perinatal Practice Guidelines** (SA PPG), which provide perinatal care providers with evidence-based standards supporting clinical practice. The GP OSC SA Protocols are available on the website at: www.gppaustralia.org.au/osc and along with the SA PPGs on the SA Health website www.sahealth.sa.gov.au/perinatal

Policy Requirements

An obstetric shared care arrangement should be recommended for all low risk women who have access to an accredited GP and a 'booking' public hospital.

Medical Indemnity

In keeping with professional and community expectations, GP OSC SA providers should ensure they:

- > hold General or Specialist registration 'without any conditions' under the Australian Health Practitioner Regulation Agency.
- > have and maintain current Medical Registration appropriate to their scope of practice.
- > prospectively ensure adequate medical indemnity cover for any consultations, procedures or related activities.
- > have a prospectively approved GP Obstetric Share Care Program accreditation with the program prior to commencement of his/her duties.
- > be responsible for the procedures he/she performs.
- > adhere to the GP Shared Care Protocols, the policies of the 'booking' hospital, SA Health Perinatal Practice Guidelines and the recognised referral system when managing complex patient care.
- > ensure that he/she has a registered Provider Number for each location of employment⁵.

Accreditation & Continuing Professional Development (CPD) Requirements

GP Partners Australia facilitates the management of the GP accreditation for the GP OSC SA.

Initial Accreditation

The GP undertaking obstetric shared care in South Australia must have maternity care training and experience or supervision and meet the accreditation requirements of the GP OSC Program SA.

Approval for full accreditation within the GP OSC Program is subject to both:

- > Satisfactory obstetric experience, *and*
- > Completion of an Accreditation Seminar.

Provisional accreditation may be approved for a period of up to 12 months on the basis that the GP attends and fulfils the requirements for a Category 1 Accreditation Seminar in that time. Provisional accreditation will usually be approved for GPs who have one of the following:

- > DRANZCOG with current recertification, or equivalent qualification;
- > Diploma Obstetrics RACOG, or CSCT in Women's Health, plus recent involvement in antenatal care provision;
- > GPs who can demonstrate recent significant obstetric experience such as having spent a minimum 3-month placement in obstetrics at a recognised teaching hospital.

The GP who does not meet the GP OSC Program maternity care experience requirements may apply via GP Obstetric Shared Care Program Manager, to undertake a supervised obstetric clinical attachment at one of the public metropolitan maternity hospitals to secure this experience.

Ongoing Accreditation

The ongoing accreditation of the GP for the GP OSC SA Program is managed within a 3-year accreditation cycle, which is conducted in parallel with the Continuing Professional Development (CPD) triennium as defined by the RACGP and ACRRM.

To maintain accreditation a GP must demonstrate over the 3 year period that they have engaged in CPD activities equivalent to a minimum of 12 CPD points specific to Obstetric Shared Care and must have attended at least one (1) Accreditation Seminar in the triennium.

Assessment of CPD activities is a role undertaken by the GP Obstetric Shared Care Program Manager.

The records management of CPD accreditation points will be managed by the GP Obstetric Shared Care Program Manager.

CPD activities are strongly encouraged and could include:

- > GP OSC (SA) CPD events
- > RANZCOG Diplomats Days
- > DRANZCOG Revision course
- > Online CPD activities eg GP learning
- > Women's health activities and other events conducted by GP Networks
- > Other educational activities that can be demonstrated to be relevant to OSC ie part of a 40 point Active Learning Module

The GP unable to meet any of the requirements should contact the GP Obstetric Shared Care Program Manager to discuss their options.

Compliance - Accreditation

The GP accredited to GPOSC SA program must ensure they remain current with maternity practice as per the SA Perinatal Practice Guidelines and the GPOSC SA protocols.

The GP Obstetric Shared Care Program Manager facilitates the review of the accreditation status of the GP and supports the GP OSC SA accreditation process including their education/training.

Procedural Guidelines

South Australian Pregnancy Record

SA Health has endorsed the SA Pregnancy Record as the substantive record of a woman's pregnancy. The aim of the SA Pregnancy Record is to assist maintaining continuity of care, women's participation in the care and to promote early and appropriate use of antenatal services, particularly among disadvantaged groups. **The SA Pregnancy Record must be used to document the care provided for all women involved in GP Obstetric Shared Care.**

The perinatal care provider must record at each visit all relevant antenatal information in the SA Pregnancy Record. Information must be sufficient to meet the provider's duty of care in diagnostic and treatment decisions.

Information need not be duplicated, but clinicians may do so by choice. If duplication is required, it is recommended that the SA Pregnancy Record be photocopied. Pathology and ultrasound results are to be recorded in the SA Pregnancy Record.

The SA Pregnancy Record should be given to the woman at her first antenatal visit after confirmation of pregnancy, with instruction to carry this with her to all appointments during her pregnancy, including those with other health professionals. The woman should be made aware that the SA Pregnancy Record is the ONLY complete medical record maintained for her antenatal care, and it is vital that it is used to record the care given to her at each visit. The woman should also be aware that the SA Pregnancy Record will become part of the hospital's medical records after the birth of her child.

As the substantive record, the SA Pregnancy Record will be filed in the woman's medical record at the hospital where the birth occurs. **The SA Pregnancy Record is not to be destroyed under any circumstances.**

The guidelines for their use can be accessed via: [SA Pregnancy Record Guidelines](#)³.

Relative Contraindications to GP Shared Care

Although GP Obstetric shared care can be provided for most pregnant women, the GP should seek advice from the GP OSC Midwife Coordinator or an Obstetric Registrar / Consultant at the 'booking' hospital to clarify the appropriate level of care for the mother or fetus. Relevant recognised risk factors may include, but are not restricted to:

Medical History

- > endocrine disease
- > cardiac disease
- > renal disease
- > hypertension, for example diastolic pressure 90-100 mm/Hg
- > respiratory disease
- > neurological disease including epilepsy on medication
- > thrombo-embolic disorders or antiphospholipid syndrome
- > illicit drug use
- > haematological disorders including haemoglobinopathy, thrombocytopenia, significant anaemia < Hb110g/L & MCV < 80fl
- > significant mental health issues requiring medication
- > gastro-intestinal disease

- > Obesity – BMI > 40 – 44 kg/m² (requires consultant from Specialist Anesthetist and Obstetrician)
- > obesity – BMI > 45 kg/m² (requires transfer of care to Obstetrician)

From Obstetric History

- > severe pre-eclampsia
- > perinatal death
- > placental abruption
- > preterm birth at less than 34 weeks
- > fetal intrauterine growth restriction or small-for-gestational age
- > recurrent pregnancy loss
- > suspected cervical incompetence

From Early Pregnancy Assessment

- > Rh or other blood group antibodies
- > multiple pregnancy
- > haemoglobinopathy

Arising During Pregnancy (any of the above conditions and/or)

- > antepartum haemorrhage
- > fetal abnormality
- > extreme psychological issues / illness
- > hyperemesis gravidarum
- > hypertension and/or pre-eclampsia
- > suspected intra-uterine growth restriction
- > recurrent urinary tract infection
- > gestational diabetes requiring medication
- > deep vein thrombosis or embolism
- > abnormal placentation (including placenta praevia)
- > non-cephalic presentation after 36 weeks
- > gestational hypertension or pre-eclampsia
- > threatened preterm labour
- > cholestasis of pregnancy
- > pre-term rupture of membranes

Booking the GP OSC SA Woman at the 'Booking' Hospital

The GP should ensure the GP OSC SA woman is referred to a 'booking' hospital as soon as possible to ensure her 1st antenatal visit is scheduled **before 20 weeks gestation and preferably in the 1st trimester.**

SA Health has established a statewide antenatal telephone booking service (Pregnancy SA Referral Line) for women wishing to birth in a public hospital in metropolitan Adelaide (including Gawler, Mt Barker and South Coast District Hospitals), the pregnant woman opting for GP OSC SA is required to secure a reference number from the Pregnancy SA Referral Line before she can be scheduled her first antenatal visit. This coordinated approach aims to optimize the opportunity for women to birth as close to their home as possible.

Women wishing to birth in a country maternity unit other than the Gawler, Mt Barker and South Coast District Hospitals should be directed to book at the local birthing hospital closest to where they live.

The Pregnancy SA Referral telephone number is: 1300 368 820. The service is available 9am- 4pm Monday to Friday (excluding public holidays).

Obstetric Shared Care Antenatal Visit Schedule

The GP OSC SA antenatal schedule of visits aligns with the SA Pregnancy Record; www.sahealth.sa.gov.au/pregnancyrecord

Documentation

The GP managing the woman in an obstetric shared care arrangement should **commence documentation in the SA Pregnancy Record at the woman's first antenatal visit.** www.sahealth.sa.gov.au/pregnancyrecord

First Appointment

At the first appointment, the GP should:

- > ensure the pregnant woman opting for GP OSC SA secures a reference number from the Pregnancy SA Referral Line (Ph: 1300 368 820) so she can be scheduled for her first antenatal visit at the 'booking' hospital
- > complete the "SA Pathology Family of Origin Questionnaire" – for antenatal thalassaemia/haemoglobinopathy screening programme
www.sahealth.sa.gov.au/perinatal. -**Anaemia in pregnancy**
- > request all required blood tests with a copy of results to be forwarded to the antenatal clinic at the 'booking' hospital
- > explain the obstetric shared care protocols to the woman, including the timing and nature of the antenatal visits shared between the 'booking' hospital and GP
- > spend time early in the pregnancy discussing breastfeeding with the woman (see Breastfeeding PPG available at (www.sahealth.sa.gov.au/perinatal))

The following areas must be addressed in the early antenatal appointments.

History

The GP should record the woman's personal details and medical and obstetric history in her SA Pregnancy Record.

Family History of Genetic Condition

An increasing number of genetic conditions can be screened for and/or diagnosed. If the woman has a relevant history, the GP should contact the Obstetric Registrar / Consultant at the 'booking' hospital for advice before any testing.

Examination

A general examination must be performed in alignment with the South Australian Pregnancy Record. Blood pressure should be assessed (measured on the right arm with the woman seated, with appropriate size cuff (see Hypertension in Pregnancy PPG available at www.sahealth.sa.gov.au/perinatal)). Weight (kg), height (cm) and BMI must be measured and calculated at the first visit with the woman's weight and BMI recorded each visit.

The GP should refer to the SA Health Perinatal Practice Guidelines and Clinical Directives for advice regarding transfer of care; www.sahealth.sa.gov.au/perinatal.

Subsequent Antenatal Appointments

Routine Assessment

All designated sections in the SA Pregnancy Record **must be completed and documented at each antenatal visit**, including the following:

- > gestation in completed weeks
- > symphysio-fundal height in centimetres, **chart in SA Pregnancy Record**
- > blood pressure (measured on the right arm with the woman seated, with appropriate size at cessation of Korotkoff IV)
- > presentation and descent (fifths of fetal head palpable) after 30 weeks gestation
- > fetal heart and fetal movements
- > laboratory test results
- > smoking assessment
- > use of illicit drugs

Additional Assessment

The GP should assess the need for additional targeted screening for pregnant woman such as:

- > Vitamin D level for women with identified risk factors (see *Vitamin D Status in Pregnancy* PPG available at www.sahealth.sa.gov.au/perinatal)
- > Cytomegalovirus for women who have frequent contact with large numbers of very young children
- > Chlamydia testing for all women < 25 years and women with risk factors if aged 25-29 years i.e having multiple sex partners, history of sexually transmitted infection).
- > Human papilloma virus for women who have never had a cervical screening test or have not had one within the last 5 years or with a low-grade abnormality without a follow-up cervical screening test 12 months afterwards
- > Trichomoniasis for women who have symptoms (genital itching, burning, redness or soreness, discomfort with urination, change in vaginal discharge)
- > Gonorrhoea for women with identified risk factors
- > Tuberculin skin test (TST) for women with a history of recent tuberculosis contact (e.g. Household) or are HIV positive (see *Tuberculosis in pregnancy* PPG available at www.sahealth.sa.gov.au/perinatal)
- > Thyroid function testing for women who have symptoms or high risk of thyroid dysfunction (see *Thyroid Disorders in Pregnancy* PPG available at www.sahealth.sa.gov.au/perinatal)

AN Screening and Testing and Managing Abnormal Results

Any investigations / tests / screening requested by the GP for the pregnant woman under his/her care must be followed up by the GP concerned. It is the GP's responsibility to follow up all abnormal results irrespective of whether a copy of the results has been sent to the 'booking' hospital.

If there are abnormal findings in any antenatal testing / screening, it is recommended that the GP should seek obstetric advice from and/or refer the woman to the 'booking' hospital.

The GP ordering and requesting antenatal tests must:

- > comply with the antenatal screening and testing as outlined in the SA Pregnancy Record www.sahealth.sa.gov.au/pregnancyrecord
- > ensure that copies of the woman's results are available at the 'booking' hospital at the time of her first antenatal visit.
- > ensure they follow up all antenatal tests requested and that there is no expectation that these results will be followed up and acted upon by the 'booking' hospital.

Complete Blood Picture

When a pregnant woman presents with a haemoglobin ≤ 110 g/L in the first trimester and ≤ 105 g/L in the second and third trimesters, or particularly if red cell abnormalities are present, iron studies folate and B12 studies are recommended as follow up for the woman.

The GP should also consider testing for thalassaemia (haemoglobin electrophoresis) where appropriate. Low white cell or platelet counts should prompt discussion with, and/or referral to the 'booking' hospital.

www.sahealth.sa.gov.au/perinatal. -**Anaemia in pregnancy**

Blood Group and Antibody Screen

When a pregnant woman presents with a positive test for red cell antibodies the GP should immediately refer the woman for consultant obstetric advice at 'booking hospital'.

Rubella Titre

In the instance that the pregnant woman shows a "non immune" level in a Rubella Titre, the GP should discuss with the woman the need for the measles, mumps, rubella (MMR) immunisation in the postnatal period. **Under no circumstances should the MMR immunisation be given in pregnancy. The pregnant woman should be advised to avoid contact with rubella.**

Syphilis Serology

The GP should request routine screening for Syphilis at the 1st antenatal visit.

The GP should offer additional Syphilis screening for all Aboriginal women residing in high risk areas (or who have travelled through an outbreak area) as well as any woman (regardless of cultural background) with an Aboriginal partner residing in high risk areas (or who has travelled through an outbreak area).

Additional screening required:

- > First antenatal visit (routine)
- > 28 weeks
- > 36 weeks
- > At birth
- > 6 week post-natal check

The GP should offer screening for other sexually transmitted diseases (i.e. Chlamydia, Gonorrhoea, Human Immunodeficiency Virus (HIV), Hepatitis B and C Virus to the woman with a positive Syphilis serology.

Further information: www.sahealth.sa.gov.au or via the SA Health Communicable Disease Control Branch direct on telephone: 1300 232 272 (24 hours/7 days)

In the instance that the pregnant woman presents with a positive Syphilis serology, the GP should immediately refer the woman for consultant obstetric advice at the 'booking' hospital.

Hepatitis B and C and HIV

The GP should request routine Hepatitis B, C or HIV serology at the 1st antenatal visit.

In the presence of complications, a pregnant woman with a positive result to Hepatitis B, C or HIV may warrant referral to an Infectious Diseases Consultant and/or consultant obstetric advice at the 'booking' hospital.

Oral Glucose Tolerance Test

The GP should assess the pregnant woman's risk factors for overt diabetes at the first antenatal visit to determine the need for additional screening.

Risk factors:

- > Previous Gestational Diabetes Mellitus (GDM)
- > Previously elevated blood glucose level
- > Age ≥ 40 years
- > Family history of Diabetes Mellitus (DM) (i.e. 1st degree relative with diabetes or sister with GDM)
- > Pre-pregnancy BMI $>30 \text{ kg/m}^2$
- > Previous macrosomic baby (birth weight $> 4500\text{g}$ or $> 90\text{th}$ centile)
- > Polycystic ovary syndrome
- > Medicated with corticosteroids or antipsychotics
- > Ethnicity (Asian, Indian subcontinent, Aboriginal, Torres Strait Islander, Pacific Islander, Maori, Middle Eastern, non-white African)

If 1 or more risk factors are present the GP should request:

- > HbA1c or OGTT at 12-14 weeks gestation (or as soon as possible prior to 20 weeks)

If the results indicate normal BGL and/or OGTT the GP should follow up with a routine request for OGTT at 24-28 weeks gestation.

Screening meets criteria for GDM: Screening meets criteria for DM:

Fasting BGL 5.1- 6.9mmol/L

HbA1c $\geq 6.5\%$

1 hour OGTT 10.0 – 11.0mmol/L

A fasting BGL $\geq 7.0\text{mmol/L}$

2 hour OGTT 8.5 – 11.0mmol/L.

2 hour OGTT $\geq 11.1\text{mmol/L}$.

A diagnosis of GDM or DM does not necessarily preclude the woman from the Obstetric Shared Care Program.

If the results indicate an abnormality in BGL or OGTT the GP should seek obstetric consultant advice from the 'booking' hospital.

For further information and alternative diagnostic tests refer to the SA Perinatal Practice Guideline www.sahealth.sa.gov.au/perinatal- **Diabetes Mellitus and Gestational Diabetes.**

Combined First Trimester Screening

Two request forms are required for the combined first trimester screening - one for the blood analysis 5-10 mLs clotted blood sample, taken 9 - 13w6d and one for the nuchal translucency ultrasound scan between 11 – 13w6d.

A list of collection centres is provided on the reverse of the SA Maternal Serum Antenatal Screening (SAMSAS) request form. Telephone (08) 8161 7285 to secure copies of the form.

Availability of first trimester screening

Combined ultrasound and biochemistry screening is not currently offered through all hospitals/clinics. Check with the hospital/clinic concerned. The GP will be expected to organise the screening through private radiology services.

Costs of first trimester screening

SAMSAS continues its policy of accepting 'Medicare only' for the serum biochemistry analyses, with no gap payment required for private or public patients. There may be a gap payment for the ultrasound measurement. Check with the practice providing this service and inform the woman.

Use a SA Maternal Serum Antenatal Screening (SAMSAS) request form:

The test request is for 'first trimester screen' – however, SAMSAS recommends ticking both the 'first trimester screen' and the 'second trimester screen' boxes on the request form. (This will assist with provision of the appropriate screen if the gestation on ultrasound scanning is different to expected gestation). The GP should:

- > Complete all information including the women's weight, ethnicity, estimated date of delivery, in-vitro fertilisation/egg donor.
- > Complete the gestational age information, the gestation must be between 9w0d – 14w0 for 1st trimester screening.
- > Specify the ultrasound practice performing the nuchal translucency scan.
- > Refer woman to the Privacy Disclosure on the SAMSAS request form and the SAMSAS pre-test information booklet.
- > Send the blood specimen to the Women's and Children's Hospital and request a copy of the results also to be sent to the 'booking' hospital.

For interstate or remote areas check with SAMSAS on what services are available.

Ultrasound

- > Book a Nuchal Translucency scan with the medical imaging group of choice. The fetus must be between 11- 14 weeks gestation or crown rump length is 45-84mm at the time of the scan.
- > Complete an ultrasound request form, specifying "**risk of fetal abnormality**"; and "**Copy to SAMSAS**" and also request a copy of the results to be sent to the 'booking' hospital. SAMSAS will coordinate the results with the ultrasound practice and you will receive a single report giving the risks calculated for the pregnancy. Post-test information booklets are provided with all reports issued by SAMSAS on pregnancies found at increased risk of fetal abnormality.

A pregnant woman with an abnormal combined first trimester screening results must be promptly referred to the 'booking' hospital for counselling with a view to offering CVS or Amniocentesis. www.sahealth.sa.gov.au/perinatal- **PAPP-A: Management of women with a low PAPP-A and normal chromosomes.**

Second trimester screening

Second trimester screening for Down Syndrome should only be offered if the woman presents too late for 1st Trimester screening and should be undertaken between 14w0d and 20w6d. The GP should remember that if a pregnancy is screened in first trimester then any request in second trimester should be confined to **neural tube defect (NTD) screening only**. First trimester screening does not include a risk assessment for fetal NTDs.

Table: SAMSAS Prenatal Screening for Down syndrome

Maternal Age in years at time of screen	Maternal Age risk at 12 weeks 1:n	Maternal Age In years at time of screen	Maternal Age risk at 12 weeks 1:n	Maternal Age in years at time of	Maternal Age Risk at 12 weeks 1:n
20	1131	30	719	40	94
21	1118	31	636	41	72
22	1102	32	552	42	55
23	1081	33	468	43	42
24	1054	34	390	44	31
25	1020	35	318	45	28
26	978	36	256		
27	926	37	203		
28	866	38	159		
29	796	39	123		

Source: SAMSAS Program Update 15, www.wch.sa.gov.au/services/az/divisions/labs/geneticmed/samsas.html (abridged version)

Non Invasive Prenatal Testing

Non-invasive prenatal testing (NIPT) is a screening test which uses free fetal DNA of placental origin in maternal serum to screen for fetal aneuploidy. NIPT is a screening test for early pregnancy to detect trisomy 21 (Down syndrome), trisomy 18 (Edward's syndrome) and trisomy 13 (Patau syndrome). Some laboratories offer testing for other chromosome conditions but this is not well validated.

NIPT, like all prenatal tests is optional. All pregnant women should be made aware of the availability of NIPT screening.

NIPT is available from 9 weeks gestation. There is no upper gestational limit. However, consideration needs to be given should the woman wish to proceed with a termination of pregnancy.

Important Points

- > The test is safe and does not pose any risk to mother or baby
- > Currently only offered through specialist centres at a significant cost to the woman. No Medicare rebate is available
- > The accuracy of NIPT tests is high for T21, T18 and T13 only- although not 100%
- > A definitive diagnosis of a chromosome condition in the baby can only be made following an invasive prenatal diagnosis test like CVS or amniocentesis
- > The NIPT does not replace the 12 week first trimester screening.
- > Maternal weight >120kgs may affect the results; due to insufficient fetal cells in the woman's blood sample.

Morphology Ultrasound

The GP should request a morphology ultrasound for when the woman is 18-20 weeks gestation.

The following women are at increased risk of fetal anomaly and the GP should consider referring the pregnant woman with one or more of these for a tertiary level morphology ultrasound:

- > Pre-existing diabetes type 1 or 2
- > Epilepsy
- > Multiple pregnancy
- > Maternal or paternal chromosome translocations
- > Known genetic disorders in parents or previous children/pregnancies

- > Maternal cardiac conditions
- > Previous fetal anomaly/chromosomal condition
- > Previous severe early onset IUGR or confirmed maternal antiphospholipid syndrome
- > Maternal Anti Ro or Anti La antibodies
- > Known maternal substance misuse
- > Prescribed antipsychotic medication

When women have a high BMI, visualisation of fetal structures is frequently more difficult, thus plan ultrasound for 19+ weeks gestation. For this group, it is important to note the following:

- > These women are at increased risk of diabetes and resultant fetal anomaly
- > If structures are not visualised, re-scheduling the ultrasound for later in pregnancy should not be done past 21+0 weeks gestation as this limits available time for referral and investigation prior to decision-making re possible termination of pregnancy

In the instance that an abnormality is noted on the Morphology Ultrasound the GP should seek obstetric advice from and/or referral to the 'booking' hospital.

Chorionic Villus Sampling (CVS)

CVS is performed as an outpatient procedure to detect whether the fetus has a chromosomal abnormality.

CVS services are offered at FMC & WCH. If a CVS is required the GP should promptly refer the woman to the 'booking' hospital.

Chorionic villus cells are obtained from the developing placenta (chorion). A small sample of chorionic villi is obtained in a syringe, via either the abdominal wall or the vagina under ultrasound guidance.

The procedure can be uncomfortable and does not require fasting. After the procedure, women should be advised to rest for 48 hours, abstain from strenuous activity or exercise, including intercourse and contact their booking hospital if they experience any cramping pain, blood loss or loss of clear fluid. Women should be instructed to contact their 'booking' hospital if they develop a fever, bleeding or loss of fluid.

- > Overall the risk of miscarriage after the procedure is approximately 1:100 with chorionic villus sampling.
- > Chorionic villus sampling is performed between 10 weeks and 13w6d; amniocentesis after 15 weeks.
- > Results from chorionic villus sampling may not be available for up to 2 weeks.
- > Because chorionic villus sampling detects an abnormality earlier than amniocentesis early termination of the pregnancy is possible.
- > Rhesus negative women require Anti-D at the time of chorionic villus sampling.

Amniocentesis

Amniocentesis is performed as an outpatient procedure after 15 weeks gestation to reduce the risk fetal malformations.

Amniocentesis is undertaken to detect whether the fetus has a chromosomal abnormality cells. A sample of amniotic fluid is obtained via the abdominal route, under ultrasound guidance for chromosomal analysis.

Amniocentesis is offered at all 3 metropolitan public maternity units.

Amniocentesis results may not be available for up to 2 weeks. However, if a Fluorescence In Situ Hybridisation (FISH) has been performed, results may be available within 48 hours.

The women may be required to cover the cost of a FISH.

Sometimes the procedure may need to be postponed for up to a week if there is inadequate amniotic fluid.

- > Overall the risk of miscarriage after the procedure is approximately 1:200 with amniocentesis.
- > Rhesus negative women require Anti-D at the time of amniocentesis.

If an Amniocentesis is required the GP should promptly refer the woman to the 'booking' hospital.

Abnormal Findings/Symptoms and their Management

While most women will have a normal pregnancy, it is imperative that thorough, comprehensive antenatal assessments are undertaken to ensure early and accurate detection of adverse clinical outcomes.

In the instance that an abnormality is noted the GP should seek obstetric advice from the 'booking' hospital.

Large for Gestational Age (Fetal Growth Accelerated)

Defined as a fetus with a recorded growth at the 90th percentile for that gestational age or has a noted accelerating growth.

The management of the Fetal Growth Accelerated fetus can be complex.

GPs should ensure they measure and 'plot' the woman's symphysio-fundal height (SFH) measurement on the Symphysio-Fundal Chart in the SA Pregnancy Record.

Further information can be sourced from the www.sahealth.sa.gov.au/perinatal-Fetal Growth Accelerated.

Intrauterine Growth Restriction (Fetal Growth Restricted)

Defined as a fetus with a recorded growth that is below the 10th centile for gestational age.

GPs should ensure they measure and 'plot' the woman's SFH measurement on the Symphysio-Fundal Chart in the SA Pregnancy Record.

If the SFH <10th percentile or serial SFH measurements are flattening, then the GP should refer the woman for an ultrasound and request:

- > fetal biometry
- > Doppler of umbilical artery flow; and
- > amniotic fluid index

The GP should ensure the ultrasound results are 'plotted' on the appropriate graph in the SA Pregnancy Record.

If any parameters are abnormal, the GP should seek obstetric advice from and/or referral to the 'booking' hospital.

Further information can be sourced from the www.sahealth.sa.gov.au/perinatal-Fetal Growth Restricted.

Abnormal Fetal Presentation

If the woman presents at >36 weeks gestation and has a suspected breech or transverse lie, the GP should seek obstetric advice from and/or referral to the 'booking' hospital.

Reduced Fetal Movements

The GP should:

- > assess fetal movements at every antenatal visit
- > ensure the pregnant woman is routinely provided with verbal and written information regarding normal fetal movements during the antenatal period. This information should include a description of the changing patterns of movement as the fetus develops and normal wake/sleep cycles
- > emphasize the importance of pregnant woman's awareness of her fetal movements at each antenatal visit

If the woman is reporting DFM \geq 28 weeks gestation, the GP should:

- > undertake abdominal palpation, assessing uterine tone and tenderness as well as fetal lie /presentation
- > ensure a minimum of 20 minute CTG is performed to exclude immediate fetal compromise
- > record maternal pulse rate and confirm different to the fetal heart rate
- > measure the maternal temperature and blood pressure
- > undertake Kleihauer test
- > consider an ultrasound scan assessment including evaluation of fetal morphology (if this has not already been performed).

If any parameters are abnormal, the GP should seek obstetric advice from and/or referral to the 'booking' hospital.

Further information can be sourced from the www.sahealth.sa.gov.au/perinatal

Decreased Fetal Movements

Hypertension

Hypertension is defined as systolic BP is greater than or equal to 140 mm Hg and/or diastolic BP is greater than or equal to 90 mm Hg.

All women with a systolic BP \geq 160 mmHg or a diastolic BP \geq 110 mmHg should be treated because of the risk of intracerebral haemorrhage and eclampsia.

Hypertensive Disorders of Pregnancy are diagnosed after 20 weeks gestation (without pre-existing hypertension). Any woman presenting with new hypertension after 20 weeks gestation should be assessed for signs and symptoms of preeclampsia.

Preeclampsia is diagnosed in the presence of hypertensive disorder of pregnancy that is also associated with any sign of a multi-system disorder including proteinuria and/or one of the following:

- > persistent cerebral symptoms (headache, visual disturbances, increased reflexes);
- > epigastric or right upper quadrant pain;
- > intrauterine growth restriction; or
- > thrombocytopenia or abnormal liver function tests.

The GP should complete a comprehensive history and clinical assessment of the pregnant woman at the first antenatal visit and then follow up with a thorough clinical assessment at every antenatal visit to identify symptoms and signs of neurological and other systematic manifestation specific to preeclampsia.

The GP should arrange the following laboratory investigations:

- > Ultrasound,
- > Urea & Electrolytes
- > Complete Blood Examination
- > Liver Function Tests
- > Urate and
- > Urine Protein Creatinine Ratio.

A diagnosis of preeclampsia dictates immediate referral to the 'booking' hospital. The GP should seek obstetric advice from the 'booking' hospital regarding these arrangements.

Further information can be sourced from the www.sahealth.sa.gov.au/perinatal.
Hypertensive Disorders in Pregnancy.

Vaginal Bleeding

Bleeding in pregnancy is recognised as a potential emergency.

Per vaginum bleeding is the most common presentation to a care provider in early pregnancy and will affect an estimated 20-25% of women, the commonest cause of which is miscarriage (up to 20% of recognised pregnancies). Further information can be sourced from

www.sahealth.sa.gov.au/perinatal **Bleeding and Pain in Early Pregnancy (Ectopic Pregnancy, Miscarriage & PUL)**

If the pregnant woman ≥ 20 weeks gestation presents with vaginal bleeding the GP should undertake a history and examination and seek obstetric advice and referral to the 'booking' hospital.

Further information can be sourced from the www.sahealth.sa.gov.au/perinatal.
Antepartum Haemorrhage of bleeding in the second half of pregnancy.

Rh D Negative

Women with red cell antibodies including Rh D antibodies are not suitable for GP shared care. The following information therefore relates only to women who are Rh D negative and have no preexisting antibodies.

Further information can be sourced from the www.sahealth.sa.gov.au/perinatal
Anti-D Prophylaxis.

Testing for Anti-D Antibodies

The GP should test the woman for blood group antibodies at the first antenatal visit. If the woman is Rh negative and had no Rh D antibodies in early pregnancy, the GP should ensure she is tested again for the presence of antibodies at the end of the second trimester of pregnancy.

Testing should precede administration of Anti-D. The GP should note that if antibody testing was undertaken at 26 or 27 weeks. There is no need to repeat this screening before Anti-D administration at 28 weeks.

Prophylactic Anti-D Administration

If the woman is Rh D negative and has no preexisting Anti-D antibodies, the GP should inform her about the need to prevent Rh D sensitisation. This includes:

- > Anti-D administration if a sensitising event occurs in pregnancy;
- > Routine prophylaxis at 28 and 34 weeks gestation; and
- > Further prophylaxis after birth if the baby is Rh D positive.

If vaginal bleeding occurs, the GP should seek obstetric advice from and/or referral to the 'booking' hospital before administering doses of Anti-D.

The GP should obtain informed consent for Anti D prophylaxis early in pregnancy. The woman's consent for Anti D prophylaxis must be documented in her South Australian Pregnancy Record.

If the woman recommended for Anti D administration declines consent / administration, the GP should immediately refer her to the 'booking' hospital.

If concerned, the GP should seek obstetric advice from and/or referral to the 'booking' hospital.

Anti-D Prophylaxis for Potentially Sensitizing Events

Potentially sensitising events are defined as any situation in which there is an increased likelihood of fetal red blood cells entering the maternal circulation.

These include:

- > Miscarriage, termination of pregnancy, ectopic pregnancy, CVS in the first 12 weeks of pregnancy. Bleeding (threatened miscarriage) prior to 12 weeks gestation does not necessitate anti-D, but if the woman goes on to miscarry, anti-D should then be given
- > any uterine bleeding in pregnancy after 12 completed weeks gestation ranging from (threatened) miscarriage to antepartum haemorrhage;
- > any abdominal trauma in pregnancy; and
- > any uterine or intra-uterine intervention (such as external cephalic version, amniocentesis, etc).

If a sensitising event occurs the GP should immediately refer the woman to the 'booking' hospital

Further information can be sourced from the www.sahealth.sa.gov.au/perinatal *Anti-D Prophylaxis*.

Routine Prophylaxis at 28 and 34 Weeks

Rh D negative women without preexisting Anti-D antibodies should receive Rh D immunoglobulin at 28 weeks (after or simultaneously testing for preformed Rh D antibodies) and again at 34 weeks.

If the woman has missed out on receiving Anti-D at 28 weeks (for example because they did not attend) Anti-D should be administered at the next visit (better late than never). In that case, the second injection should be planned 6 weeks later, provided that the woman is still pregnant.

If the woman has received Anti-D for a potentially sensitising event, e.g. antepartum haemorrhage or trauma, before 28 weeks, she should still receive Anti-D at 28 and 34 weeks as scheduled unless the Anti-D for the sensitizing event was administered less than 1 week before the prophylactic dose being due.

Further information can be sourced from the www.sahealth.sa.gov.au/perinatal *Anti-D Prophylaxis*.

Table: Summary of Dose Recommendations for Rh D Negative Women

Sensitising events	Dose of Rh D immunoglobulin
Before 13 weeks	250 IU
At or after 13 weeks	625 IU
Routine prophylaxis	
At 28 and at 34 weeks	625 IU

Medications in Pregnancy

The GP should advise the pregnant woman to:

- > only take medications that have been prescribed by a doctor
- > remain on any necessary medication without prior discussion with the doctor concerned
- > only use Paracetamol for the treatment of pain and fever,
- > refuse aspirin or other non-steroidal anti-inflammatory drugs, e.g. Ibuprofen

The GP can seek advice from the Medicines and Drug Information Centre at the Women's and Children's Hospital Pharmacy (Phone (08) 8161 7222 Monday- Friday 9 am – 5 pm).

Supplements in Pregnancy

The GP should consider the following suggestions regarding advice given to the woman for the use of vitamins in pregnancy:

- > Calcium, vitamins and fluoride are not usually necessary.
- > Supplemental iron is recommended if haemoglobin is below 110g/L before 12 weeks and if below 100g/L > 12 weeks. NB Facilities and staff trained in management of anaphylaxis should be available when administering a Fe infusion. **IV iron should not be administered to pregnant women outside a hospital setting**
- > If Ferritin is less than 30mcg/L recommend a supplement
- > Folic Acid .5 mg ; although it is recommended to be taken at least one month prior to conception it is also recommended until 12 weeks gestation.

If the woman:

- Is at increased risk of neural tube defect,
- Is on antiepileptic drugs,
- has diabetes, or
- has hyperhomocysteinaemia,

a daily dose of Folic Acid 5 mg is recommended until 12 weeks gestation.

- > Vitamin D as per the SA Perinatal Practice Guidelines
www.sahealth.sa.gov.au/perinatal - **Vitamin D Status in Pregnancy**
- > Iodine 150mcg(ug)/day should be taken during pregnancy and breastfeeding
- > Vitamin B12 during pregnancy and lactation for women who are vegetarian or vegan.

Further information can be sourced from the www.sahealth.sa.gov.au/perinatal.

- > ***Vitamin and mineral supplementation in pregnancy.***
- > ***Anaemia in Pregnancy***
- > ***Vitamin D Status in Pregnancy***

Immunisations in Pregnancy

The GP OSC SA antenatal schedule aligns with the SA Pregnancy Record;
www.sahealth.sa.gov.au/pregnancyrecord

The NHMRC recommends routine administration of 2 vaccines during pregnancy i.e influenza and pertussis.

The influenza vaccine is recommended as early as possible in pregnancy. A repeat dose of the influenza vaccination is suggested if the pregnancy endures over 2 flu seasons.

The pertussis vaccine is recommended as a single dose from 20 weeks gestation. The optimal time for vaccination is between 20 and 32 weeks gestation, but the vaccine can be given at any time after the 20 week gestation up until birth. (Early vaccination is preferred because pertussis antibody levels do not peak until approximately 2 weeks after vaccination and active transport of maternal antibody to the fetus occurs predominantly from 20 weeks gestation onwards).

Further information can be sourced from www.sahealth.sa.gov.au/perinatal.
Vaccines Recommended in Pregnancy.

Perinatal Mental Health

The recognition of depression and other mental health conditions in the antenatal period is important as it may require treatment during the pregnancy and is a strong predictor for postpartum depression.

Screening for perinatal mood disorders, in the form of a psychosocial assessment or administration of a validated tool, such as the Edinburgh Postnatal Depression Scale (EPDS), should be considered part of routine antenatal and postpartum care.

Further information can be sourced from the www.sahealth.sa.gov.au/perinatal.

> ***Anxiety and Depression in the Perinatal Period***

Referral Services

There are a variety of services available for the GP seeking assistance with managing perinatal mental health issues. Specific services available may depend on geographic location, but these include:

- > Emergency Mental Health Triage can undertake urgent assessments, **telephone 13 14 65**. The service is staffed by mental health clinicians who can provide advice and information in a mental health emergency or crisis situation. They will assess and refer to acute response teams where appropriate.
- > Mental health/perinatal mental health team at the 'booking' hospital.
- > The Margaret Tobin Centre situated in close proximity to the Flinders Medical Centre can provide specialist psychiatric adult inpatient and intensive care. The GP in the first instance should call the **Mental Health Triage** on **131 465** who can advise on the best course of action.
- > Access to Allied Psychological Services.- The GP can establish a Mental health Care Plan refer the woman with significant depression and anxiety. A private health provider can be an alternate referral the GP may wish to consider in this situation.
- > National Health Services Directory - available services at <http://www.nhsd.com.au/>
- > Beyond Blue Infoline 1300 22 4636. Beyond blue is a national organisation working to address issues associated with depression & anxiety in Australia. www.beyondblue.org.au
- > The Post and Antenatal Depression Association (PANDA) National Helpline 1300 726 306 provides information, support and referral to anyone affected by depression and anxiety during pregnancy and after childbirth www.panda.org.au
- > Helen Mayo House (HMH) is a State-wide acute mother-baby unit which admits parents (usually mothers) and their children 3 years of age or younger, if the parent needs treatment for mental health problems such

as depression, anxiety or psychosis following childbirth. Inpatient, outreach day patient and group treatment programs are available, as well as brief telephone consultations for advice regarding patient care. Contact telephone (08) 7087 1030.

Labour and Birth

The care of the woman during labour and birth is the responsibility of the maternity team at the 'booking' hospital.

The 'booking' hospital is expected to provide a discharge summary of the pregnancy and birth outcome for the GP at discharge of the woman.

Postnatal Care

Breastfeeding advice should be readily available during the immediate postnatal period whilst the woman is in hospital, and follow-up support post discharge is commonly arranged through the home visiting Midwifery Service.

A universal contact visit by Child and Family Health Services will be facilitated with the woman's consent.

Women will be advised by the 'booking' hospital to secure follow-up postnatal visits with their GP at 2 and 6 weeks, unless needed prior to this. Some women may be required to return to the 'booking' hospital if they have experienced particular problems during pregnancy or childbirth. This appointment should be made for the woman prior to discharge.

Postnatal Visits

At the 2 and 6 week postnatal visit the GP should assess both the mother and the baby.

The GP should review the **mother's obstetric and medical history and that of her baby** including:

Mother:

- > pregnancy, birth and delivery history including any complications
- > breasts /nipples/ breastfeeding
- > general physical assessment abdomen – fundus, uterus involuted
- > perineum, vaginal examination, uterus involuted, Pap smear if due
- > examine perineum +/- abdominal wound (if caesarean section delivery)
- > lochial discharge
- > family and social supports
- > BP (if hypertension during pregnancy)
- > contraception
- > administer the Edinburgh Postnatal Depression Scale, if necessary
- > intercourse
- > urinary or faecal incontinence
- > follow-up on pregnancy complications i.e gestational diabetes, hypertension

Discuss vaccination of the mother, and vaccinate as recommended. Ensure all family members are up to date with their vaccinations, particularly pertussis. Refer www.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook10-home

Administer the Edinburgh Postnatal Depression Scale, if necessary.

Discuss any questions or concerns the mother/father/carer may have.

Discuss referral to the CYH contact/centre and ascertain need to refer to:

- > Paediatrician
- > Community health centre
- > Lactation consultant
- > Australian Breastfeeding Association
- > Social worker.

Baby:

- > examine the baby and review:
 - weight, length and head circumference including percentiles
 - head – shape, mobility, control
 - eyes – movement, conjunctiva, cornea
 - mouth – tongue, cheeks, ? thrush
 - CVS – colour, heart sounds, murmurs, pulses (femoral)
 - respiratory – effort, noises such as stridor or cough
 - GIT/GUT – umbilicus, abdomen, groin (hernias), perineum, genitalia
 - CNS – alertness/awareness, movement, tone
 - MSS – jaundice, skin rashes, hips, feet position
- > neonatal history, e.g. resuscitation needed, nursery admission
- > feeding – breast/bottle/mixed; frequency; any difficulties
- > feeding pattern – vomits/spills, “wind” colic, stools
- > behaviour between feeds.

Discuss the six week immunisations as per the Child Immunisation Schedule.

Discuss baby safety checks and SIDS advice, including sleeping (site, position), hygiene (bathing site, frequency), travel (pram, car).

Observe parent’s handling technique and attachment (confidence, interaction).

The GP should **document the visit**, including examination findings, in the baby’s **My Health Record** (“blue book”).

At the **six-week visit** the GP should also:

- > check if any parental concerns about baby’s hearing or vision
- > recommend six week immunisations as per the Child Immunisation Schedule
- > developmental screen/guidelines
- > eyes – appearance, fixation, following

Further Information for the GP

Perinatal Practice Guidelines

The SA Perinatal Practice Guidelines are available on the web at www.sahealth.sa.gov.au/perinatal, or via the web-based APP ‘Practice Guidelines’ available at <https://extapps2.sahealth.sa.gov.au/PracticeGuidelines/>. As they are continually being updated web access is the most appropriate means of accessing this information. The perinatal practice guidelines cover a broad range of topics that have not been repeated in these protocols.

Patient Assistance Transport Scheme (PATS)

The PATS is a subsidy program that provides money to pay for some travel, escort and accommodation costs when rural and remote South Australians travel over 100kms each way to see a specialist.

- > The scheme is intended to subsidise the unavoidable financial costs for those residents of South Australia that have no option but to travel a long distance to receive essential medical specialist services from an approved medical specialist.
- > The scheme is not intended to support choice of specialists. Patients should be treated as close to home as possible without compromising the safety and quality of the care provided. The scheme will not support the additional costs of travel if a patient makes a choice to travel beyond their closest specialist services.

Application forms are available online at www.sahealth.sa.gov.au/PATS

The PATS Guidelines for Assessment is also available on the PATS website.

To optimise safety and birth outcomes, women who live more than a two hour drive from their maternity hospital should be advised to temporarily relocate closer to the hospital from 36 weeks of pregnancy. A PATS subsidy may be available to assist the woman with the costs associated with this relocation.

NB: GPs and Specialist medical practitioners must register and be certified by PATS for portal access. The GP must approve the online application or sign the paper based PATS form before the woman travels to see her specialist to ensure the woman can qualify to receive the reimbursement.

Further Information:

Contact: PATS, Rural Support Service, SA Health:

Phone: 1300 341 684

Visit www.sahealth.sa.gov.au/PATS

Email: PATS@sa.gov.au or contact your local PATS office

Information Related to 'Booking' Hospitals

While the 'booking' hospitals maintain the GP OSC Program in accordance with agreed standards and protocols, each unit has some specific services that the GP may wish to discuss with the pregnant woman and/or her family.

Flinders Medical Centre (FMC)

The Flinders Medical Centre (FMC) provides a comprehensive perinatal service for women, neonates and their families. Services provided at FMC include:

Obstetric Clinics

Obstetric clinics are provided by Obstetricians/Registrars and Midwives on most mornings and some afternoons at FMC. Noarlunga Health Service holds obstetric clinics usually in the afternoons and evenings.

Maternal Fetal Medicine (MFM) Unit

MFM is a branch of obstetric medicine that focuses on managing the health concerns of the mother and fetus prior to, during, and shortly after conception. It manages ongoing surveillance and management for women whose pregnancies are significantly complicated by maternal and/or fetal conditions.

Medical Complications of Pregnancy Clinics

Obstetric medicine clinics are held on Monday, Wednesday and Friday mornings by Medical specialists in medical conditions that effect pregnancy.

Women's Assessment Service (WAS)

WAS operates Monday – Friday from 8am – 4pm. This service predominately assesses women in early pregnancy for possible loss and surveillance and assessment in pregnancy such as blood pressure monitoring and decreased fetal movements.

Childbirth and Parenting Education

Antenatal, labour and breast feeding classes are provided at Flinders Medical Centre and Noarlunga Health Service upon request.

Perinatal Mental Health Service

A perinatal Mental Health Nurse is available by referral for primarily antenatal but available postnatal for support. A referral is required.

Southern Midwifery Group Practice

The Southern Midwifery Group Practice is a model of maternity care offered by a group of midwives that provide continuity of midwifery care to women during their pregnancy, childbirth and the postnatal period, to low risk women. Southern Midwifery Group Practice is referred after POB (Booking Visit) at FMC.

Maternity Outreach Service

Maternity Outreach Service is a home visiting service provided by Midwives to women postnatal after discharge. Midwives will provide two home visits with additional scheduled as required.

Postnatal Support Service

This service is conducted by a lactation consultant/midwife and is designed to help with unexpected feeding and settling difficulties that may arise in the early days after birth.

Multiple Birth Support Service

A midwife is available to support and educate families with a multiple birth pregnancy in liaison with the Multiple Birth Association.

Drug and Alcohol Support Service (DASSA) Clinic

Flinders Medical Centre has a clinic managed by DASSA to support women with drug and alcohol dependence in the perinatal period. A referral is required.

Baby-Friendly Hospital Initiative (BFHI) Accredited

A World Health Organisation initiative to promote, support and encourage breastfeeding. FMC has been accredited as a BFHI hospital since 2003.

Contact Numbers for the Flinders Medical Centre

Women's Health Clinic	(08) 8204 5197	Fax 8204 5120
Birthing & Assessment (BAS) Unit	(08) 8204 5511	– ask for BAS
Women's Assessment Service	(08) 0204 4645	
Maternity Outreach	(08) 8204 4650	
Mental Health Nurse	(08) 8204 5511	Pager: 38903
Multiple Birth Co-ordinator	(08) 8204 5511	Pager 48033
Obstetric	(08) 8204 5197	
Obstetric Clinic Appointments	(08) 8204 5197	
Radiology (Ultrasound)	(08) 8204 5367	
Shared Care Midwife	(08) 8204 4650	
Noarlunga Health Service	(08) 8384 2222	
Noarlunga Health Service Maternity	(08) 8384 9454	Fax 08 8384 9711

Northern Adelaide Local Health Network (NALHN)

NALHN offers a full range of obstetric, midwifery and paediatric services to mothers and babies. NALHN is one of South Australia's major teaching hospitals and has been accredited as a Baby Friendly Hospital (BFHI) since 2000.

Antenatal Clinics

NALHN has multiple obstetric and midwifery care pathways for pregnant women across numerous sites including: Northern Area Midwifery Group Practice (NAMGP), Birthing Centre, Northern Aboriginal Birthing Program (NABP), midwifery & obstetric led care and GP Obstetric Shared Care. These services are offered at multiple sites including: Lyell McEwin Hospital (LMH), Modbury Hospital (MH), GP Plus sites, community and outreach clinics.

Women's Assessment Unit

The Womens Assessment Unit provides specialist obstetric care, information and support to women who are pregnant and up to six weeks postnatal. This would include pain or bleeding at any gestation of pregnancy, unusual or offensive vaginal loss, headache and visual disturbances, labour assessment, a decrease or change in fetal movement, abnormal ultrasound results, iron infusion or any other obstetric concerns. Appointments are not necessary, however each woman is seen on the basis of clinical urgency, rather than order of arrival.

Obstetric clinics

Women with medical conditions or complications of pregnancy can be seen in the antenatal clinic located at both the Lyell McEwin & Modbury Hospitals. These clinics provide care with Consultant Obstetricians as well as Consultant Physicians, Midwives and Anaesthetists as required. The clinic is also staffed by training registrars and RMO's. Specialised Obstetric clinics with multidisciplinary health teams available include Diabetes Antenatal Care and Education (DANCE) and Antenatal Drugs Alcohol Service South Australia (DASSA) Clinic.

Drugs and Alcohol Services South Australia (DASSA) Clinic

This is a multidisciplinary clinic in partnership with women who have current and/or a recent history of substance and/or alcohol use, once a week at the LMH. The service provides support with reduction and quitting techniques and provides women, their partners and families with strategies to manage their addictions to promote the safety and wellbeing of their babies. The women are also seen by the obstetric and midwifery team and the Northern Aboriginal Birthing team if appropriate in order to provide holistic care.

Shared Care with a General Practitioner

A GP, accredited to provide Obstetric Share Care can provide antenatal care to women who have a low risk pregnancy. The GP will undertake the triage appointment and provide the woman with her pregnancy hand held record. The pregnancy booking blood tests and the 1st trimester screening should be ordered by the GP. The woman would be required to attend the hospital for a booking visit, before 20 weeks gestation. To book an appointment for a woman requesting GP Shared Care, the GP should send a fax to the Family Clinic on (08) 8282 1612 marked "Attention Shared Care"; or alternatively, the woman may ring the telephone appointment number (08) 8282 0255 Lyell McEwin Hospital or (08) 8161 2154 Modbury Hospital and ask for an appointment with the GP Share Care Midwife. Further appointments are made between 30-32 weeks if the woman wants to have her baby in the Birth Centre. All women having GP Share Care will require an appointment at 36 weeks and 40 weeks at the booking hospital.

Birth Centre/Team Midwifery

This is an option for women assessed as low risk of complications and who prefer a more natural approach to childbirth with little intervention. Women and their families are supported through pregnancy and birth by a team of midwives who support active birth in a relaxed, homely environment.

Women wishing to use the birth centre and have shared care with their GP ideally should make their wishes known at the shared care booking visit. If undecided at this time, later bookings can be made by negotiation. An initial visit to the team midwives should be made at 30-32 weeks so that the woman can be allocated a birthing team. Women usually continue to see their GP until the 36 week hospital visit then transfer to the team midwives for remaining visits. This plan is negotiable.

Northern Area Midwifery Group Practice (NAMGP)

NAMGP is an "all risk" midwifery model of care, with midwives working collaboratively with the medical teams at the LMH and Modbury Hospital. The woman may have her antenatal care in an outreach clinic in the community by a known midwife and the midwife will be the primary care provider throughout the pregnancy, birth and up to 4 weeks in the postnatal period. For further information 8182900 page Midwifery Unit Manager of NAMGP.

Planned Homebirth

Women can access planned homebirth services through NAMGP. Criteria as per the SA Health “Planned Birth at Home in SA” Clinical Directive.

Northern Aboriginal Birthing Program (NABP)

NABP provides culturally appropriate and holistic healthcare for Aboriginal and Torres Strait Islander (ATSI) women or women carrying ATSI babies throughout their pregnancy journey, within a continuity of care framework for up to 4-6 weeks following the birth of the baby. Aboriginal Maternal Infant Care (AMIC) Workers work alongside midwives to provide culturally appropriate care.

Continence Clinic

Coordinated by a team of continence nurse advisors, to assess, educate and support women with continence issues (both faecal and urinary). All women who have had previous 3rd or 4th degree tears or significant perineal trauma are referred to this team during the antenatal period for support and advice regarding the mode of delivery for the current pregnancy. This clinic interlinks with the colorectal and urodynamic team.

Perinatal Mental Health Team

Pregnant women, at antenatal triage are offered screening via the ANRQ and EPDS for risk of depression and anxiety in the perinatal period. Referrals for the Perinatal Mental Health team are generated by the antenatal triage midwife. There are a limited range of supports including psychoeducation, referral to our perinatal psychiatrist, short intervention counselling and support. The perinatal team encourage utilization of mental health care plans and GP referral to other psychological services such as PANDA (perinatal and anxiety Australia) and COPE (Centre of perinatal excellence). When booked, LMH women can be enrolled in “Ready to cope” For further information: 82820794

Northern Links: Antenatal psychosocial high risk triage meeting and Northern links monthly review meeting

An antenatal psychosocial high risk meeting held with the aim to reduce the risk of harm to infants and their mothers who are receiving maternity care in NALHN by collecting and disseminating information within a multidisciplinary team to facilitate a holistic service response for women with complex psychosocial needs.

Childbirth and Parenting Education

A wide range of childbirth classes designed to meet the woman's needs, lifestyle and information preference are provided including a tour of the maternity unit. Modbury Hospital offer a dedicated breast-feeding education session that is held fortnightly on Friday afternoons. For bookings phone LMH (08)8182 9431 and Modbury (08) 8161 2154.

Home Visiting Midwives

Home Visiting Midwives provide community postnatal care for those women living in the NALHN catchment and not cared for through Northern Area Midwifery Group Practice. Visits are daily or second daily according to need and are generally completed within the first postnatal week.

Mothercarer Program

The LMH is the only metropolitan maternity service in Australia to offer the Mothercarer Program. Postnatal women discharged after a ‘short stay’ are eligible for the program which provides a carer in the home for up to 5 hours per day, for up to 4 days.

The Mothercarers work in conjunction with the visiting midwives and care of the baby and other children in the home, providing education for new parents, light home duties, emotional support, transport and connection with ongoing community services.

Breastfeeding Day Assessment and Support Unit

Available to all breastfeeding mothers of babies of up to 8 weeks. The unit is staffed by experienced midwives. The unit is operational Tuesday & Friday by appointment only. Phone (08) 8182 9380 for an appointment.

Contact Numbers for the Lyell McEwin Hospital (LMH)

Hospital number	(08) 8182 9000	
Obstetrics Department Office	(08) 8182 9306	Fax: (08) 8182 9337
Birthing Centre	(08) 8182 9326	
Clinic Midwife	(08) 8282 1613	
Clinic Receptionist	(08) 8282 1611	
Continence Midwife	(08) 8282 9000	Pager: 6187(Mon-Fri)
High-risk pregnancies	(08) 8182 1607	
Perinatal Mental Health Midwife	(08) 8182 9000	Pager: 6006 (Mon-Fri)
Phone appointments	(08) 8282 0255	
Shared Care Midwife Coordinator	(08)8182 9000	Pager: 6470 Mobile 0417840062 NALHN.Sharedcare@sa.gov.au
Ultrasound appointments	(08) 8182 9999	
Antenatal Educator	(08) 8182 9431	
Birthing Assessment Unit High	(08) 8182 9111	
Women's Assessment Unit	(08) 82821301	
Home Visiting Midwifery Service	(08) 8182 9252	

Modbury Hospital (MH)

Contact Numbers for the Modbury site

Hospital Number	(08) 8161 2000	Fax (08) 8161 2227
Antenatal Appointments	(08) 8161 2593	
Shared Care Midwife Coordinator	(08)8182 9000	Pager:6470 Mobile 0417840062

NALHN.Sharedcare@sa.gov.au

Antenatal Educator	(08) 8182 9431
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Women's and Children's Hospital (WCH)

The Women's and Children's Hospital (WCH) provides a comprehensive obstetric service, providing all levels of care. The initial visit to the hospital, offered at approximately 12 weeks gestation is a 90 minute Triage appointment with a midwife who will assess the woman to determine the appropriate referral pathway and model of care. All models of care are discussed with woman at this visit. WCH has been accredited as a Baby-Friendly Hospital since 2012.

Community Midwifery Outreach Clinics

Midwifery care is delivered by the WCH midwives in 7 community based locations. Low risk woman will see the same midwife for most of the visits. The birth will occur in the hospital delivery suite, and care will be provided by the duty medical and midwifery team.

Midwives Clinic

Low risk women who attend the midwives clinic will see the same midwife for most visits. Women may ask to see a doctor at any time during their pregnancy. The birth will occur in the hospital delivery suite, and care will be provided by the duty medical and midwifery team.

Midwifery Group Practice (MGP)

Also known as "Caseload Midwifery", Midwifery Group Practice (MGP) enables women to be cared for by the same midwife (primary midwife) supported by a small team of midwives throughout their pregnancy, during childbirth and in the early weeks at home with a new baby.

Home Birth

Accredited MGP midwives can facilitate home birth for low risk women who meet the criteria.

Aboriginal Family Birthing Program

Aboriginal Family Birthing Program Any woman who identifies as Aboriginal and/or Torres Strait Islander or whose unborn baby identifies as Aboriginal and /or Torres Strait Islander can have their care provided in partnership with a designated Aboriginal Maternal Infant Care Practitioners (AMIC) and a Midwife. This decreases cultural and communication barriers in providing maternity health care. The AMIC program provides antenatal and postnatal service for Aboriginal woman and their babies for up to 4 weeks post birth

Shared Antenatal Care with a General Practitioner

Low risk woman can see their GP who is accredited with the GP Obstetric Shared Care Program. Women will need to visit the hospital as per this protocol. GPs may send a referral via fax to the midwife coordinator's office on (08) 81616246; or contact the Midwife Coordinator directly on (08) 8161-7000, pager 4259 to arrange an appointment. Antenatal clinic days are held on Tuesday, Wednesday, Thursday and Friday.

Medical Antenatal Care (Public Patients)

Women with medical conditions or complications of pregnancy can be seen in the public antenatal clinic by Consultant Obstetricians as well as Consultant Physicians and Anaesthetists as needed. The clinic is also staffed by training registrars and RMO's.

Medical Antenatal Care (Private Patients)

Women may be referred for private antenatal care at the WCH. Patients will require a letter of referral addressed to one of the 'booking' obstetricians by name. Further information can be obtained by phoning (08) 8161 7633.

Maternal Fetal Medicine Unit

The Maternal Fetal Medicine Unit at the WCH in Adelaide provides a sub-specialist referral centre to women who are experiencing complicated pregnancies and problems with their unborn babies.

Drug and Alcohol Service SA (DASSA clinic)

DASSA clinic is available to women who are drug dependent or have had previous problems with drugs and/or alcohol. The WCH can provide antenatal care for pregnant women attending the clinic if required.

Parent Education

Group education sessions on specific topics are available and offered in different languages as demand requires.

Pregnancy to Parenting Group Antenatal Care

Young women less than 20 years can have midwifery care provided in a group setting in partnership with the MY Health Community Liaison Midwife. Antenatal care is provided together with pregnancy labour and birth education in multiple two hour group sessions during pregnancy.

Diabetes education

Women who develop Gestational Diabetes Mellitus are referred to the Diabetic Educator at WCH for an information session and ongoing monitoring.

Strengthening Links Program and Perinatal Mental Health Program

All women are screened using the Antenatal Risk Assessment Questionnaire and Edinburgh Postnatal Depression Scale. Women with psychosocial needs are referred to the Woman Social Work team. Perinatal Mental Health team accept referrals for assessment and coordination of services for women with significant Mental Health/ Psychiatric illness.

Breast feeding Support

Lactation consultants dedicated to breastfeeding support are available whilst women and babies are inpatients. Support continues with LCs will visit at home as part of the domiciliary home visiting service or MGP.

Domiciliary Midwife

The postnatal domiciliary care service is offered to all women who live within a 20km radius of the WCH, when they leave the Hospital after their baby is born. WCH provides a midwifery home visiting service for up to 5 days.

Criteria Led discharge

Women are likely to be discharged from hospital 4-24 hour after a normal birth, this is criteria led. Women are offered home visiting through the domiciliary service for the first week depending on clinical needs and the baby can be referred to the postnatal baby clinic if needed in the first 7 days.

Neonatal Clinic

Babies who have been admitted to the WCH nurseries or who have other complications will be seen in the neonatal outpatient clinic for up to 12 months.

Contact Numbers for the Women's and Children's Hospital

Admissions	(08) 8161 7508	
Antenatal Bookings	(08) 8161 7590	Fax: (08) 8161 6246
Antenatal/Gynaecology Ward	(08) 8161 7726	
Core Laboratory	(08) 8161 6704	
Cytogenetics (Amnio/ CVS results)	(08) 8161 7413	
Day Assessment Unit	(08) 8161 7530	
Director of Obstetrics &	(08) 8161 7000	
Drug Information	(08) 8161 7222	
Maternal Fetal Medicine (MFM)	(08) 8161 9263	Fax: (08) 8161 9264
Medical Genetics	(08) 8161 6281	
Midwifery Group Practice	(08) 8161 8406	
Multiple Births Co-ordinator	(08) 8161 7520	
Parent Educator	(08) 8161 7571	
Physiotherapy	(08) 8161 7579	
Private Referrals	(08) 8161 7633	
Shared Care Midwife Co-ordinator	(08) 8161 7000	Pager 4259
	(8am-4.00pm M - F)	Fax: (08) 8161 8189
Social Work	(08) 8161 7580	
South Australian Maternal Serum Antenatal Screening Program (SAMSAS)	(08) 8161 7285	Fax: (08) 8161 8085
Ultrasound Bookings	(08) 8161 6055	
Ultrasound Results	(08) 8161 7391	
Women's Assessment Service (Emergency)	(08) 81617530	

Gawler Health Service (GHS)

Gawler Health Service provides comprehensive care of women deemed to be 'low risk', whereby the woman delivers her baby at a gestation greater than or equal (i.e. \geq) to 37 weeks and the newborn weight is greater than or equal to (i.e. \geq) 2500gms.

Antenatal Service

Midwives manage many low risk ante-natal women in 'Zadow Suite'. For GP Shared Care women, a triage appointment with a midwife is the woman's first contact. GP Shared Care clients may be seen by a consultant either at this visit or an additional appointment is made for this prior to 20 weeks gestation, if required. Obstetric clinics are held in Zadow Suite and the Women's Health Centre. GP clinical attachments are offered at these clinics as well.

Midwifery Group Practice (One 2 One)

This One 2 One midwifery service enables women to be cared for by the same midwife (primary midwife) supported by a small team of midwives throughout their pregnancy, during childbirth and in the early weeks postnatal at home.

Postnatal Service

For most normal births women are discharged within 3 days of admission. Each woman will be visited by a community midwife at least once, (and more if needed).

Women who are experiencing difficulties with breastfeeding after discharge, or have any other concerns, are encouraged see their GP in the first instance.

Baby Friendly Hospital Initiative (BFHI) Accredited

A World Health Organisation (WHO) initiative to promote, support and encourage breastfeeding. GH has been accredited as a BFHI hospital since 2007.

Childbirth and Parenting Education Sessions

Various programs are available, including condensed sessions and breastfeeding sessions. Alternatively, 1:1 sessions are available through the community midwifery service.

Community Midwifery Service

A home visiting program operates Monday – Saturday, with women being visited in their homes for care and support. Breastfeeding is supported by this service.

Postnatal Clinic

This is run in the Zadow Suite and the Women's Health Centre on a weekly basis. All women who undergo caesarean section delivery are seen at 2 and 6 weeks. Women can choose to have their routine 6 week check with their GP, or at the health service.

Booking Procedures

GPs may send new patient referrals (indicate 'shared care') via fax to Zadow Suite on (08) 8521 2069. The referrals are reviewed by the midwife coordinator, a consultant and an appropriate appointment time arranged.

Contact Numbers for GHS

Hospital switchboard	(08) 8521 2000	
Antenatal Clinic (Zadow Suite)	(08) 8521 2369	Fax: 8521 2069
Forge Ward (Inpatients)	(08) 8521 2060	
Community Midwives	(08) 8521 2011	

Private Practice Lactation Consultants

Details available through <https://www.breastfeeding.asn.au/>

References

1. Royal Australian and New Zealand College Obstetricians and Gynaecologists statement: *Shared maternity care obstetric patients*; Cultural Competency WPI 20; July 2016.
2. SA Health Strategic Plan 2017-2020; www.sahealth.sa.gov.au
3. SA Pregnancy Record Guidelines;
<https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+programs/sa+pregnancy+record/sa+pregnancy+record+guidelines?contentIDR=6893fc804a00e370b8edfad925144668&useDefaultText=1&useDefaultDesc=1>
4. *National Midwifery Guidelines for Consultation and Referral 3rd Edition Issue 2*; <https://www.midwives.org.au/shop/national-midwifery-guidelines-consultation-and-referral-3rd-edition-issue-2-book>.
5. Royal Australian and New Zealand College Obstetricians and Gynaecologists guideline; *Guidelines for locum positions in specialist obstetric and gynaecological practice in Australia and New Zealand WPI 12*; March 2017.

Acknowledgements

The GP Obstetric Shared Care SA Program was established in 2002 as a result of an initiative by SA Health, facilitated by the Healthy Start Clinical Reference Group (now known as the SA Maternity Neonatal Gynaecology Community of Practice - Clinical Reference Work Group).

The members of the group that participated in the review of the GP OSC SA Protocols 2020 were:

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