GP Maternity Share Care Online Bridging Program

The goal of this course is to maintain a level of GP workforce expertise in maternity care, and improve the knowledge, communication & relationships in the workforce, ultimately providing safe quality driven care to pregnant women and children in the Metro South Health and Hospital Service catchment.

An alignment program exists to ensure GP's maintain adequate knowledge and skill in maternity care, in order to care for women in accordance with current evidence based maternity practice and be familiar with the policies and available services of the relevant local MSH hospital service.

By successfully completing this course, you agree that your name may be published on the BSPHN website as an aligned GP with Metro South Health. If you do **not** wish to be listed, please email GPLO_maternity_share_care@health.qld.gov.au.

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Learning objectives

This bridging program is designed for GPs who have completed clinical updates elsewhere and who wish to obtain Alignment with Metro South Hospitals – Logan/Beaudesert and Redland.

Information about the specifics of GP shared maternity care with these hospitals is provided such as the:

- Models of care available to women
- Referral process /template
- Allied Health clinics
- Lines of communication into the respective hospitals.

CONTINUE

Resources

You should also be aware of resources such as:

- [ ] The current Metro South Health Clinical Guidelines GP Maternity Shared Care
- [ ] The "Refer Your Patient" Antenatal and Maternity webpages
- [ ] Spot on Health Pathways
- [ ] Arange of Queensland Health resources, such as the Maternity and Neonatal Clinical Guidelines and Maternity Shared Care - Operational Framework

CONTINUE

Maternity Models of Care

Continuity of carer models are consistently identified as being very important to women, not only through midwifery models of care, but also the continuity of care provided by their own GP.

A lack of continuity of carer leads to a fragmented and broken journey for the woman through her pregnancy, and in the postnatal and early childhood experiences of health service provision for the family. Hence **continuity is a priority** in maternity services for women, ensuring the accessibility of safe, quality and responsive maternity services for all women in Australia.

The decision regarding the appropriate model of care for a pregnant woman remains one made **jointly** by the woman, her GP, and the MSH Maternity Services, depending on the identification of risk or complications in the pregnancy, and includes assessment of:

- Woman's choice
- Medical and Obstetric History
- Psychosocial Factors
- Ethnicity
- Engagement of an Aligned GP
- Availability of MGP Services (for eligible groups of women)

Maternity Models of Care

Logan Hospital	Beaudesert Hospital	Redland Hospital
GP shared care	GP shared care	GP shared care
Hospital midwifery care	Hospital midwifery care	Hospital midwifery care
Specialist obstetric care	GP Obstetrician (Rural Generalist with Advanced Diploma) Care	Specialist obstetric care
Community Maternity and Child Health Hubs (MGP Model for eligible women)	Midwifery Group Practice	Midwifery Group Practice

Maternity and Child Health Hubs/Midwifery Group Practice (Logan)

Maternity and Child Health Hubs are specially designed for local women who are:

- Aboriginal and/or Torres Strait Islander
- Maori or Pasifika
- Cultural and linguistically diverse (CALD) or non-English speaking women, including refugees

- Under the age of 18

Sometimes women with complex needs may also access Maternity and Child Health Hubs, or women from these groups may choose one of the other options for model of care.

Midwifery Group Practice (Redland)

Continuity of Care to all risk women, with expanding eligibility criteria:

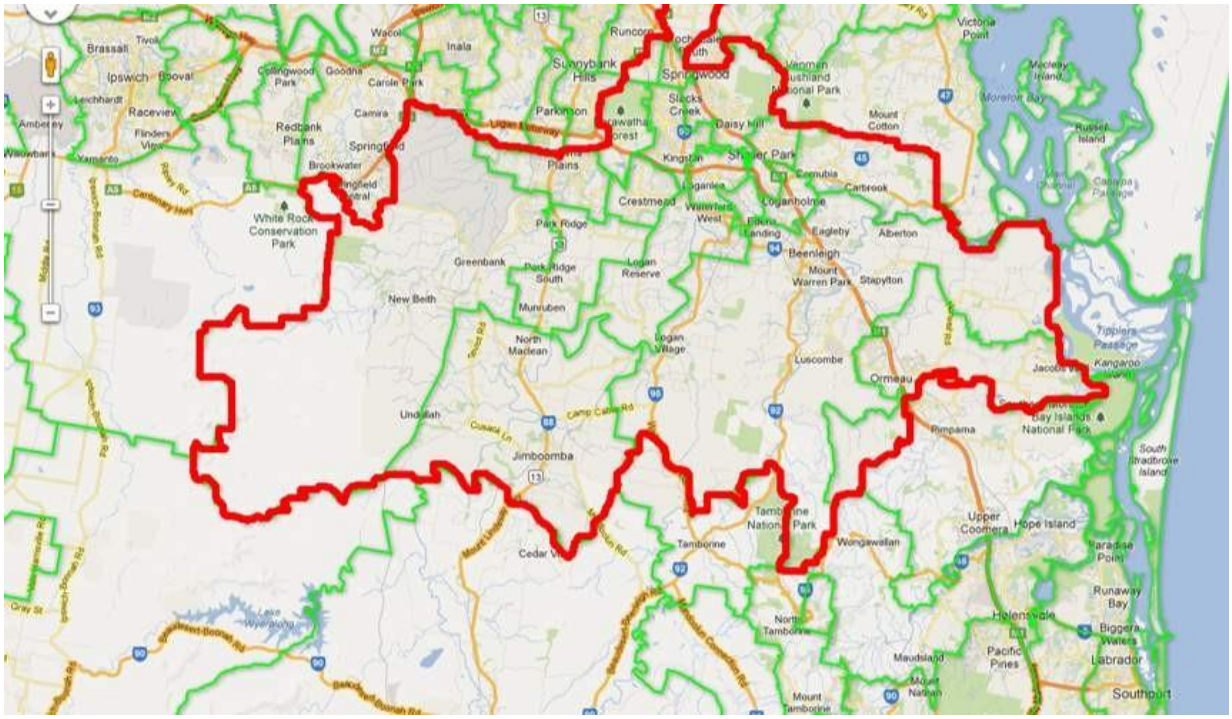
- Indigenous/Torres Strait Islander
- Live on an island
- Past traumatic birth, e.g. IUFD
- 18 years and under within RH geographical boundaries
- Expansion of service will allow increased access for other low-risk women (within limits of service capacity).

Hospital midwifery care (Logan/Redland Hospital)

Care during pregnancy and birth is delivered by a team of midwives, and occurs at the hospital, or in some community settings e.g. Yarrabilba Family and Community Place, Gundu Pa (Wynnum-Manly Community Health Centre). Attempts are made for midwives to be rostered for regular clinic days so they can build a rapport and provide some continuity for women.

Team Care Midwifery is available to women in the Redland Hospital catchment providing continuity of care to low risk women planning for normal and active birthing.

Hospital midwifery care is available for women who are healthy with a normal pregnancy, but midwives will be involved in the care of more complex pregnancies, in association with Obstetricians and other health professionals.



Logan catchment map

Maternity Models of Care - Beaudesert Hospital

Women who have Low Obstetric Complexity may be cared for by either MGP and/or RGOs (Rural Generalist Obstetricians)/ hospital midwives, with antenatal care done locally, birthing in the hospital, and Postnatal care locally.

Beaudesert women who develop complications in pregnancy may be transferred to Logan Hospital for birth, with Beaudesert Hospital Midwives and MGP midwives continuing to be

involved in care as much as practicable, and postnatal care undertaken locally where possible.

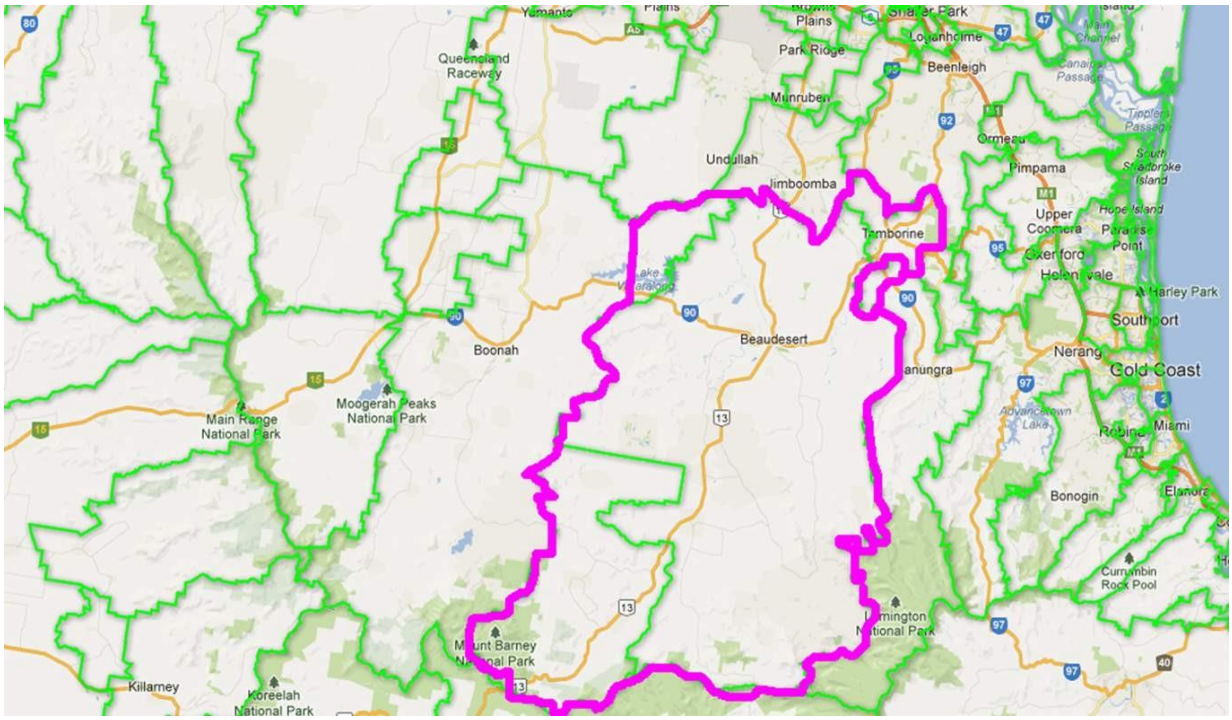
Women who do not live in the Beaudesert area may be able to birth at Beaudesert Hospital, with Antenatal care provided either at the hospital (RGO's/midwives) or in a GP Shared Care arrangement.

All women have a case review by a visiting Obstetric Consultant.

Midwifery Group Practice (Beaudesert Hospital)

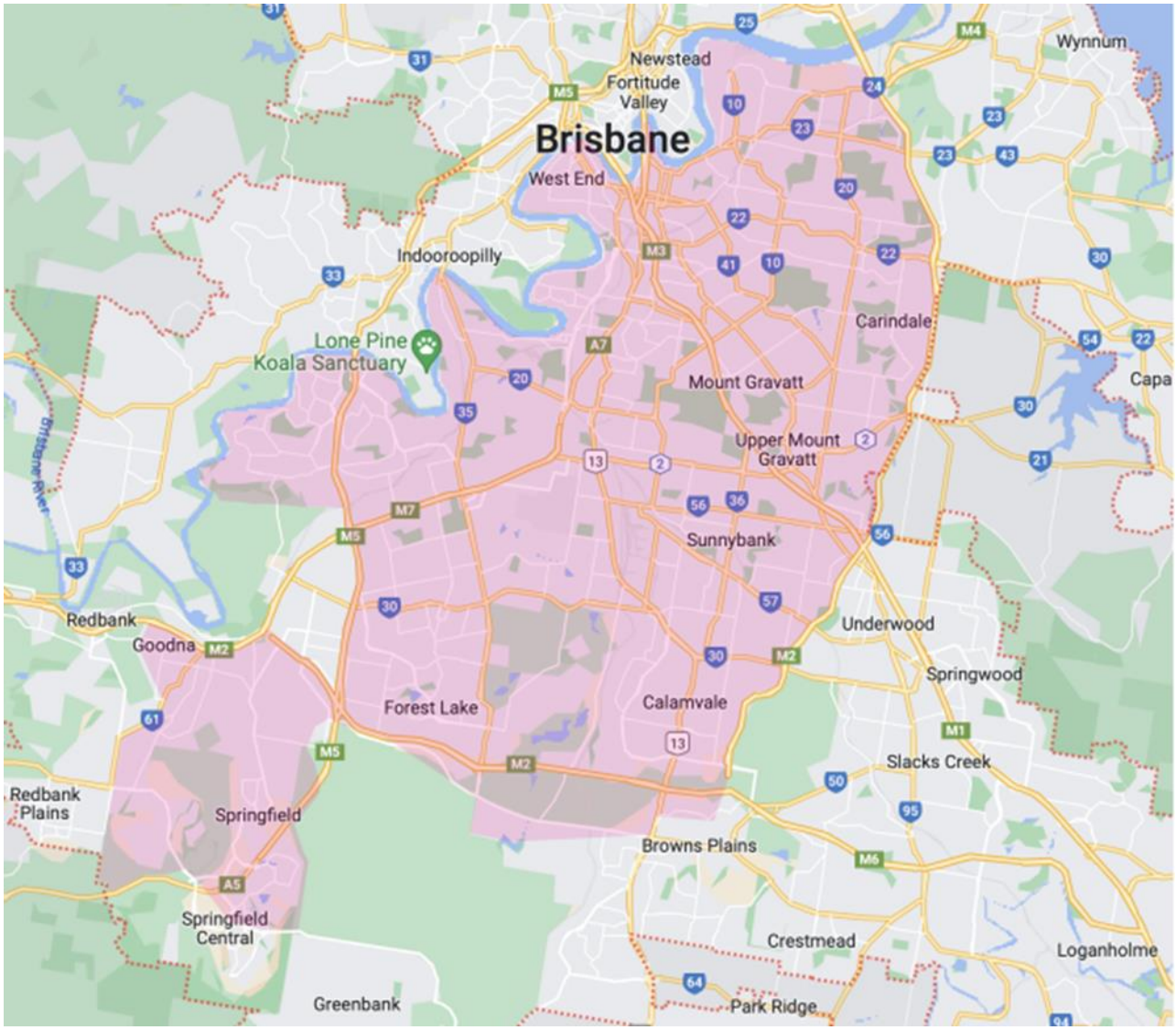
MGP offered to **local** Beaudesert women only.

Women cared for by the same midwife or small group of midwives at their choice of location: their home, Beaudesert Hospital, or in the community, e.g. Yarrabilba Family and Community Place, Mununjali.



Beaudesert catchment area

Mater Mothers' Hospital



Mater Mothers Hospital catchment area - https://www.materonline.org.au/MaterOnline/media/materonline/MM_A4_Antenatal_Clinic_Catchment_Map_May2023_V3_.pdf

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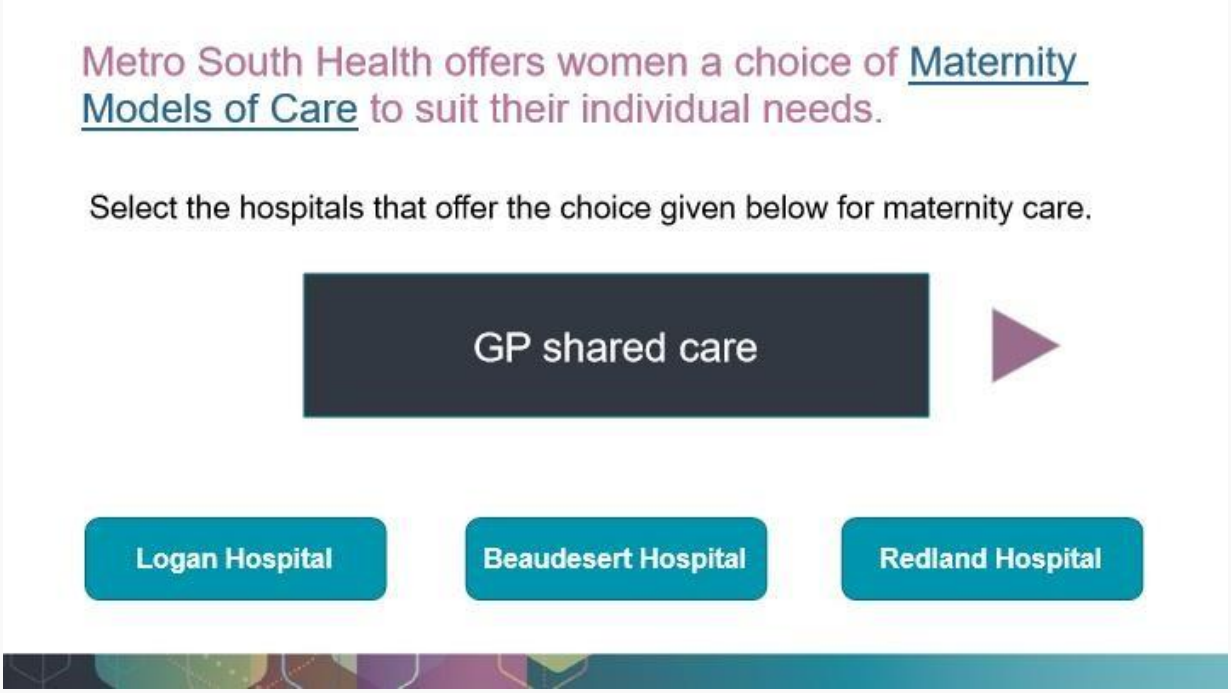
Only women living within the catchment area will be accepted, however proof of address is required. These maps are approximations only.

Aboriginal and Torres Strait Islander women will be accepted from outside of MMH catchment but this needs to be made clear on the referral.



CONTINUE

QHealth referral template

The QHealth referral template is a helpful document, with decision support built in.

An electronic version is available for MD on the Brisbane South PHN webpage and on the MSH "Refer Your Patient" webpage and is a supplied template on BP (QHealth Maternity).

You can also download a copy for print.

This template is expected to be replaced in Metro South Health by an Antenatal "Smart Referral" (in draft).

CONTINUE

Routine

Antenatal Referrals

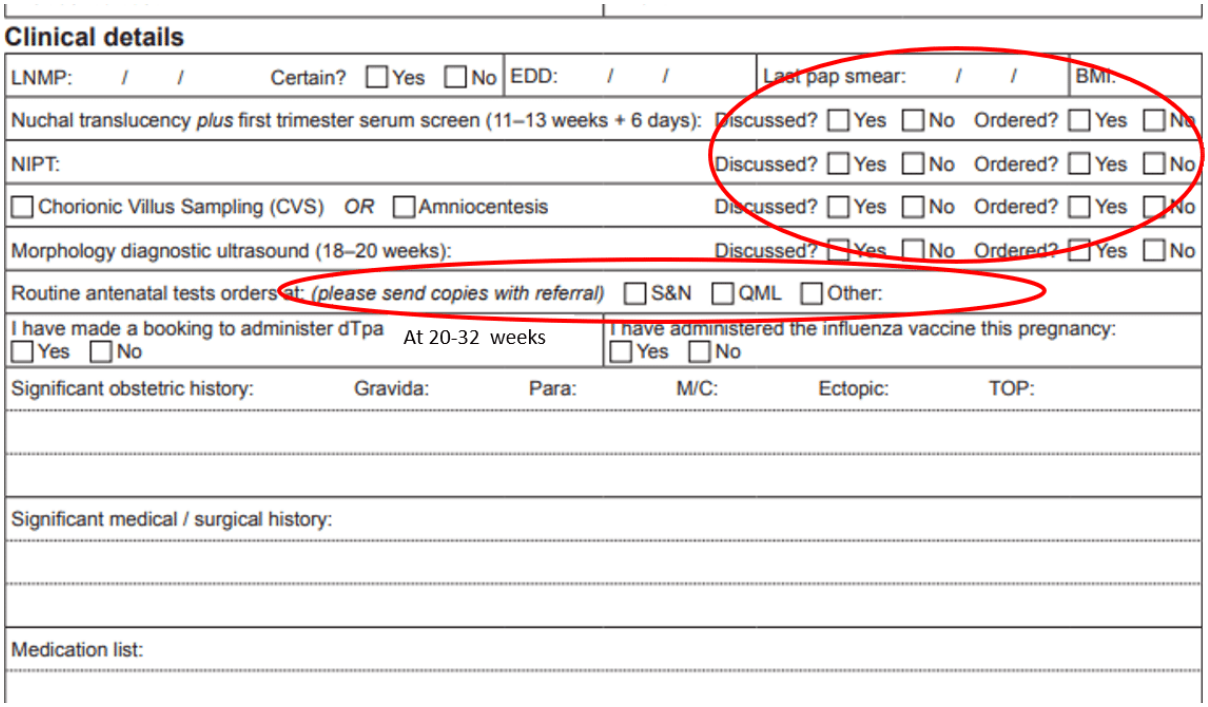
Prompts within the template are there to assist with appropriate screening, and completeness of information. Information requests assists with appropriate triage of women. Information = safe, effective and eficient triage.

Please indicate clearly:

- Medical and Psychosocial risk factors (including BMI)
- Significant Obstetric History e.g. past Pre-eclampsia, Premature Deliveries, Stillbirths
- Any indications for early appointment
- Please include ethnicity/ primary language spoken

Please **cc the hospital ANC on *all* pathology and ultrasound requests** and include **copies of any available results** with your referral as this helps with triage.

During the pregnancy, new results should be printed at antenatal appointments and added to the Pregnancy Health Record (blue folder).



Clinical details

LNMP: / / Certain? ☐ Yes ☐ No	EDD: / /	Last pap smear: / /	BMI:
Nuchal translucency *plus* first trimester serum screen (11–13 weeks + 6 days):		Discussed? ☐ Yes ☐ No	Ordered? ☐ Yes ☐ No
NIPT:		Discussed? ☐ Yes ☐ No	Ordered? ☐ Yes ☐ No
☐ Chorionic Villus Sampling (CVS) *OR* ☐ Amniocentesis		Discussed? ☐ Yes ☐ No	Ordered? ☐ Yes ☐ No
Morphology diagnostic ultrasound (18–20 weeks):		Discussed? ☐ Yes ☐ No	Ordered? ☐ Yes ☐ No
Routine antenatal tests ordered at: *(please send copies with referral)* ☐ S&N ☐ QML ☐ Other:			
I have made a booking to administer dTpa ☐ Yes ☐ No At 20-32 weeks		I have administered the influenza vaccine this pregnancy: ☐ Yes ☐ No	
Significant obstetric history: Gravida: Para: M/C: Ectopic: TOP:			
Significant medical / surgical history:			
Medication list:			

Please attach copy *and* cc Logan/Beaudesert/Redland Hospital ANC

Having a copy of the results (if available) in the referral helps to triage a woman. Copying results to Logan/Beaudesert/Redland ANC and providing the woman with a printed copy of ultrasound results and pathology reports allows clinicians immediate access to information wherever she presents. Inclusion of a printed copy of all relevant notes/investigations also gives other clinicians immediate access to relevant clinical information.

All antenatal referrals should be directed to the MSH - CENTRAL REFERRAL HUB nominating the woman's **local maternity facility.**

Referrals should be forwarded as **early** as practicable, so optimal planning for safe antenatal care can occur.

Please indicate if you wish to and are aligned to provide shared antenatal care (prompt on electronic template or add this as free text "other" section).

Nominate the woman's preferred model of care after you have counselled her regarding her options (and provided access to information regarding these models).

Maternity referrals are transferred from the Referral Hub **directly** to the local facility for triage. Women identified as suitable for Midwifery Group Practice (MGP) can then be directed to these services, while most women will be seen initially for a booking in visit with a hospital midwife, before Obstetrician review at about 20 weeks, and the MOC confirmed. GPs should then receive correspondence confirming the woman's model of care.

Referrals beyond the local maternity hospital, e.g. patients with complex medical issues/specialist care at other hospitals, e.g. at MMH/RBWH, or to MMH (Maternal-Fetal Medicine Service) may be accepted out of catchment, but usually only after discussion with or on the recommendation of the local Obstetrician.

Significant medical/surgical history:

Date	Condition
27 January 2012	Dysmenorrhoea - Primary
26 July 2012	Diagnostic Laparoscopy
7 August 2012	Labioplasty
11 October 2012	Tonsillitis - recurrent
3 June 2013	Hepatitis B immunisation
3 June 2013	Rubella immunisation
9 June 2015	Iron deficiency
4 December 2015	Miscarriage - complete
2 September 2016	Reflux - gastro-oesophageal
21 September 2016	B12 Deficiency
20 January 2017	Mastitis (Right)
20 June 2018	Smoking cessation
18 September 2018	Gastric Banding

Medication List:

Drug Name	Strength	Dosage
FERRO-GRAD C MR Tablet (Ferrous sulfate/Ascorbic acid)	325mg (equivalent to 105mg elemental iron)/500mg	one tab daily
FOLIC ACID Tablet (Folic acid)	500mcg	1 tablet daily
ONDANSETRON OralDisTab (Ondansetron)	8mg	take b.d. p.r.n.

Allergies:

No known allergies/adverse reactions.

Smoking & Alcohol

Cigarettes: Ex-smoker - was 15/day - ceased once pregnancy diagnosed

Alcohol: 1 or 2 std. drinks: monthly or less when not pregnant

Warnings and alerts:

None recorded.

Other comments: (eg social concerns, BMI)

Gastric Banding Surgery June 2018 - BMI remains > 30

Has been Iron deficient in past and persistent post gastric surgery - Hb maintained but remains iron deficient (Ferritin 25). Is taking oral iron supplement.

Rubella - Low immunity noted - has had boosters in 2013 (pre first pregnancy) and in 2015 (post natally after daughter born), but poor response noted. (Rubella IgG - 11 IU/ml).

Please help your Obstetric colleagues by making any **important** information easy to find!

Dating ultrasound

A dating scan should be considered and offered to all women who are unsure of their conception date. When undertaken between 8 weeks 0 days and 13 weeks 6 days it offers valuable information to determine

- gestational age
- confirm viability and intrauterine position of pregnancy
- detect multiple pregnancies and
- accurately time fetal anomaly testing.

A copy of the report should be included with the referral.

A dating scan is particularly indicated if there is:

- Uncertainty re date of LMP
- Irregular Menstrual Cycle
- Abdominal pain or bleeding in early pregnancy
- Conception within 3 months of a miscarriage
- Conception while breastfeeding or within 3 months of breastfeeding cessation
- Conception while taking oral contraception or within 3 months of cessation
- Conception within 9 months of Depoprovera injection
- Women planning to undergo NIPT testing
- Women with pre-existing hypertension, diabetes or other medical condition that may influence pregnancy risks (including high BMI)
- Women with previous GDM /high GDM risk
- Previous ectopic pregnancy
- Conception as a result of assisted reproduction

The referral pathway - Logan/Beaudesert/Redland Hospitals

Women with **chronic medical problems** should be referred to the Obstetrician/ANC as soon as possible after pregnancy is diagnosed, and the Obstetric Team will liaise with the woman's other specialists if required.

Identify medical and social risk factors and any **indications for an early appointment,** so the specialist staff can assess, liaise and if necessary, refer further.

Midwife Navigators (MN) are available to support women diagnosed with Gestational Diabetes and vulnerable women with complex needs (in Logan catchment) to assist them in engaging with and navigating the health care system. Aim to:

- Increase vulnerable women's access to continuity of care and to work in partnership with the woman, her lead care provider (including GP), specialist and allied health professionals involved with the woman and her care.
- Improve perinatal outcomes for vulnerable women and their families.
- Midwife Navigator: Complex Care -Email: MN.Complexcare@health.qld.gov.au – Mob. 0436 850 016
- Midwife Navigator: GDM Email: mn.gdm.logan@health.qld.gov.au - Mob. 0436 850 028

Where can you find the Queensland Health antenatal referral template (for downloading into your practice software)? (select more than one)

- [ ] Refer Your Patient Portal
- [ ] Brisbane South PHN website
- [ ] Metro South Health website

SUBMIT

Where will you find the essential referral information direction to guide completion of a referral? (select more than one)

- [ ] Refer Your Patient Portal
- [ ] Brisbane South PHN website
- [ ] Spot on Health Pathways

SUBMIT

CONTINUE

Urgent conditions

For more URGENT Antenatal patients needing immediate EARLY Obstetric Review:

If a GP identifies that a woman needs to be seen for high medical or obstetric risk within the following 10-14 days, there may be an indication for an extra early appointment (before the antenatal referral has negotiated the usual Referral Hub processes) e.g. Pre-pregnancy hypertension with poor control.

Complete the Antenatal referral noting the higher risk, and forward to the Referral Hub.

Additional please **PHONE the Obstetrician on Call** to discuss the risk (and they may offer to review the woman even before the routine ANC appt (usually through the EPAU at Logan Hospital, or with an early appointment at Beaudesert/Redland Hospitals).

If there are early indications that MFM review will be needed, GP's can refer direct to MMH – Maternal Fetal Medicine, but strongly consider discussing with local maternity team first (and copy them in to get any test results).

Early and fully completed antenatal referrals with the clear identification of any clinical and social issues will assist with the swift referral triage process and enable women to see the right clinicians at the right time to suit her individual needs.

Which sections of the antenatal referral template should becompleted to assist clinicians with the provision of care to meet individual needs? (select one)

- Name and address
- EDB and gestation at referral
- Ethnicity and requirement for an interpreter
- Medical and obstetric history sections
- Psychosocial issues
- Preferred maternity facility
- Indications for and results of early GDM testing if undertaken
- Current discussion and testing organised for fetal anomaly
- Preferred maternity model of care

- ◯ Immunisations given during pregnancy
- ◯ Pre or Early Pregnancy BMI
- ◯ All of the sections

SUBMIT

True or false: a dating scan report should be undertaken and included with the referral in most cases (especially if there is uncertainty re LMP dates or pregnancy duration).

- ◯ True
- ◯ False

SUBMIT

True or false: I should attach all results of booking bloods, and cc ANC into any further tests ordered during the pregnancy.

- ○ True
- ○ False

SUBMIT

I should refer a woman to a maternity facility: (select one or more)

- ☐ Before 20 weeks gestation
- ☐ After 20 weeks gestation
- ☐ As soon as possible when presents as pregnant

SUBMIT

I should provide the woman's ethnic identity and whether any interpreter will be required.

- True
- False

SUBMIT

CONTINUE

New medical problem or complication during pregnancy

Medical condition develops after referral

Should a woman develop a **complication during pregnancy**, or a **medical condition after referral sent** please refer her back to the booking hospital/ANC (not the Referral Hub).

This process enables the specialist staff to assess, liaise and if necessary, modify or change the plan for MOC or refer further.

FAX a new referral/letter to ANC with results attached, and problem clearly identified:

- Logan FAX: 3299 8202
- Beaudesert FAX: 5541 9132
- Redland FAX: 3488 3436

OGTT positive?

Refer her back to ANC, not the Referral HUB

URGENT medical condition, e.g. escalating BP - Contact the relevant Obstetrician / Registrar / Maternity Assessment Unit by **PHONE.**

Separate referral to Medical Specialist Clinics is not required from the GP for women with *pre-existing* medical conditions identified in the antenatal referral. The obstetrician will assess the woman at the first appointment and refer if necessary.

If a woman *develops* a medical condition after referral to the antenatal clinic, a new referral (using a standard referral letter, not an antenatal referral) should be faxed to the antenatal clinic, including a copy of the results.

"High risk" identified on Fetal Anomaly Screening

"High Risk" identified on Combined First Trimester Screening +/or NIPT (or other tests offered to assess for fetal anomaly) should prompt the need for further assessment and counselling ASAP. Once identified, Obstetrician review is recommended, with the referral sent back to the booking hospital/ANC (not the Referral Hub). GP's are advised to contact the Obstetrician on call to discuss the result and follow up arrangements.

Tertiary USS assessment may be offered soon at Logan Hospital.

If MFM review will be needed, GP's can refer direct to MMH – Maternal Fetal Medicine, but strongly consider discussing with local maternity team first (and copy them in to obtain any test results).

Termination of Pregnancy Referrals

Termination of Pregnancy (TOP) is a legal medical procedure in Queensland from December 2018 (Termination of Pregnancy Act 2018). Where there is a conscientious objection to being involved in TOP care, clinicians have a professional responsibility and legal requirement to ensure transfer of care without delay.

Registered medical practitioners may perform a lawful termination on a woman who is:

- Up to gestational limit of 22+0 weeks, for any reason
- 22+1 weeks or more if 2 medical practitioners agree that, in all the circumstances, the termination should be performed.

Local Hospital and Health Services provide access to a very limited number of TOPs for unintended pregnancies. Most TOP referrals need to be via private services. Priority appointments are for women with complex health care needs and/or significant social disadvantage. Consider referral to support services as appropriate, especially where risk factors have been identified (e.g. young women, women with physical or intellectual disabilities, mental illness, rape or sexual assault, domestic violence, fertility issues and cultural beliefs/values).

If under 16 years, greater consideration of an independent and appropriate counsellor or support person being available and engaged should be considered.

In paediatric and adolescent patients: refer to Statewide Paediatric and Adolescent Gynaecology Services (SPAG) at QCH/RBWH.

- Queensland Clinical Guideline: Termination of Pregnancy .

TOP Service (Logan Hospital) has a nursing case manager - Phone 2891 5578 - Mon - Fri 9:00am to 4:00pm.

The recommended pathway is for the GP to phone the case manager, followed by a detailed referral letter stating relevant circumstances leading to request for publicly funded TOP i.e. complex health needs and/or significant social disadvantage (send by fax to 3089 2016).

For **Redland Hospital**, please phone the Consultant on Call for advice/consideration (through Switchboard) prior to sending a written referral.

TOP services are not available at **Beaudesert Hospital**.

All relevant investigations need to be attached to the referral letter as per Qld Termination of Pregnancy Clinical Guidelines.

Registration and online training for GPs who wish to undertake medical terminations of pregnancy (up to 9 weeks of pregnancy) is available at https://www.ms2step.com.au/

Essential referral information

- Medical, surgical, obstetric and psychosocial history
- Menstrual history and last menstrual period (LMP) date (if available)
- Results of physical exam as indicated by history + Vital signs & BMI if surgical termination likely
- Confirm the diagnosis of pregnancy (βhCG) and gestation of intra-uterine live pregnancy by ultrasound
- Qld Termination of Pregnancy Clinical Guidelines
- SpotOnHealth Pathways

Additional referral information to be included:

- Blood group/Rh status and Antibody Screen
- Routine antenatal bloods: FBC, Rubella antibody, hepatitis B/C serology, HIV serology, syphilis serology
- HPV vaccination history /CST result if undertaken
- STI screen - endocervical swab for chlamydia +/- gonorrhoea, T vaginalis. Results may not be available pre referral but is an essential part of management.
- History of smoking and alcohol and substance use
- History of Domestic/ family violence or sexual violence

Clinical Override may be requested if a specific test result is unable to be obtained due to access, financial, religious, cultural or consent reasons. This reason must be clearly articulated in the body of the referral.

Facilitate timely referral to enable coordination with other facilities/departments if required, for example:

- Specialist medical assessment (e.g. cardiologist, clinical genetics services, tertiary imaging)
- Psychosocial counselling/support, especially where risk factors are identified (e.g. young person, women with physical or intellectual disabilities, mental illness (past or current), rape or sexual assault, domestic violence (including sexual violence), fertility issues and religious or cultural beliefs/values)
- Mental health support/treatment

- Discuss contraceptive options at the time of initial consultation or immediately after.

Develop a plan to follow up with the patient following TOP.

Patient Resources

- 13 HEALTH - 13 43 25 84 is a phone line that provides health information, referral and services to the public
- Children by Choice -1800 177 725 (free call) offers free all-options pregnancy counselling, information and referrals Queensland-wide.
- Women's Health Queensland - 1800 017 676 (free call) offers health promotion, information and education services for women and health professionals throughout Queensland.
- True Relationships and Reproductive Health provides expert reproductive and sexual health care.
- Key facts about Termination of Pregnancy Act

Termination of pregnancy (select one or more correct statements):

- [ ] Became a legal medical procedure available to all Queensland women in 2018

- [ ] Very limited services for TOP of an unplanned pregnancy are able to be accessed via MSH Hospitals (if strict criteria are met regarding complex medical or psychosocial issues and social disadvantage)
- [ ] Requirements for referrals include confirmation of live intrauterine pregnancy by BHCG and Ultrasound
- [ ] Where there is a conscientious objection to being involved in TOP care, clinicians have a professional responsibility and legal requirement to ensure transfer of care without delay

SUBMIT

Information is available about referrals for TOP at:

- ◯ Refer Your Patient
- ◯ 13HEALTH
- ◯ Children by Choice

- ◯ Queensland Health Clinical Guidelines
- ◯ MSH Hospital Gynaecologist/Registrar on call
- ◯ Spot on Health Pathways
- ◯ All of the above

SUBMIT

Essential referral contacts and other information about TOP services in MSH are available at:

- ◯ Refer Your Patient
- ◯ Spot On Health Pathways
- ◯ Both of the above

SUBMIT

CONTINUE

Pre-pregnancy Assessment Clinic

Women considered to be of high medical or obstetric risk can now be referred to a Preconception Clinic at **Logan Hospital** when planning a pregnancy – Tuesday PM (Ambulatory Building 2). The purpose of this clinic is to provide comprehensive assessment, counselling and optimisation of conditions prior to future pregnancies.

Patients may be referred from 6-8/52 post a pregnancy to discuss planning for a subsequent pregnancy.

The clinic is not intended for examinations or procedures.

Patients with the following conditions meet the criteria for referral to the Clinic. The conditions may be **pre-existing or new onset during a recent pregnancy:**

- Poorly controlled GDM patients on Metformin (>2.5grams/day) - internal referral.
- Type 1 or 2 Diabetes
- Thyroid conditions and other endocrine disorders
- Haematological/Respiratory/Cardiology/Renal/Hepatic and Gastrointestinal/Connective tissue/Neurological Disorders
- Infectious diseases

- Genetic conditions
- Previous poor Obstetric outcomes

Please ensure that appropriate investigations are completed prior to review in the clinic. For example, if the patient has a renal condition it is expected that FBC, E/LFT's, Urine M/C/S and Cytology +/- renal ultrasound would have been organised and results ready to be discussed at the review appointment.

Preconception & Fertility Clinics at MMH

Consultation in the Mater preconception clinic is available to any woman interested in optimal preconception care. Referral is by a named MAH referral template to Gynaecology OPD. The referral should clearly indicate that it is for preconception care and identify any specific reasons for the referral, including relevant results. The clinic is staffed by a midwife, an obstetrician/gynaecologist and an obstetric medicine specialist.

Couples will have an hour consultation to address specific health conditions that might affect a pregnancy as well as a thorough assessment of health and lifestyle issues that could be improved prior to conceiving. Assisted Reproductive Services, e.g. IVF, are not offered through this service.

The Fertility Assessment and Research (FAR) Clinic offers specialised care to couples experiencing infertility and recurrent miscarriages.

GPs should include results of any initial work up, specifically sperm count, blood work to confirm ovulation and imaging of the pelvis, including day 5-10 salpingohysterogram or sonohysterogram.

Women **do not** need to live within the MMH catchment area to be referred to these clinics, however having been seen at these clinics **does not entitle the woman** to obstetric care at MMH.

CONTINUE

Abnormal Results and follow up/documentation

Who is responsible for abnormal results?

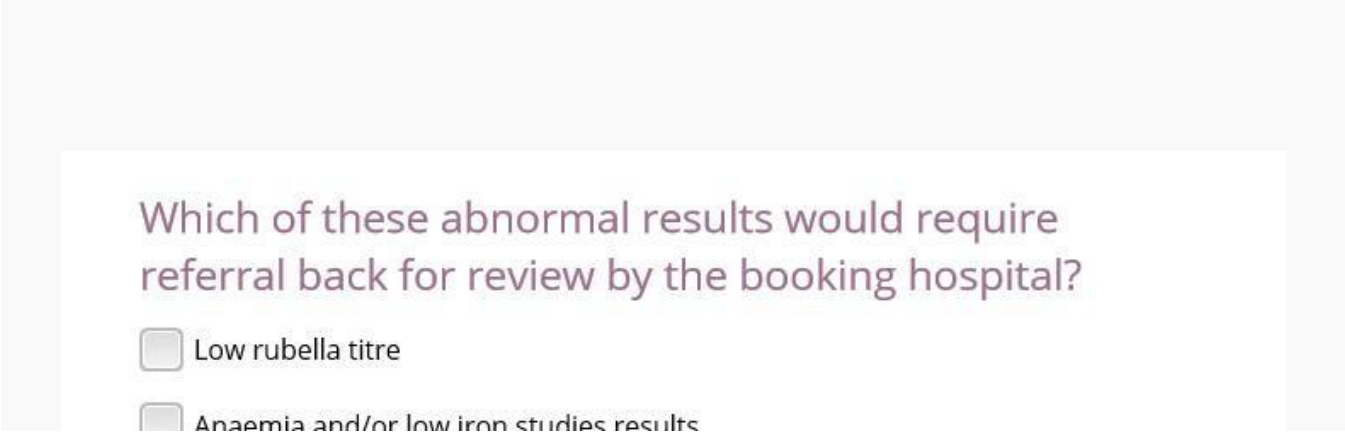
The clinician who orders the test is responsible for follow up and prompt referrals when appropriate.

Even if a copy of the result is sent to ANC, there can be delays in the processing and hence review of a result by a clinician. Please make prompt contact to arrange follow up of abnormal results for tests you have ordered.

Booking Hospitals will endeavour to contact women also, if they have a copy of the results. MMH does not have this capacity at present.

What to do with what you have found can be guided by the MSH GP Maternity Shared Care Guideline (in draft) or phone the GPLO Maternity Midwife/GP or Obstetrician/Registrar on call.

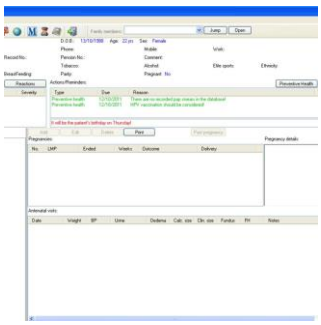
Document your actions in the Pregnancy Health Record.



- [x] Positive Syphilis screen
- [x] High risk CFTS or NIPT
- [x] Positive GDM screening test
- [x] Any morphology scan abnormality that identifies increased maternal and/or fetal risk

Where are you entering your observations?

*Medical Director



*Best Practice

Use the obstetric tabs in your software!

- Easy to enter data
- Print a copy for PHR
- Ready for digital PHR/"Smart referrals" - soon to be available.

CONTINUE

Early Pregnancy Problems and Pathways for Assessment

EPAU - Early Pregnancy Assessment Unit

Logan Hospital offers an Early Pregnancy Assessment Unit for the assessment of early pregnancy complications, specifically dealing with problems in early (< 20/40) pregnancy. The most common problems are vaginal bleeding or pain. Haemodynamically unstable women should be directed to ED.

EPAU can assist with management of threatened and incomplete miscarriages and investigate causes of pain, as well as the management of non-viable pregnancies that have opted for conservative/medical management.

EPAU manages confirmed stable ectopic pregnancies that are to be medically/ conservatively treated or pregnancies of unknown location that are stable, but require follow up. They manage pregnancies with high risk combined first trimester screen or NIPT - assisting GPs with appropriate counselling, options available for further assessment, and further referral to Foeto-Maternal Medicine (MMH) as needed.

Surgical management of miscarriages and ectopic pregnancies can be arranged through the EPAU if offering medical management is unsuitable.

The EPAU does not look after women with hyperemesis (refer to ED if IV fluids etc. are required). ED review is also necessary if narcotic administration for pain control is needed. Women with clinically suspected unstable ectopic (shoulder tip pain, rebound tenderness, abdominal rigidity, tachycardia, unstable BP) should be directed urgently to ED (via QAS if required).

Opening hours and location

8 am to 4 pm, Monday to Friday (except public holidays) by appointment only.

Contact the EPAU Nurse/Midwife or Obstetric Registrar to arrange an interview.

Phone: 3299 8456 / FAX – 3089 2016

Redland and Beaudesert Hospitals

For non-urgent specialist review or advice regarding women with positive pregnancy test or suspected pregnancy, ≤20 weeks completed gestation, and experiencing any of the following symptoms:

- Pain or vaginal bleeding but clinically stable
- No bleeding but with a non-viable pregnancy
- A confirmed stable ectopic pregnancy to be treated conservatively
- Pregnancy of unknown location, stable and requiring follow up
- Hyperemesis gravidarum requiring follow up

Redland Hospital contact details:

- Phone On-Call Obstetrician 3488 3111 or Registrar - on their advice may be booked for next "Early Pregnancy Clinic" OR
- Refer to the Emergency Department

Beaudesert Hospital contact details:

- Phone On-Call GP Obstetrician 5541 9174 OR
- Refer to the Emergency Department

Haemodynamically unstable women or needing IV fluids – send directly to Emergency Department.

Incomplete miscarriage treatment options

All women should be counselled and offered all options from the time of early pregnancy loss diagnosis, with all options being valid choices, guided by the woman's preference and any acute clinical considerations.

- Early Pregnancy Loss Queensland Clinical Guideline

Expectant

Follow up USS if still bleeding after 2 weeks OR if painful, heavy bleeding - may be managed by GP with specialist advice if required.

Medical management

Initiated usually by hospital, or can be prescribed by Registered GP providers - training available at https://www.ms2step.com.au/)

- Misoprostol has proven effective in 80 – 85% of miscarriages < 13/40
- x2 doses administered sublingual on consecutive days as an outpatient
- Bleeding and pain occur ~ 2-4 hours after the first dose and lasts up to 24-72 hours before the miscarriage is completed
- Period-like bleeding will then occur over the next week or so
- ~ 10% of women have excessive pain or bleeding—medical review and possibly D & C may be required
- Hospitalisation for heavy bleeding or infection occurs in < 1% of women
- Not TGA registered for use in pregnancy. Use supported by Qld Health and RANZCOG

Surgical management

Available at Logan, Beaudesert and Redland Hospitals.

CONTINUE

Maternity Assessment Clinic (Logan and Redland)

The Maternity Assessment Clinic is for the review of urgent pregnancy related concerns >20 weeks gestation. MAC is located near to Birth Suites (tell the women to go to Birth Suites).

GPs should contact the MAC before sending a woman in for assessment and consider QAS transfer if considered urgent.

Team leader (Logan) - Phone: 3299 8811

Women can self-refer by calling 3299 8811.

Team leader (Redland)- Phone: 3488 3044

Women can self-refer by calling 3488 3044.

Beaudesert Hospital: For women with these concerns at Beaudesert Hospital, please contact the **GP Obstetrician on call - Phone:** 5541 9174 or women can self-refer by calling the **Triage Midwife - Phone:** 5541 9144

Common presentations would include:

- Suspected Preterm labour
- Uncertainty about or premature rupture of membranes
- Change in fetal movements
- Review of hypertensive women referred by their GP, obstetrician or midwife

- Bleeding after 20 weeks

Women may be reviewed in the Maternity Assessment Centre up to 6 weeks postnatally should complications arise that require Obstetric review e.g. suspected retained products of conception, sepsis, escalation of BP postnatally.

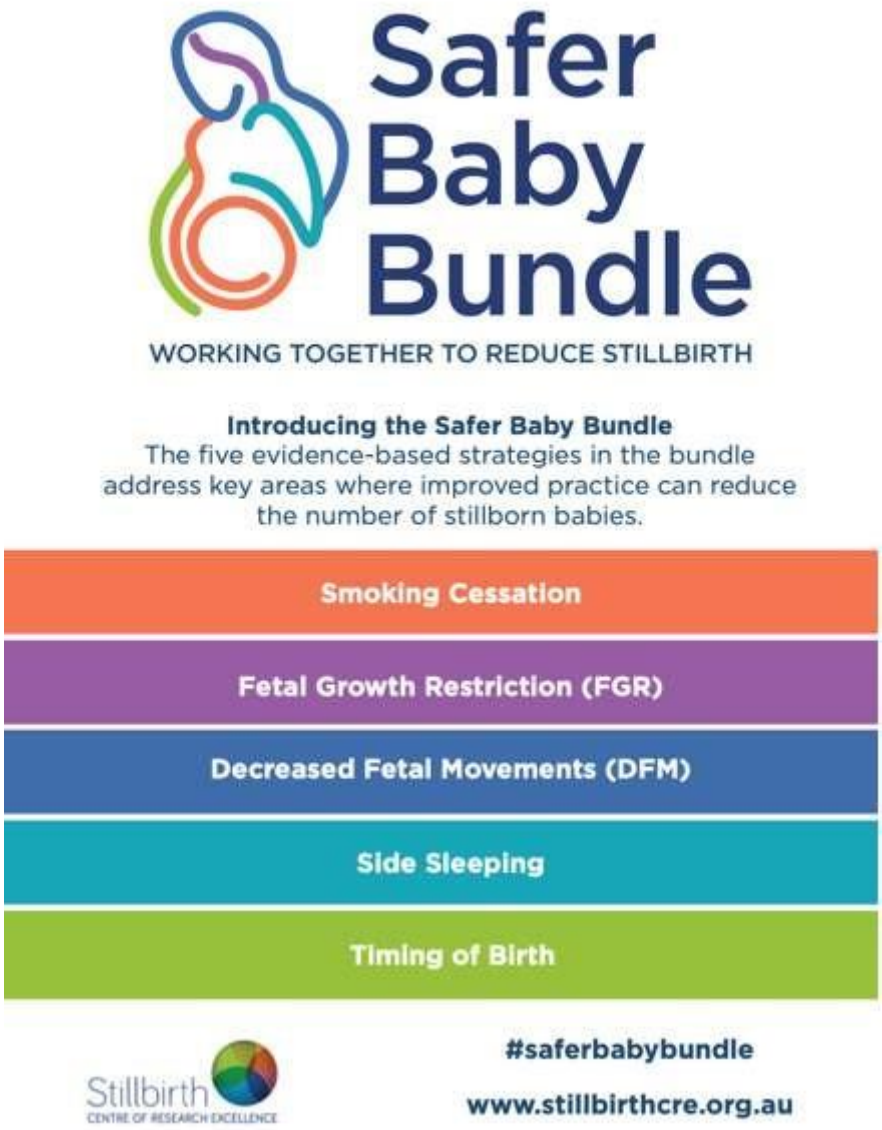
Decreased fetal movements

Antenatal education has been shown to decrease the time a woman waits to show health seeking behaviour after noting a change in fetal movements. Early reporting potentially reduces the incidence of poor fetal or maternal outcomes.

OUT	IN
Kick charts	Watch for a **change** in the pattern, frequency or strength of fetal movement.
Cold water / sweet drinks	Third trimester - encourage to start every sleep lying on side
Reassurance without review	Apps (My Baby's Movements) may assist the mother to monitor
	Decreased or changed fetal movements after 24/40 needs URGENT review at the maternity facility

Risk factors for Stillbirth

Safer BabyBundle (https:/ www.stillbirthcre.org.au/safer-baby-bundle/)



20% reduction in stillbirth rates has been seen in the UK and Scotland, where a care bundle has been implemented.

A Safer Baby Bundle Handbook and Resource Guide has been created as an informational support to assist maternity healthcare professionals with implementation of the Bundle. Free and accredited CPD training for healthcare professionals is available through e-learning modules.

What clinical symptoms would warrant a referral and request for assessment at MAC? Tick more than one.

- [ ] Changes in fetal movements
- [ ] Contractions at >37 weeks gestation
- [ ] Contractions at < 37 weeks gestation
- [ ] Suspected premature rupture of membranes (PROM)
- [ ] White vaginal discharge
- [ ] Vaginal bleeding at < 20 weeks gestation
- [ ] Cold, Flu or COVID symptoms
- [ ] Vaginal bleeding at >20 weeks gestation
- [ ] Abdominal pain and/or associated hypertonic uterus
- [ ] Suspicion of chest infection or pneumonia

- [ ] New hypertension and/or other symptoms indicative of suspected PET
- [ ] Current substance misuse
- [ ] Suspicion of Perinatal Mental Health Issues
- [ ] Symphysis Pubis Dysfunction
- [ ] Feeling very unwell with non-specific symptoms that may be attributed to pregnancy or have an effect on maternal and/or fetal health
- [ ] BMI of more than 40

SUBMIT

CONTINUE

High Prevalence Conditions

Clinical data suggests several conditions have a higher than average prevalence in the MSH catchment and may cause significant problems during pregnancy for women in this area and have serious health consequences ongoing:

- Syphilis
- Iron deficiency (with or without anaemia)
- Gestational Diabetes Mellitus
- Hypertensive Disorders of Pregnancy
- Excess weight gain in pregnancy /Prenatal weight excess
- Perinatal Substance Use

Syphilis screening in Metro South Health

Over the last 18 months there has been a steady increase of notifications throughout Queensland, including in South East Queensland. There has been a steady increase in notifications in both indigenous and non-indigenous women.

Logan and Beaudesert Hospital women are now being routinely screened with the initial antenatal bloods, AND again at 26-28 weeks. Very high risk women may require further screening at 34-36 weeks and postnatal follow-up.

For further information, please refer to the Queensland Clinical Guidelines - Syphilis in Pregnancy.

Iron Deficiency

True prevalence of IDA in pregnancy within Australia – approx. 18-20% in several studies (50% worldwide).

Risk factors for developing anaemia in pregnancy	
• younger age (<18 years) • multiparity • previous iron deficiency • shortened interval between pregnancies • disadvantaged socioeconomic status • poor nutrition • vegetarian or vegan diet	• past bariatric surgery • Aboriginal and Torres Strait Islander women • non-white ethnic origin • haemoglobinopathy • chronic blood loss • parasitic disease
Consider women at increased risk from the effects of anaemia • women at risk of haemorrhage at birth • who have bleeding disorders • are on anticoagulation therapy • who, for religious or cultural reasons, might decline blood products	

IRON supplementation is not recommended as routine in pregnancy.

Routine screening for IDA is recommended by measuring **Haemoglobin level + Ferritin level** at the first antenatal screen and at 26-28 weeks' gestation (recommended in Logan/Beaudesert/Redland Hospital catchments as high incidence noted (see Queensland Clinical Guidelines - IRON DEFICIENCY and ANAEMIA Updated August 2020).

Treat Iron Deficiency before anaemia develops; aim for target ferritin level 60 µg/L (ensuring adequate iron stores to cover routine blood loss during delivery/puerperium).

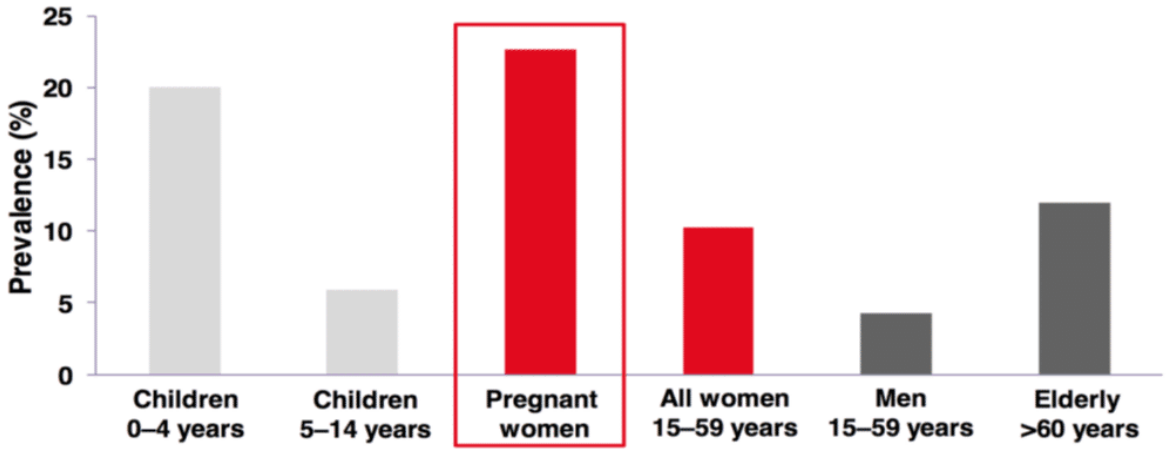
- Average blood loss in normal vaginal delivery = 500mls (250 mg elemental iron) approx. to ferritin of 30 µg/L.
- Average loss x 2 in women undergoing caesarean section

Goal: Maximise red cell mass at time of delivery and reduce reliance on transfusion as emergency therapy to treat blood loss.

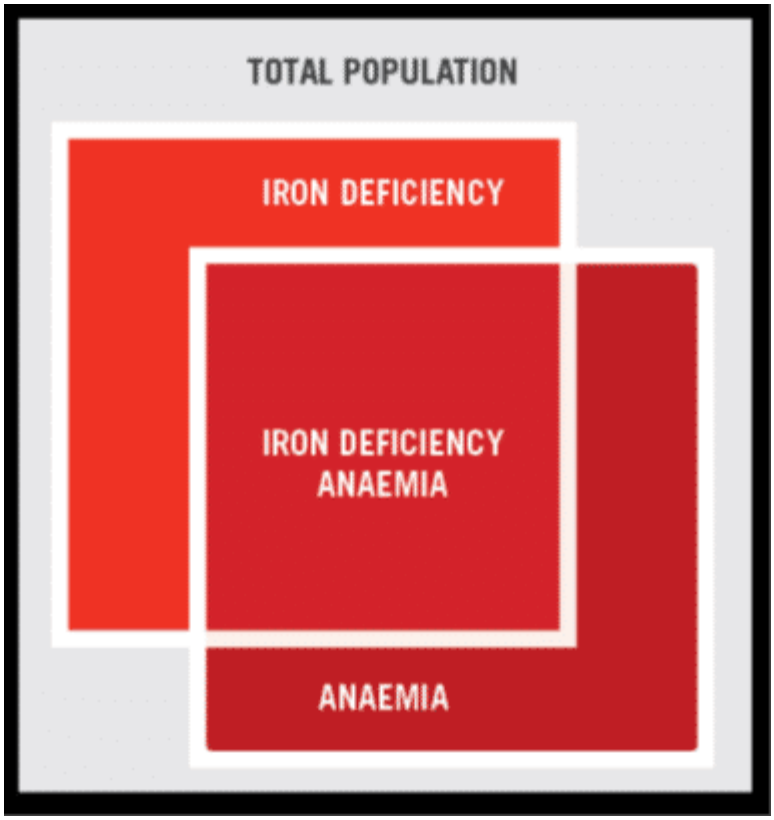
References: 1. Haemoglobin Assessment and Optimisation in Maternity

2. Toolkit for Maternity Blood Management (Aust Red Cross) - https://transfusion.com.au/node/2410

Gastro-intestinal absorption increases when the body's iron stores are low, and reduces the absorption when there are sufficient stores. Requirement for iron ranges from 0.8mg/day in the first TM to 7.5mg/day in the third TM, averaging approximately 4.4mg daily through pregnancy. In the second and third TM due to fetal growth, intestinal iron absorption in the gut is not sufficient to meet this increased demand. Thus maintaining iron balance depends on adequacy of maternal iron stores during this period. A guide to recommending iron supplements in pregnancy is available at: ORAL IRON CHOICES - A Guide For Maternity



Reference: Looker AC et al. JAMA 1997;(12):973-976



https://www.health.qld.gov.au/___data/assets/pdf_file/0033/931695/ed-lifeblood.pdf

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Definitions

Anaemia Hb≤ 110 g/L

Iron deficiency without anaemia x 3 incidence of iron deficiency anaemia ? 60 -70%

Ferritin ≤ 30 mcg/L

Iron deficiency anaemia

Low ferritin and low Hb

NOT all microcytic anaemias are due to iron deficiency. Haemoglobinopathy, needs to be considered (If MCV <80, or FHX/ethnicity indicators)

Consequences of Iron deficiency anaemia in pregnancy	
Maternal	**Foetal /Neonatal**
• Fatigue • Reduced physical and mental performance • Poor gestational weight gain • IUGR (poor placental perfusion) • Preterm delivery • Increased risk birth complications - haemorrhage, need for transfusion, infection, risk of hospitalisation • Depression • Inhibited lactation • Higher incidence of thyroid autoimmunity • Restless legs syndrome • Mortality increased	• Impaired placental growth/placental insufficiency • Low birth weight • Preterm birth • Neurological impairment - behavioural and cognitive disorders • Increased mortality • Associated with retinopathy of prematurity • Iron Deficiency/anaemia in childhood

A few facts about patient demographics and chronic diseases

- Logan Hospital patients approx.14.2% Pacific Islander and New Zealander
- **Samoans have 7x higher hospitalisation rates for diabetes** complications than the rest of Queenslanders
- **A&TSI women are 10x more likely to have T2D in pregnancy and 1.5x more likely to have GDM**
- There were 7779 registered cases of gestational diabetes in Queensland in 2018 – 11-12% of women who gave birth and of these, about 25% required insulin. Key Facts - Diabetes in Queensland - Chief Health Oficer Report 2018
- ***"Women diagnosed with GDM were over 20 X more likely to develop type 2 diabetes, had almost twice the risk of developing hypertension and were 2.5 X more likely to develop ischaemic heart disease following delivery compared with control women."*** Diabetes Queensland - Diabetes in the News - January 2018

Testing for diabetes during Pregnancy

- First trimester **HbA1c** (or early OGTT if k>12) for women at high risk of GDM
- **No** random or fasting BSLs
- **No** glucose challenge testing (OGCT)
- Routine OGTT (24 – 28 weeks) for all women not previously noted as abnormal (HbA1c NOT suitable)

Amended GDM Testing Protocol during Covid-19 Pandemic

Temporary amendments to the GDM testing protocol have been made during 2020 to take into consideration various levels of community Covid-19 risk (to maintain adequate social distancing guidelines and minimise Covid-19 risks to pregnant women). These are aligned with the ADIPS (Australian Diabetes in Pregnancy Society) recommendations for GDM diagnostic testing during the Covid-19 pandemic (April 2020)

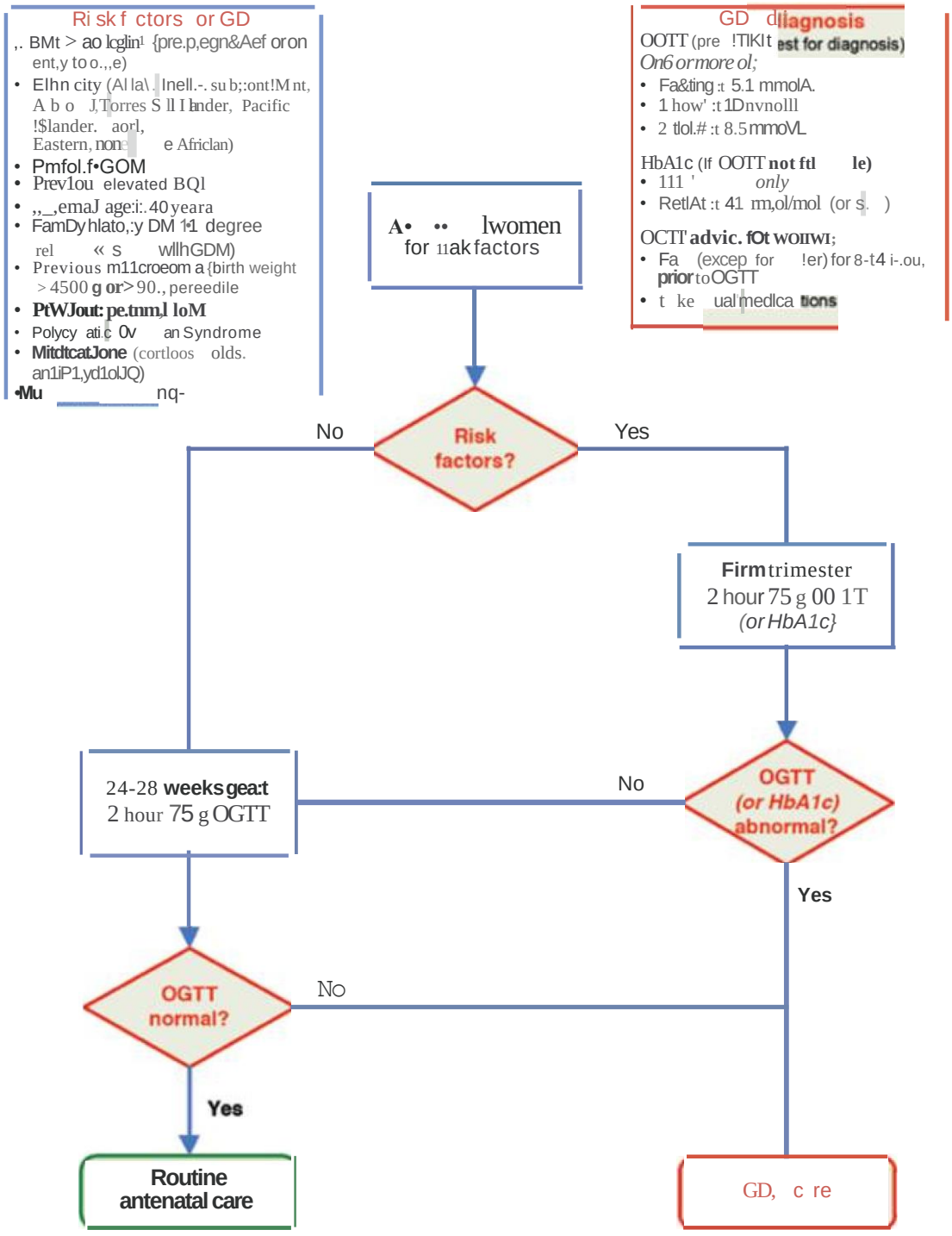
Recommendations regarding these amendments are also available on the Refer Your Patient Antenatal and Maternity webpage.

HbA1c

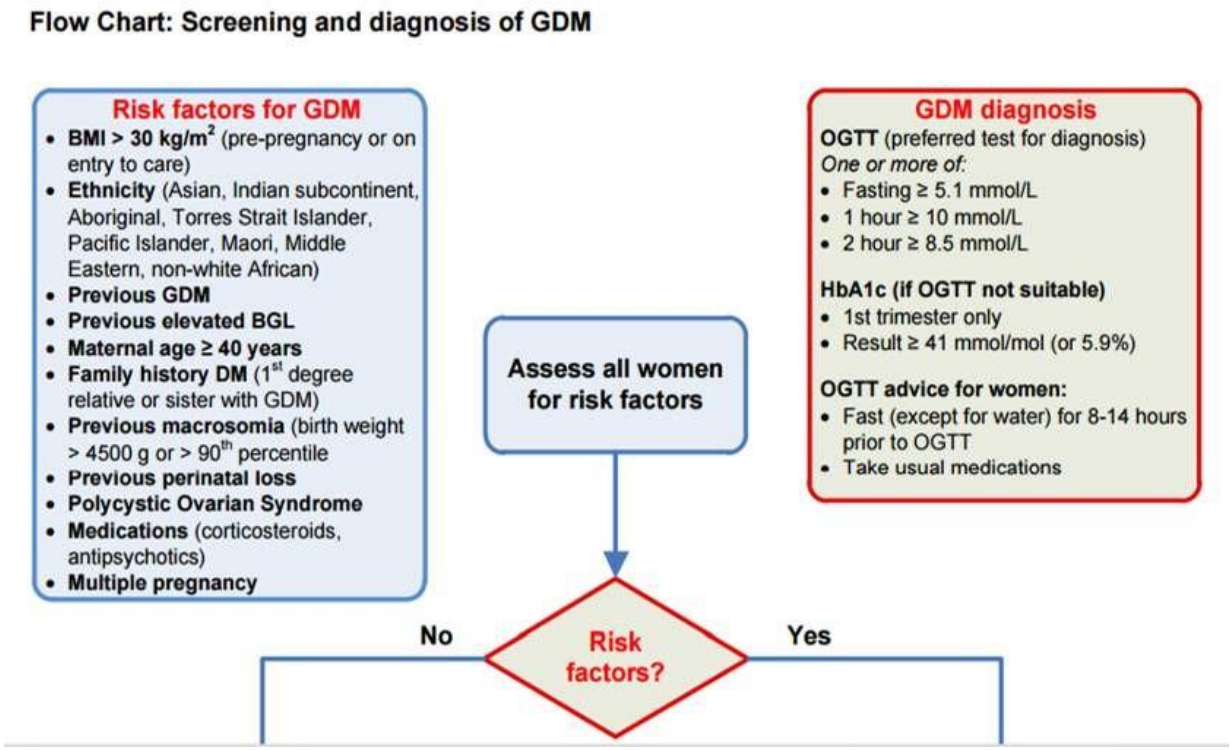
- HbA1c can be used as a diagnostic test for diabetes in *irst trimester*.
- HbA1c of ≥**5.9%** (41mmol/mol) required for GDM diagnosis.

- **>6.5%** (48mmol/mol) to diagnose type 2 diabetes.
- This DOES NOT replace the OGTT for women after first trimester, or in the 6-8 weeks postpartum.
- HbA1c can be used for long term follow up of women with past history of GDM – check in early pregnancy or preconception testing in a high-risk woman.
- Recommend lifelong screening for diabetes at least every 3 years.

17.3.2 Flowcholt for Gestational Diabetes Mellitu5



Qld Clinical Guidelines GDM Flowchart



Qld Clinical Guidelines - Gestational Diabetes (page 3)

Gestational Diabetes Mellitus - Pathway for ongoing care

Once you have discussed the diagnosis with the woman (please do so **urgently**) **notify ANC ASAP** - send a referral back to booking hospital ANC noting (in big, bold letters) **"New diagnosis of GDM"** including a copy of the OGTT (or HBA1C).

Send back to ANC **directly (not the Referral Hub):**

- Logan Hospital FAX: 3299 8202 Ph: 3299 8527
- Redland Hospital (Triage Midwife) FAX:3488 3436 Ph: 3488 3044
- Beaudesert Hospital FAX: 5541 9132 Ph: 5541 9144

Please note if women need an interpreter or are not suitable for a group presentation.

Women may initially attend a single group session with a nurse practitioner (NP) in diabetes within a week or so of the referral + Dietitian education and Glucometer use will be arranged.

As the woman is no longer low risk, her care will transfer back to the hospital obstetric team for care, with multidisciplinary input.

Lifestyle modifications are the primary therapy, with Metformin used prn. If insulin is required, women will be managed with physician input, and the Diabetes NP helps adjust insulin dosing.

NDSS referral completed by GP or Maternity Service. A Midwife Navigator is available at Logan Hospital to assist women with Gestational Diabetes who are experiencing dificulties accessing the extra care required and to assist in negotiating the care pathway. Contact 0436 850 028.

Tight sugar control is recommended:

- Fasting BSL's of < 5.0
- 1hour post prandial of < 7.4
- 2 hour post prandial of < 6.7

Queensland Clinical Guidelines - Gestational Diabetes Mellitus Clinical Guideline

Education Resources

Understanding gestat ional diabetes

These videos *are* about gestational abe1es. *aw* it is managed ere *o* ge me- onnatioo **and support** *you* need.

P, aseno e these videos totel1!' *dpriorto rheCOVID-19* par>demi *I>SS would e* torenund *v i e o f the Aus an Government Oepanment of Health* **rociaf di:rancing guid:mce** ***(it***

What is gestational diabetes?

Looking after gestational diabetes

Heatthy eating

Physical activity

Blood glucose monitoring

NDSS – National Diabetes Services Scheme Patient Education Videos

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The National Diabetes Services Scheme now provide a series of video education resources for parents about GDM, covering the following topics:

What is gestational diabetes?

- Looking after gestational diabetes
- Healthy eating
- Physical activity
- Blood glucose monitoring
- Medication
- Emotional Well-being
- Pregnancy, Labour, birth
- After your baby is born
- Future health

View the videos at the NDSS website.

Gestational Diabetes Mellitus

Women with GDM have a very high risk of developing Type 2 DM in the next 10 years, hence careful GP follow up is essential.

- OGTT 6-12/52 postpartum – reminder via NDSS if we have not already set up in our GP software.

- HbA1c every 1-3 years
- Repeat HbA1c prior to or early in next pregnancy
- Follow up other risk factors for macrovascular disease

Practice points

Women with pre-existing Type 1 or 2 Diabetes (or other medical problems e.g. Renal disease/ Autoimmune disease) can be referred to the **PREPREGNANCY ASSESSMENT CLINIC (via OPD) for Obstetrician management (Logan Hospital).**

Diabetics can be referred to preconception through the Diabetes/Endocrinology OPD pathway to access the Nurse Practitioner (NP), and to the dietitian – no direct referrals at this time.

Early ANC Referral is **ESSENTIAL** for these women once they are pregnant (Obstetrician will liaise with relevant Medical Specialist as required).

Diabetics can also be referred back to the NP ASAP once they conceive - address a separate referral to the "Nurse Practitioner Diabetes c/o ANC, (Logan Hospital/Redland Hospital/Beaudesert Hospital).

Notes will be made in the woman's PHR regarding her progress and recommendations.

You have received a positive screening test result for Gestational Diabetes for a shared care patient. What is the next step? (tick two correct responses)

- [ ] Advise on dietary measures, and commence glucose monitoring
- [ ] Initiate dietary measures +/- BSL testing but also contact booking ANC sending through a letter documenting the abnormal result, and requesting urgent review for "Newly Diagnosed GDM"
- [ ] Send referral as urgent to Central Referral Hub
- [ ] Call Obstetrician for advice if you require guidance

SUBMIT

Obesity in pregnancy

Obesity in pregnancy

For women with a BMI > 30:

- Routine scheduled bloods are recommended plus **E/LFT**, **HbA1c** (or early OGTT if k>12), and **urine protein/creatinine ratio**.
- Advise women to take **5mg of Folate** daily preconception and in the first trimester as they have higher risk of neural tube disorders.

- **Advise the hospital of the woman's BMI** so they can organise appropriate internal referrals, such as Dietitian and consider Anaesthetic assessment & consider suitability for a modified model of care.
- **Measure and document weight at each visit (on weight for BMI tracking graph), and advise on weight gain recommendations**
- **U/A with each visit**
- If the first trimester diabetes testing is negative, repeat OGTT is to be performed at 26-28 weeks
- Consider supplemental vitamin D, VTE risk & Aspirin if pre-eclampsia risk

Pre and inter-conception

- Analysis of BMI and waist circumference
- Risk counselling – increased risk of adverse maternal fetal outcome
- Discuss benefits of inter-pregnancy weight loss – refer o dietitian, stabilise weight loss before conception
- Advise re lifestyle interventions – weight loss, activity, behaviour modification, smoking cessation
- Folic Acid 5 mg daily at least one month prior to conception

Antenatal

- Comprehensive history (including previous bariatric surgery)
- Document pre-pregnancy BMI
- Folic Acid 5 mg daily until 12 weeks
- Initial laboratory investigations (BMI >30 kg/m^2):
  - OGTT or HbA1c at entry to care
  - Baseline liver and renal function, transaminases
  - Urine protein creatinine ratio
- Develop care plan with woman that identifies strategies to reduce risk
- Referrals:
  - Dietetic services for nutritional advice
  - If BMI > 35 kg/m^2, obstetric consult
  - If BMI > 40 kg/m^2, anaesthetic consult
  - Other specialist referrals as indicated
- Counsel about:
  - Maternal and fetal risks of obesity
  - Implications for birthing, model of care, breastfeeding and transfer of care
  - Recommended weight gain during pregnancy
  - Physical activity
- Clinical assessments:
  - Document GWG at each visit
  - Risk of VTE
  - Surveillance for preeclampsia – consider low dose aspirin
  - If initial OGTT/HbA1c negative, repeat OGTT at 24–28 weeks
  - Fetal surveillance to identify/exclude fetal malformations, macrosomia, growth restriction
  - Awareness of psychosocial wellbeing

Obesity in Pregnancy Guidelines - Queensland Clinical Guidelines

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Queensland Clinical Guidelines

Translating evidence into best clinical practice

Maternity and Neonatal **Clinical Guideline**

Obesity in pregnancy

Obesity guidelines - http://www.health.qld.gov.au/qcg/

- Pre-pregnancy BMI is inversely associated with serum Vitamin D concentrations among pregnant women, therefore obese women are at increased risk of Vitamin D deficiency. There is no conclusive evidence on the benefits of maternal vitamin D supplementation on pregnancy outcomes, however supplementation in women who are vitamin D deficient may be beneficial for long term maternal health – Obesity in Pregnancy – QCG.

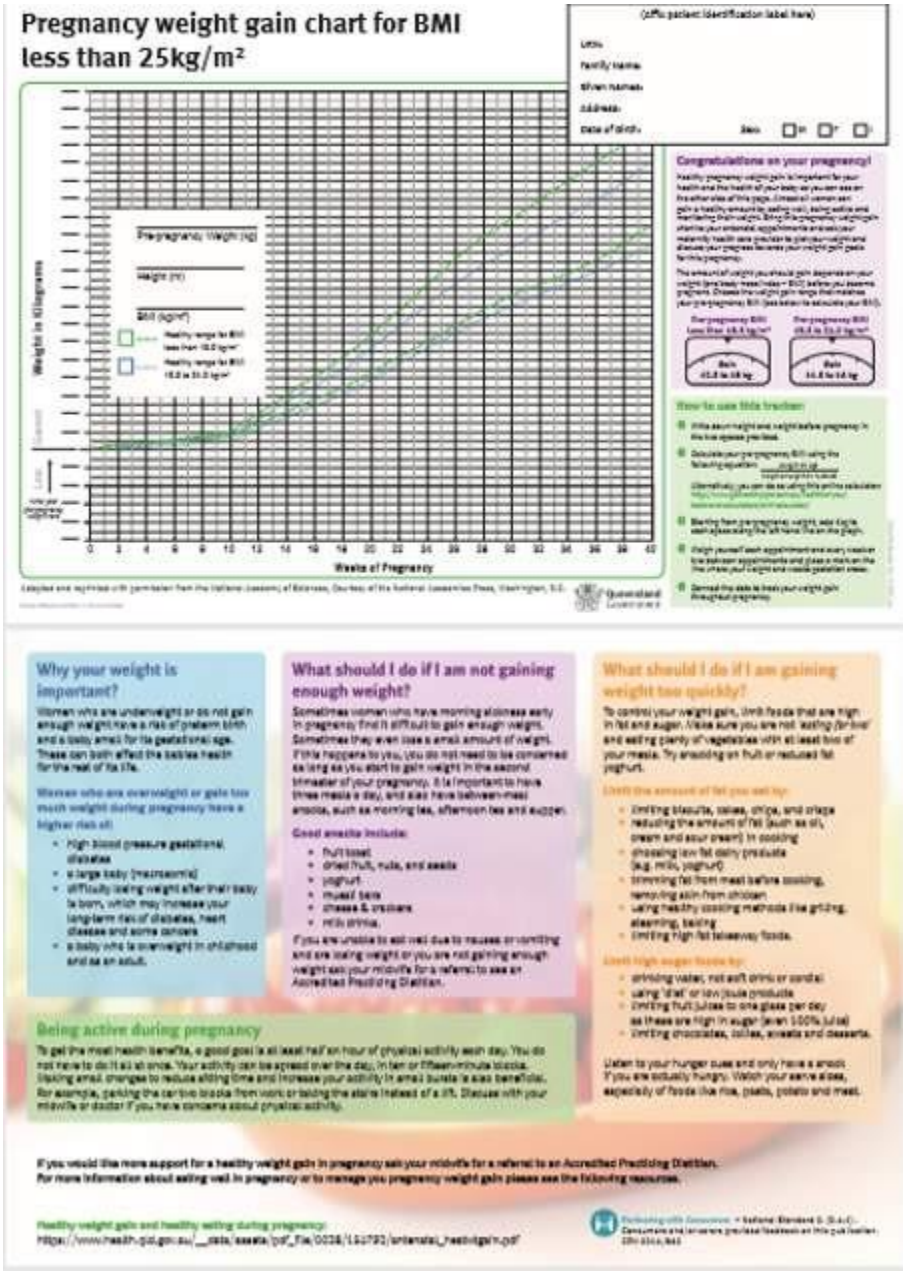
Target Weight Gains

*Calculations assume a 0.5–2kg weight gain in the first trimester for single babies. Refer to dietitian if multiple pregnancies, as different goals required. Dietary and physical activity requirements discussed (refer to page b2). Refer to Queensland Clinical Guideline: *Obesity in pregnancy* for further information.	Pre-pregnancy BMI (kg/m^2)	Rate of gain 2nd and 3rd trimester (kg/week)*	Recommended total gain range (kg)
	Less than 18.5	0.45	12.5 to 18
	18.5 to 24.9	0.45	11.5 to 16
	25.0 to 29.9	0.28	7 to 11.5
	≥30.0	0.22	5 to 9

It is recommended that all women are weighed each visit.

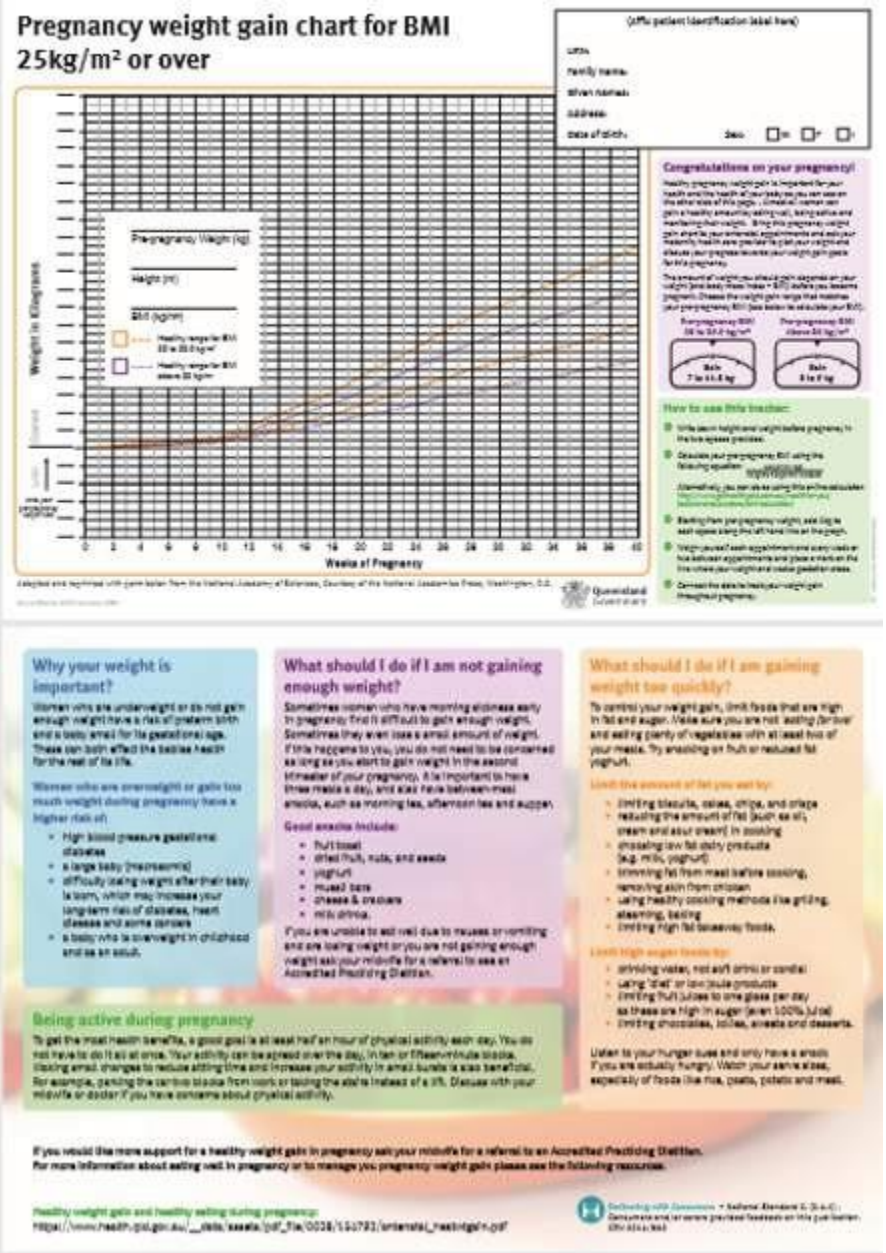
Advise women of their target weight gain (see page 6 PHR) or use a weigh tracker.

- Weight Tracker for BMI
- Electronic Pregnancy Weight Gain Tracker



Pregnancy weight gain chart for BMI less than 25kg/m

Available to download [BMI <25 Kg/m²]



Available to download [BMI>25kg/m²]

Practice points

GPs are advised to make clear in the referral if Dietitian review is considered likely in the pregnancy.

Early referral will assist in ensure the Dietitian in Antenatal Clinic is involved in a timely manner.

Consider in:

- Women with BMI > 40
- Women with BMI < 18
- Women who are Vegans
- Women with previous weight loss surgery, multiple allergies, nutrition related co-morbidity e.g. Coeliac disease, Colitis, iron deficiency
- Some women may be directed to services external to the hospitals for further healthy eating support, e.g. Good Start Program – works with Maori and Pasifika families (in pregnancy, and early childhood period) to build knowledge , skills and confidence in healthy eating and lifestyle practices.

https://www.childrens.health.qld.gov.au/service-good-start/

Get Healthy Queensland: Get Healthy in Pregnancy

Free confidential information and/or telephone coaching service for all pregnant women in QLD.

Your Free ea h Coach!

Get Started

Or Call

13 ALTH
13 432 84

onday • Friday | **8am-8pm**

Your health coach could help you to:

- Eat healthily
- Get active
- Gain or maintain a healthy amount of weight during your pregnancy
- Not drink alcohol during your pregnancy
- Return to your pre-pregnancy weight.

What's included?

- Your own personal health coach throughout your pregnancy and in the early postnatal months
- 10 confidential coaching calls over six months - all at a time and day that suits you
- Option to re-enrol for coaching or get six months of SMS based coaching for FREE
- www.gethealthyqld.com.au/program/get-healthy-in-pregnancy

Obesity is a known risk factor for multiple complications in pregnancy such as, and not limited to, maternal complications of GDM, PET and fetal complications such as IUGR, preterm birth and stillbirth.

What additional tests would be indicated for women with a BMI >30 (as per state-wide guidelines)? (tick more than one)

- [ ] E/LFTs
- [ ] Treponemal antibodies
- [ ] Hep B and Hep C Serology
- [ ] Iron Studies
- [ ] Early GDM screening (Hb A1c or OGTT)
- [ ] Urine protein/creatinine ratio

SUBMIT

Pregnancy - high blood pressure

Quick Links

- Types of hypertension in pregnancy
- Treatment of pre-eclampsia
- Eclampsia

Pregnancy—high blood pressure

Types of hypertension in pregnancy

Gestational hypertension—the term used when your blood pressure rises above 140/90 mmHg after 20 weeks of pregnancy, but was normal before this time. It does not produce any other symptoms and usually returns to normal soon after the birth of your baby.

Pre-eclampsia—refers to a more complex and severe medical condition of pregnancy involving high blood pressure and usually protein in the urine. You may never have had high blood pressure at all before this pregnancy. This is discussed in greater detail below.

Chronic hypertension—the term used when you have high blood pressure before and during your pregnancy. This continues after the birth of your baby.

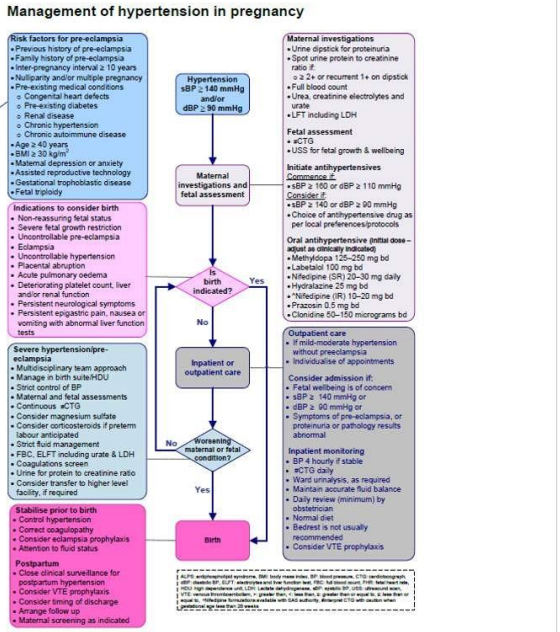
Treatment for hypertension

Gestational and chronic hypertension can be treated with medication to lower your blood pressure, although this is not always required. Several medications have been used safely in pregnancy for many years; sometimes it is necessary to take more than one type of medication to control your blood pressure.

Queensland Clinical Guidelines – Hypertension in Pregnancy Guidelines – February 2021

Risk factors for pre-eclampsia

- Previous history of pre-eclampsia
- Family history of pre-eclampsia
- Inter-pregnancy interval ≥ 10 years
- Nulliparity and/or multiple pregnancy
- Pre-existing medical conditions
  - Congenital heart defects
  - Pre-existing diabetes
  - Renal disease
  - Chronic hypertension
  - Chronic autoimmune disease
- Age ≥ 40 years
- BMI ≥ 30 kg/m^2
- Maternal depression or anxiety
- Assisted reproductive technology
- Gestational trophoblastic disease
- Fetal triploidy



Pre-eclampsia

Pre-eclampsia (PE) is the most common serious medical disorder of human pregnancy. It is most common in primiparous women. Family and personal history of pre-eclampsia is

important.

Signs and symptoms include:

- Hypertension
- Renal dysfunction
- Proteinuria
- Oedema - hands, feet, face
- In severe cases dizziness, headaches and visual disturbances

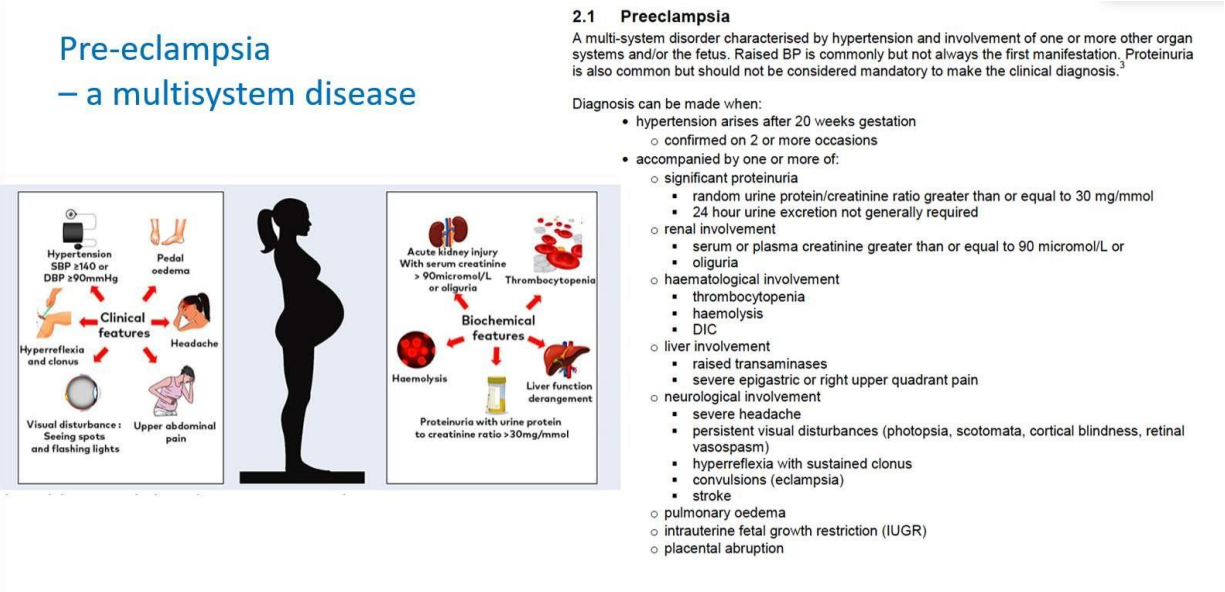
Untreated, it can lead to convulsions and other life-threatening problems for both mother and baby. Pre-eclampsia only occurs when a woman is pregnant, and currently, the only cure for it is to end the pregnancy, even if the baby is premature.

In Australia

- Mild pre-eclampsia occurs in 5-10% of pregnancies
- Severe pre-eclampsia in 1-2% of pregnancies
- Pre-eclampsia and complications associated with this condition account for 15% of direct maternal mortality and 10% of perinatal mortality
- Pre-eclampsia is the indication for 20% of labour inductions and 15% of Caesarean sections.
- It accounts for 5-10% of preterm deliveries.

Worldwide, pre-eclampsia and its complications kill many tens of thousands of women and their babies each year.

Source: The Women's Hospital



Prophylactic aspirin use in pregnancy to reduce PE and IUGR

High Risk Factors - Women with any of the following	Moderate Risk Factors - Women with more than one of the following:
• Hypertension • Renal disease • Auto-immune diseases such as SLE or anti-phospholipid syndrome • Diabetes (Type 1 or Type 2) • Past history of pre-eclampsia	• Primiparous • BMI > 35 • Age > 40 • Multiple pregnancy • Family history of pre-eclampsia (mother or sister) • More than 10 years since last pregnancy

150 mg aspirin nocte

BEFORE 16 weeks gestation

Ideally from 12 weeks until birth

Calcium has been shown to reduce BP, relax smooth muscle, lower resistance in uterine and umbilical arteries. If a woman has deficient intake, 1.5g/day is recommended.

A woman presents with an asymptomatic change to her BP reading at an Antenatal visit. Her booking BP was 115/70 mm/Hg. Which BP level would initiate an urgent referral for obstetric review? (select one or more)

- [ ] BP ≥ 140/90
- [ ] BP 130/90
- [ ] BP 110/65
- [ ] BP ≥ 145/85

SUBMIT

Pre-eclampsia is: (select one or more)

- [ ] A singular system hypertensive disorder
- [ ] A multi system disorder

- [ ] More prevalent in women with chronic hypertension
- [ ] Evident as severe PET in 1-2% of pregnancies
- [ ] Not always represented by hypertension

SUBMIT

Risk factors for PET are: (select one or more)

- [ ] Nulliparity (father specific)
- [ ] Age > 35 years
- [ ] BP at booking > 130/80
- [ ] Family History
- [ ] 10 years since last pregnancy

- [ ] BMI > 35 at booking
- [ ] Medical history of chronic hypertension, diabetes, renal disease, SLE, previous PET
- [ ] Multiple pregnancy

SUBMIT

Aspirin 150mg nocte should be commenced for women before 16 weeks gestation with chronic hypertension.

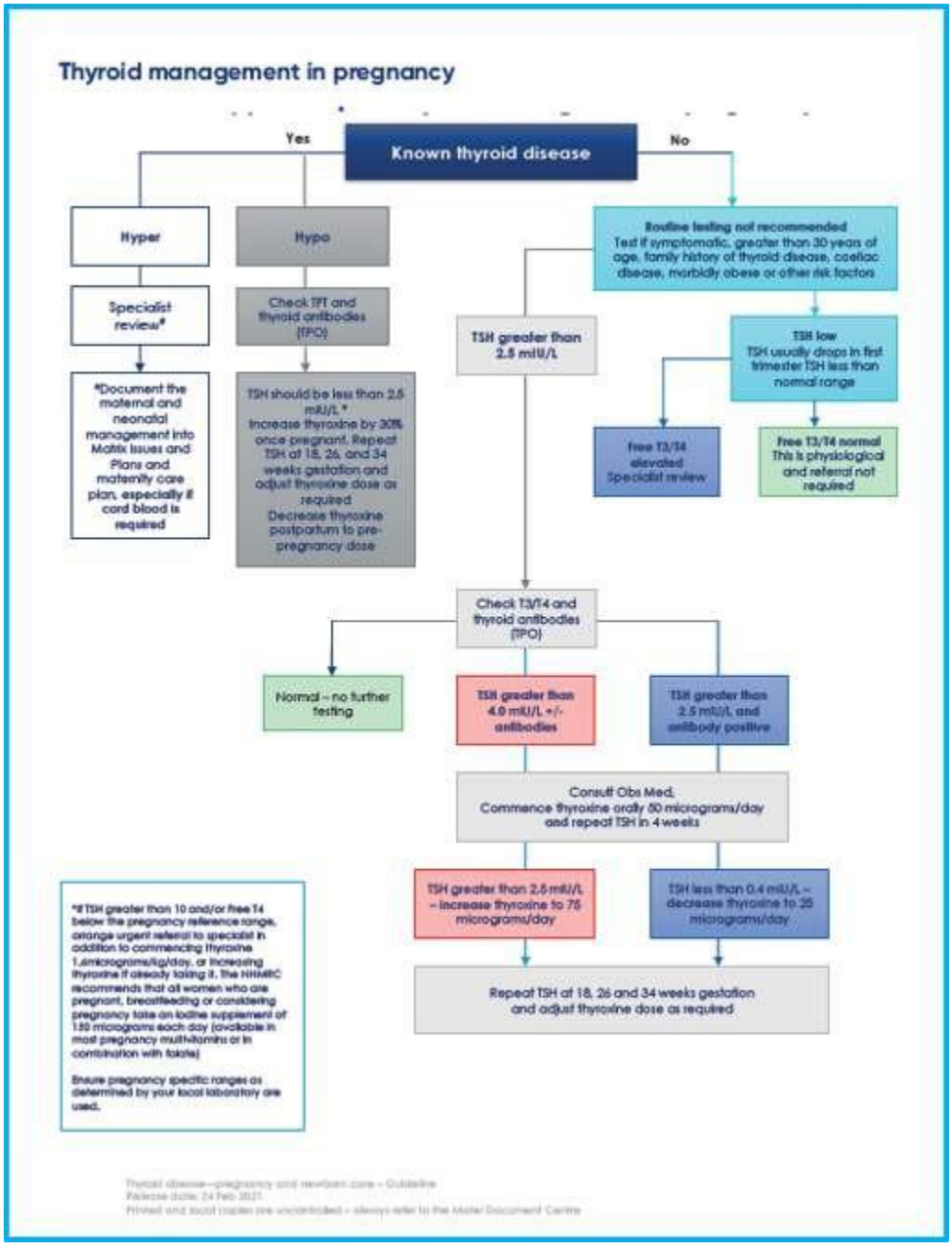
- ( ) True
- ( ) False

SUBMIT

Hypothyroidism

Overt hypothyroidism:

- Increase thyroxine dose by 30% at conception (**= extra 2 doses/week**) - Thyroxine dose requirements increase in pregnancy
- TSH >10? Commence thyroxine & refer urgently
- Measure TSH at first visit; 6/52 later; then end 2nd and 3rd trimester if normal
- Reduce back to preconception dose postpartum
- Aiming for TSH < 2.5 first trimester, < 3 second trimester, < 3.5 third trimester
- 24 % of Australian women are positive for thyroid antibodies
- Studies regarding treatment of euthyroid anti-TPO antibody women with thyroxine are inconclusive with respect to reduction in miscarriage and adverse pregnancy outcomes – **so don't routinely test!**



[PDF available for downloading at Brisbane South PHN or page 30 of the Mater Mothers' GP Maternity Shared CareGuideline]

Thyroid tips

- Don’t routinely test for TFT in pregnancy in low risk women!
- Most common cause suppressed TSH in first trimester is hCG mediated hyperthyroidism ~ 10% women
- Occasionally Free T4 and Free T3 mildly elevated
- Differentiate from Grave’s disease by presence TSH receptor antibody and increased colour flow Doppler sonography on US
- Don’t treat – will resolve in 2nd trimester
- RANZCOG Statement

Debate Continues Over Universal Thyroid Screening in !Pregnancy

Kl'f$tln J nkrns

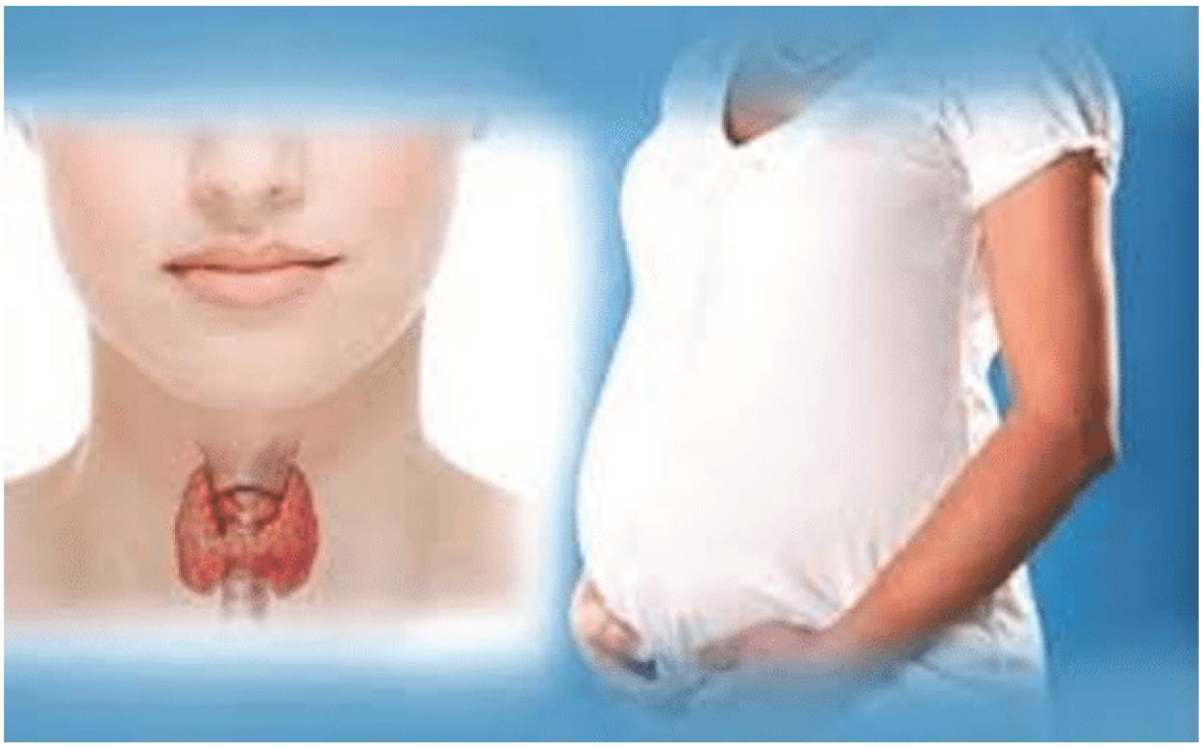
Novt'MIX!r 06 , 2018

Although universal thyroid screening in early pregnancy holds promise for improving fetal and maternal outcomes, achieving consensus on its merits is unlikely without more controlled trials to address •areas of uncertainty;• experts say.

Results from a literature review on the risks and benefits of universal thyroid screening during pregnancy confirm that there is a lack of high-quality evidence for screening and management of asymptomatic borderline abnormalities that make up the bulk of thyroid dysfunction cases seen in pregnancy.

"A universal screening strategy is likely to predominantly identify women with subclinical thyroid disease for whom the benefits of systematic screening and correction remain controversial," write Peter N. Taylor, MBChB, of the Thyroid Research Group, Systems Immunity Research Institute, Cardiff University School of Medicine, Wales, United Kingdom, and colleagues.

Their findings were published online on October 25 in *Frontiers in Endocrinology.*



ADAPT Clinic - Alcohol and Drug Awareness in Pregnancy Team

ADAPT is a midwife clinic (Thursdays) offering specialised support for pregnant women with substance use & psychosocial issues. Women see the same midwife at every appointment & are offered flexibility in times +/- phone appointments.

Illicit drug use has high association with mental health issues, and many substance using women are polysubstance users. Coexisting mental health disorders may contribute to substance use or the effects of substance use in pregnancy and include anxiety, schizophrenia, PTSD, BPD, and personality disorders. Perinatal Substance Use: Maternal – Queensland Clinical Guidelines

Later pregnancy recognition & 50% unintended pregnancies increases risks/harmful effects of substance use.

Refer as per usual pathways, but please identify in the referral as much information as you have available to assist in suitable triage to dedicated services:

- EDC (by USS determined dates if possible)
- Substance used (as specific as can), amount and frequency
- Consent to referral
- Brief History of past + DV, Child Protection Service/ Dept of Child Safety history, if known
- STI Screen , Cervical Screening Test result, Screening for blood borne viruses

If non-attendance, & information re substance use included in referral, ADAPT Midwife will courtesy call, and follow up.

Purpose of ADAPT Clinic

- Retain attendance of women who use illicit substances or alcohol during pregnancy to antenatal appointments.

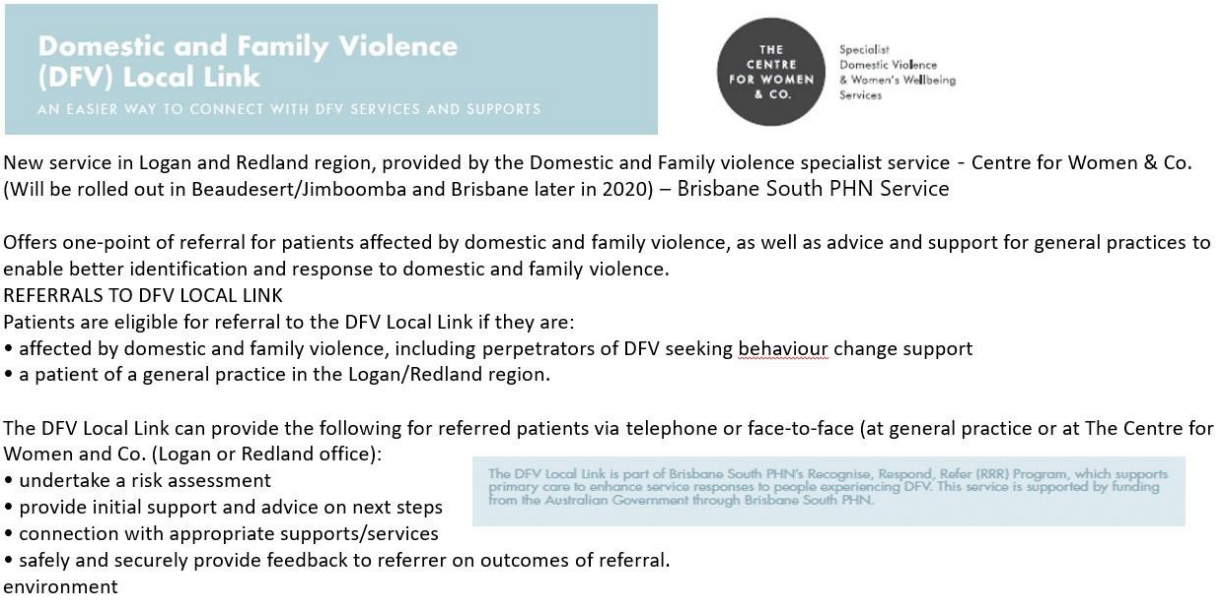
- Provide care with known carer & care planning within same multidisciplinary team, in a non-judgemental environment, to build a trusted relationship, in a positive environment supporting the individual woman's needs.
- Promoting engagement in a partnership with support services that aim to improve outcomes for mother and infant.
- Minimise harm by undertaking a comprehensive assessment and recommendations for care around continued substance use & associated risks for mother and infant.
- Planning for a safe birth, care planning for medication requirements, and reducing risks of presentation with acute maternal withdrawal and fetal distress, and/or effects of substance abuse.
- Consider comorbidities and necessary referrals for further management e.g. STI management, postnatal Hepatitis C treatment.
- Include internal and external support networks as appropriate – GP, Community-based Addiction (Alcohol and Drug) Service, Quitline, Social Worker, Complex Care Midwifery Navigator, Dietitian, Women's Legal Service, Family and Child Connect.

Discharge planning from 32-34 weeks

- Breastfeeding support and education – risks and benefits.
- Work in collaboration with the internal multi-disciplinary team, including Neonatology & Special Care Nursery teams for individualised care planning and building relationships to grow trust and rapport. Tour of SCN for parents if likely to be needed
- Assist in building relationships with external alcohol and drug services for postnatal support.
- Liaise with GP, MH Team, right@home (Children's Health Queensland), Community Midwifery Service - Extended Home Visiting Service for ongoing individualised family follow up and support.
- Woman provided with information and educational resources about "Neonatal Abstinence Syndrome" (NAS) including the effects of prescribed medications e.g. SSRI's,

symptom duration (Sub-acute withdrawal" can last 4-6 months), assessment – Finnegan scoring, and the and ongoing risks of polysubstance use on maternal health and infant health.

Domestic and Family Violence (DFV) Local Link



General Practice DFV Support and Advice

The DFV Local Link can also provide the following to general practice staff by telephone or practice visits:

- confidential advice on managing patients affected by DFV
- information sessions on the role of primary care in responding to DFV
- connection to RACGP accredited DFV training opportunities
- support to implement practice-level measures to enable safe and supportive responses to DFV in the general practice

DFV Local Link service is for General Practices only, but midwives/other medical staff can contact the DFV services directly on the contact information provided.

Secure referral via "The Centre for Women & Co." on Medical Objects or via links on BSPHN - Domestic and Family Violence webpage

Available : Mon|Tue|Wed|Fri -9.00am - 4.00pm, Thurs 1.30pm - 4.00pm

Closed Saturday, Sunday and Public Holidays

For referrals or practice support contact:

For secure referrals please find The Centre for Women & Co. on Medical Objects.

Grace Tuaoi

DFV Local Link Coordinator, Redlands on **0482 811980** or **redlandslocallink@centreforwomen.org.au**

Mikaela Martyn

DFV Local Link Coordinator, Logan on **0460 626 502** or **loganlocallink@centreforwomen.org.au**

Beaudesert/Jimboomba service currently operated by Youth and Family Services (YFS) - Phone: 07 3826 1500 Email: beaudesertdfv@yfs.org.au

Summary of routine bloods

- Routine first trimester AN screening = FBC, Blood group and Antibody screen, Ferritin, Rubella, Hep B, Hep C, HIV, Syphilis and Urine M/C/S. (CST if due).

- Women with BMI > 30 to have first trimester HbA1c or early OGTT if K>12, E/LFTs urinary protein/creatinine ratio as well as the above.
- 26-28 week bloods = FBC, Ferritin, OGTT and Blood group and Antibody screen, consider Syphilis Serology at 28 weeks (Logan/Beaudesert).
- 34-36 week bloods = FBC, consider Ferritin (if previously low), consider repeat Syphilis Serology (high risk women).

Summary of Ultrasound Scan Recommendations

- All women should be offered a dating scan in the first trimester, particularly those who have uncertain dates (accurate assessment of gestational age)
- Pregnancy Care Guidelines recommends GPs should provide information and offer pregnant women who are unsure of their conception date an ultrasound scan between 8 weeks 0 days & 13 weeks 6 days to determine gestational age, detect multiple pregnancies and accurately time fetal anomaly screening (Grade B evidence).
- Women with bleeding should be offered a viability scan
- All women should be offered the following scans in pregnancy:
  - Nuchal Translucency Scan (between 11 & 13 +6 weeks gestation) in combination with B HCG and PAPP-A (Combined First Trimester Screen)
  - Morphology Scan (between 18-20 weeks)
- Women may, of course, decline to have any or all of these scans
- Women who, after counselling, chose to undertake NIPT, should still undergo Nuchal translucency scan, but the associated biochemistry provides a less sensitive indicator of trisomy risk than the more accurate NIPT result.
- Assessment of foetal growth and well-being by USS in the third trimester should be considered if fundal height is 3cm above or below expected for gestational age (or difficult to monitor because of maternal BMI). Consider assessment of amniotic fluid volume (deepest vertical pocket) & Doppler umbilical artery flow measurements.

Eligibility

Medicare Requirements

- Eligibility for Obstetric USS has changed - Medicare Rules for rebates changed (June 2020) recognising that all pregnancies are at risk of fetal anomaly & miscarriage.
- If ordered by a GP, a Medicare rebate is payable for an ultrasound of the pelvis related to pregnancy or a complication thereof, for a gestational age of **less than 16 weeks** (as determined by ultrasound).
- GP's limited to one pregnancy ultrasound request for services performed from 17 to 22 weeks gestation + one request for scans performed on patients > 22 weeks gestation.

- To attract a Medicare rebate any additional scan beyond 22 weeks must be referred by a DRANZCOG holder or RANZCOG Fellows/Member (as clinically indicated).

Which of the following are the correct routine tests in pregnancy? (tick more than one)

- [ ] FBC, Blood Group and Antibody screen, Ferritin, Hep B and C, Syphilis serology, HIV, Rubella serology, Urine M/C/S
- [ ] FBC, Blood Group and Antibody screen, Ferritin, Hep B and C, Syphilis Serology, HIV, Rubella, Urine M/C/S, HbA1c if at risk for GDM
- [ ] FBC, Blood Group and Antibody screen, Ferritin, Hep B and C, Syphilis Serology, HIV, Rubella, Urine M/C/S, E/LFTs, HbA1c and urine creatinine/protein ratio if BMI > 30
- [ ] Syphilis serology at booking, and consider at 28 weeks and at 36 weeks and postnatally (dependent on local policy)
- [ ] OGTT at 26-28 weeks
- [ ] FBC and consider Ferritin at 34-36/40

- [ ] Blood Group and Antibody Screen, Ferritin and OGTT at 26-28 weeks gestation
- [ ] OGCT at 26-28 weeks

SUBMIT

Which women should be offered a NT screening test/Combined First TM screen?

- ( ) All women regardless of age, history and ethnicity
- ( ) Only women over the age of 35 years old

SUBMIT

At what gestation is Combined First Trimester Screening undertaken?

- ◯ 11 to 13+6 weeks gestation
- ◯ Over 18 weeks gestation
- ◯ Any gestation

SUBMIT

A woman can have both the NT screen and NIPT with advice that the biochemistry for the NT is less sensitive than the NIPT in predicting risk of fetal anomaly.

- ◯ True
- ◯ False

SUBMIT

21. Pregnancy checklist

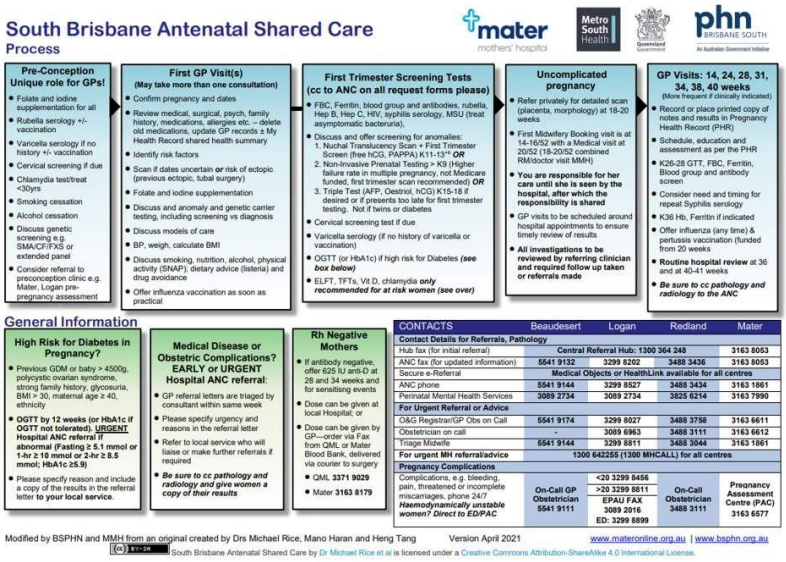
☐	Decide on where and how you wish to have your child—do you wish to be looked after privately or publicly? Do you wish to be looked after by a midwife, general practitioner (GP) or obstetrician?
☐	Screening for depression during and after pregnancy is recommended for all women. Depression is a common, significant complication both during pregnancy and after baby is born. ☐ Do you feel safe at home and work?
☐	When was your last Cervical Screening Test or Pap Smear? It is recommended that it is up to date.
☐	The following tests are recommended: Full Blood Count; Blood Group and antibodies; Rubella immunity, Hepatitis B, Hepatitis C, HIV and Syphilis serology and a urine test for kidney disease and infections. If you have a high risk of diabetes, you are advised to have a first trimester glucose tolerance test or HbA1c.
☐	Chicken Pox, thyroid, chlamydia, iron stores or vitamin D levels may be recommended, depending upon **your** history.
☐	Supplements of folic acid and iodine are recommended.
☐	Reliable information on safe use of drugs and alcohol, diet, exercise and lifestyle activities in pregnancy can be found on www.matermothers.org.au/journey, www.pregnancybirthbaby.org.au, www.raisingchildren.net.au/pregnancy
☐	Smoking during pregnancy is associated with significant health problems and if you are a smoker, we would like to work with you to help you to stop during this pregnancy. www.quitnow.gov.au
☐	It is recommended that alcohol be stopped as it is known to cause problems for you and/or your baby. If you are having difficulty stopping, we would like to work with you to help you to stop drinking alcohol.
☐	It is recommended that you have a free* influenza vaccine from your GP as soon as they are available. They can be safely given at any time in your pregnancy.
☐	If you are not sure when you fell pregnant, a scan is recommended to confirm how many weeks pregnant you are.
☐	There is a blood test (B HCG and PAPPA-A) and an ultrasound test (the Nuchal translucency scan) that can be done between 11 and 13 weeks of pregnancy. This test assists to determine your chance of having a child with genetic conditions including Down Syndrome, as well as confirming how many weeks pregnant you are and baby's anatomy.
☐	The noninvasive prenatal test (NIPT, cost ~ $400) gives information about a limited range of chromosomal abnormalities, including Down Syndrome and there are tests for chromosomal conditions including cystic fibrosis, spinal muscular atrophy and fragile X syndrome (~$400 for these 3 tests). These blood tests do not have any Medicare funding.
☐	An ultrasound test, the morphology scan, is recommended and usually done between 18 and 20 weeks of pregnancy to check on the position of the placenta, anatomy and development of the baby.
☐	It is recommended that you have a visit with your midwife or doctor to follow up the results of any blood tests or ultrasound scans as soon as practical after the test. Don't just assume everything is OK if you have not been contacted.
☐	If you have a Rhesus negative blood group, it is recommended that you have an injection, commonly called AntiD, if you have vaginal bleeding during pregnancy and routinely at 28 and 34 weeks. If you have any vaginal bleeding, it's very important that you let us know as soon as possible. Most Rh-negative women who bleed in pregnancy will require an injection within 72 hours of the bleeding starting. This significantly reduces the risk of you developing antibodies which could harm your baby.
☐	It is recommended that you have a free* whooping cough booster from 20 weeks' gestation in each and every pregnancy, even if the pregnancies are less than two years apart.
☐	At 26-28 weeks of pregnancy, your blood count and blood group antibodies are checked again and a glucose tolerance test is recommended, unless it is already known that you have diabetes.
☐	Visits are generally recommended every four weeks from week 12 until 28 weeks, every three weeks until 34 weeks and every two weeks until 40 weeks, with follow up at 41 weeks if you have not yet had your baby. If you have special needs or other health concerns, you may be asked to come in more often or you can choose to be seen more often.
☐	A blood test for anaemia is recommended at 36 weeks of pregnancy.
☐	If you choose to have Shared Antenatal Care with your GP, you will usually be seen at the hospital for a booking in appointment at 16-20 weeks (earlier if you are at higher risk) and 36 weeks.
	How do you plan to feed your baby?

*There may be a fee to see your GP | Dr Wendy Burton | Creative Commons License | February 2020

PREGNANCY CHECKLIST

Available from page 51 of the Mater Mothers' GP Shared Care Guideline

South Brisbane Antenatal Share Care Summary – April 2021



South Brisbane Antenatal Shared Care Process

Pre-Conception Unique role for GPs!
- Folate and iodine supplementation for all
- Rubella serology +/- vaccination
- Varicella serology if no history +/- vaccination
- Cervical screening if due
- Chlamydia test/treat <30yrs
- Smoking cessation
- Alcohol cessation
- Discuss genetic screening e.g. SMA/CF/FXS or extended panel
- Consider referral to preconception clinic e.g. Mater, Logan pre-pregnancy assessment

First GP Visit(s) (May take more than one consultation)
- Confirm pregnancy and dates
- Review medical, surgical, psych, family history, medications, allergies etc. – delete old medications, update GP records ± My Health Record shared health summary
- Identify risk factors
- Scan if dates uncertain *or* risk of ectopic (previous ectopic, tubal surgery)
- Folate and iodine supplementation
- Discuss and anomaly and genetic carrier testing, including screening vs diagnosis
- Discuss models of care
- BP, weigh, calculate BMI
- Discuss smoking, nutrition, alcohol, physical activity (SNAP), dietary advice (listeria) and drug avoidance
- Offer influenza vaccination as soon as practical

First Trimester Screening Tests (cc to ANC on all request forms please)
- FBC, Ferritin, blood group and antibodies, rubella, Hep B, Hep C, HIV, syphilis serology, MSU (treat asymptomatic bacteriuria),
- Discuss and offer screening for anomalies:
  1. Nuchal Translucency Scan + First Trimester Screen (free hCG, PAPPA) K11-13+6 ***OR***
  2. Non-Invasive Prenatal Testing > K9 (Higher failure rate in multiple pregnancy, not Medicare funded, first trimester scan recommended) ***OR***
  3. Triple Test (AFP, Oestriol, hCG) K15-18 if desired or if presents too late for first trimester testing. Not if twins or diabetes
- Cervical screening test if due
- Varicella serology (if no history of varicella or vaccination)
- OGTT (or HbA1c) if high risk for Diabetes ***(see box below)***
- ELFT, TFTs, Vit D, chlamydia ***only recommended for at risk women (see over)***

Uncomplicated pregnancy
- Refer privately for detailed scan (placenta, morphology) at 18-20 weeks
- First Midwifery Booking visit is at 14-16/52 with a Medical visit at 20/52 (18-20/52 combined RM/doctor visit MMH)
- **You are responsible for her care until she is seen by the hospital, after which the responsibility is shared**
- GP visits to be scheduled around hospital appointments to ensure timely review of results
- **All investigations to be reviewed by referring clinician and required follow up taken or referrals made**

GP Visits: 14, 24, 28, 31, 34, 38, 40 weeks (More frequent if clinically indicated)
- Record or place printed copy of notes and results in Pregnancy Health Record (PHR)
- Schedule, education and assessment as per the PHR
- K26-28 GTT, FBC, Ferritin, Blood group and antibody screen
- Consider need and timing for repeat Syphilis serology
- K36 Hb, Ferritin if indicated
- Offer influenza (any time) & pertussis vaccination (funded from 20 weeks
- **Routine hospital review** at 36 and at 40-41 weeks
- ***Be sure to cc pathology and radiology to the ANC***

General Information

High Risk for Diabetes in Pregnancy?
- Previous GDM or baby > 4500g, polycystic ovarian syndrome, strong family history, glycosuria, BMI > 30, maternal age ≥ 40, ethnicity
- **OGTT by 12 weeks (or HbA1c if OGTT not tolerated). URGENT Hospital ANC referral if abnormal (Fasting ≥ 5.1 mmol or 1-hr ≥ 10 mmol or 2-hr ≥ 8.5 mmol; HbA1c ≥5.9)**
- Please specify reason and include a copy of the results in the referral letter **to your local service**.

Medical Disease or Obstetric Complications? EARLY or URGENT Hospital ANC referral:
- GP referral letters are triaged by consultant within same week
- Please specify urgency and reasons in the referral letter
- Refer to local service who will liaise or make further referrals if required
- ***Be sure to cc pathology and radiology and give women a copy of their results***

Rh Negative Mothers
- If antibody negative, offer 625 IU anti-D at 28 and 34 weeks and for sensitising events
- Dose can be given at local Hospital; or
- Dose can be given by GP—order via Fax from QML or Mater Blood Bank, delivered via courier to surgery
- QML **3371 9029**
- Mater **3163 8179**

CONTACTS	Beaudesert	Logan	Redland	Mater
Contact Details for Referrals, Pathology				
Hub fax (for initial referral)	**Central Referral Hub: 1300 364 248**			**3163 8053**
ANC fax (for updated information)	**5541 9132**	**3299 8202**	**3488 3436**	**3163 8053**
Secure e-Referral	**Medical Objects or HealthLink available for all centres**			
ANC phone	**5541 9144**	**3299 8527**	**3488 3434**	**3163 1861**
Perinatal Mental Health Services	**3089 2734**	**3089 2734**	**3825 6214**	**3163 7990**
For Urgent Referral or Advice				
O&G Registrar/GP Obs on Call	**5541 9174**	**3299 8027**	**3488 3758**	**3163 6611**
Obstetrician on call	-	**3089 6963**	**3488 3111**	**3163 6612**
Triage Midwife	**5541 9144**	**3299 8811**	**3488 3044**	**3163 1861**
For urgent MH referral/advice	**1300 642255 (1300 MHCALL) for all centres**			
Pregnancy Complications				
Complications, e.g. bleeding, pain, threatened or incomplete miscarriages, phone 24/7 ***Haemodynamically unstable women? Direct to ED/PAC***	**On-Call GP Obstetrician 5541 9111**	**<20 3299 8456** **>20 3299 8811** **EPAU FAX 3089 2016** **ED: 3299 8899**	**On-Call Obstetrician 3488 3111**	**Pregnancy Assessment Centre (PAC) 3163 6577**

Modified by BSPHN and MMH from an original created by Drs Michael Rice, Mano Haran and Heng Tang Version April 2021 www.materonline.org.au | www.bsphn.org.au

Available at Metro South Health – "Refer Your Patient" and the BSPHN "Maternity Shared Care" webpage

South Brisbane Antenatal Shared Care Summary

To apply the best practice share care models in antenatal and postnatal care, we all need to be:

Clinically competent

Up to date

Following the guidelines

Thinking

Communicating

CONTINUE

Who can you call?

If you uncertain about the best approach to take in caring for or referring a woman, phone the:

- On-call Obstetrician
- Registrar
- Dedicated MATERNITY GP Liaison Midwife Manager /GPLO - GP
    - GPLO Midwife Manager
    - GPLO General Practitioner - Maternity

Primary Care Partnerships Unit | Metro South Health

2404 Logan Road Eight Mile Plains

PHONE: 07 3156 4336

EMAIL: GPLO_Maternity_Share_Care@health.qld.gov.au

If she requires **urgent review**, call the On-call Obstetrician / Registrar (or Maternity Assessment Unit at Logan Hospital)

Who can you call at Logan Hospital?

- Antenatal Clinic Reception (8 am- 4 pm Mon to Fri) Telephone: 3299 8527 Fax: 3299 8202
- Triage Midwife Telephone: 3299 8811
- Women's, Men's and Pelvic Health Physiotherapy Logan and Beaudesert Hospitals - Telephone: 3299 8858 Fax: 3299 8280
- O&G Registrar – Telephone: 3089 6963 or via Switchboard
- Obstetrician on Call – Telephone: 3299 8027 or via Switchboard
- Early Pregnancy Assessment Unit (K<20): Telephone: 3299 8456
- Maternity Assessment Clinic (Complications K>20): Telephone: 3299 8811
- Postnatal Community Midwifery Service: Telephone: 07 3089 2814

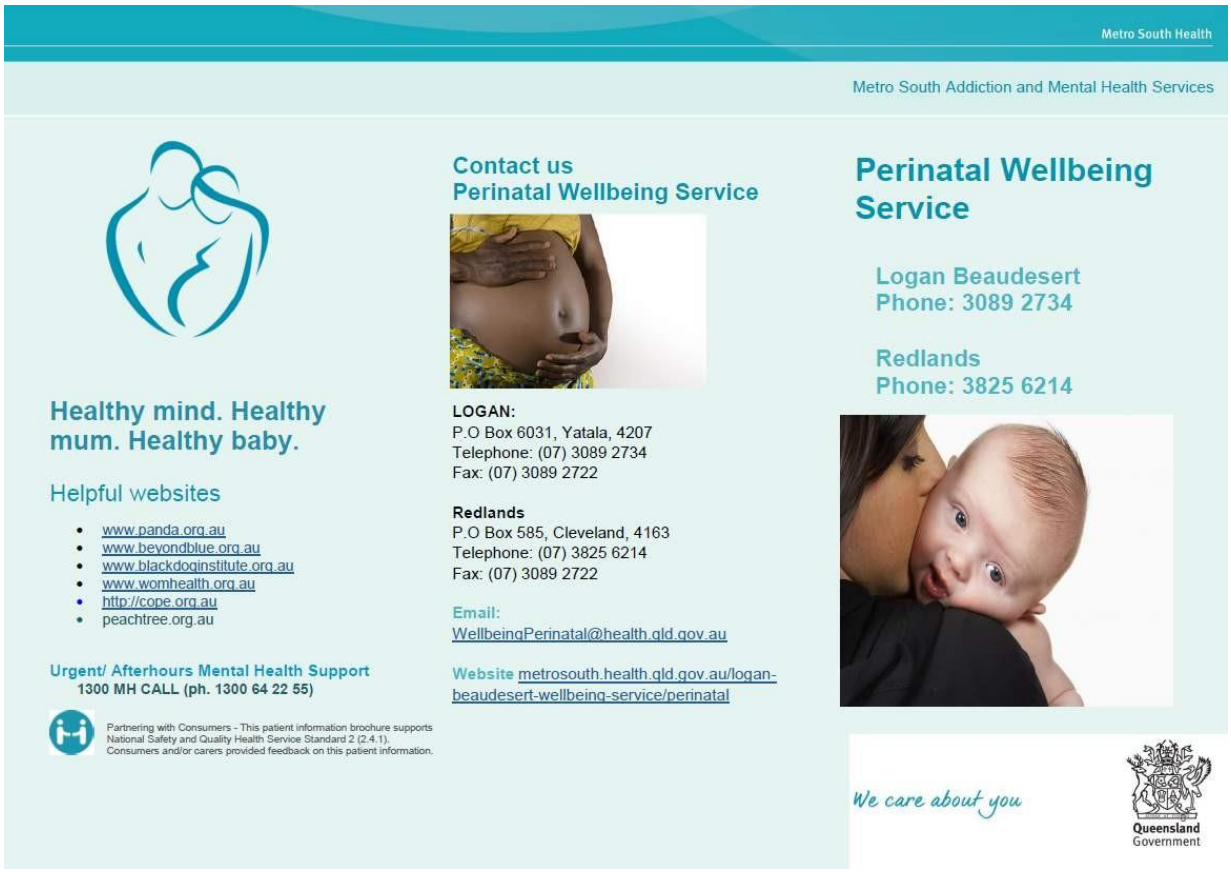
Who can you call at Redland Hospital?

- Antenatal Clinic Reception (8 am- 4 pm Mon to Fri) Telephone: 3488 3434 Fax: 3488 3436
- Karragarra ward (maternity inpatient ward) Telephone: 3488 3444
- Team Leader Midwife Telephone: 3488 3044
- ACT intake - Telephone: 3825 6000 Fax: 3825 6006
- Physiotherapy & Nutrition and Dietetics – Telephone: 3488 3222 Fax: 3488 3223
- Indigenous Hospital Liaison Oficer at Redlands Hospital - Telephone: 3488 3111

Who can you call at Beaudesert Hospital?

- Antenatal Clinic Reception (8 am- 4 pm Mon to Fri) Telephone: 5541 9144, FAX: 5541 9132

- Triage Midwife Telephone: 5541 9144
- Women's, Men's and Pelvic Health Physiotherapy (Logan and Beaudesert Hospitals) - Telephone: 3299 8858 Fax: 3299 8280
- GP Obstetrician/Rural Generalist on Call – Telephone: 07 5541 9174



Perinatal Wellbeing Service

Perinatal Wellbeing Fact Sheet

Information on this service is available on the Addiction and Mental Health Services "Refer Your Patient" webpage.

Wellbeingperinatal@health.qld.gov.au or fax: 30892722 Ph. (07) 3089 2732 (Logan/ Beaudesert) or (07) 3825 6214 (Redlands)

Perinatal Wellbeing Service

- For women aged ≥18 years who are pregnant or have a baby aged up to 12 months and their families, living in Logan, Beaudesert or Redland suburbs who are having trouble coping.
- Free and friendly services provided by a Nurse Practitioner and a Clinical Nurse Consultant who work closely with GP's, maternity services, child health services and other health staff.
- Offers specialist perinatal assessment & intervention (up to 6 appointments)
- Provide information about perinatal emotional health and wellbeing and illnesses (such as depression and anxiety)
- Provide advice on the treatment of mental illness
- Offer education around coping and managing stressful situations
- Provide counselling, treatment and support (including prescribing)
- Works with women, their family, GP and other services to provide them with support links to community services, non-government services and other specialists.

MSH074

Queensland Government

Metro South Addiction & Mental Health Services

Perinatal Wellbeing Service Referral

Qld Health identification label only

Scan and email form to: WellbeingPerinatal@health.qld.gov.au or fax to (07) 3089 2722

Telephone enquiries: Logan-Beaudesert ph. (07) 3089 2734, Redlands ph. (07) 3825 6214

Patient Family Name: .....
Given Name: .....
Date of Birth: ..... **Country of Birth:** .....

Marital Status: ☐ Single ☐ Defacto ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Religion: .....

Interpreter Required? ☐ Yes ☐ No

If yes, language: .....

Baby's Details (if applicable):
Name: .....
Date of Birth: ..... ☐ **M** ☐ **F**

Indigenous Status:
☐ Aboriginal but not Torres Strait Islander origin
☐ Torres Strait Islander but not Aboriginal origin
☐ Both Torres Strait Islander and Aboriginal origin
☐ Neither Torres Strait Islander nor Aboriginal origin
☐ Not stated or unknown

Address: .....
Phone (home): ..... **Work:** ..... **Mobile:** .....
Email: .....
Has the patient agreed to the referral? ☐ Yes ☐ No
Next of Kin (name): ..... **Relationship:** .....
Contact No.: .....

Referrer's Name: ..... **Designation:** .....
Service: .....
Address: .....
Phone: ..... **Email:** .....
Reason for Referral: .....
.....
.....

Antenatal - EDC: ..... **Postnatal - number of weeks:** .....

Other relevant medical history:
.....
.....
.....

Mental health history:
.....
.....
.....

GP (name): ..... **Phone:** ..... **Fax:** .....
Address: .....
Email: .....
If the GP is not the referrer, are they aware of the referral? ☐ Yes ☐ No

Referrer's signature: ..... **Date of Referral:** .....

Non-urgent, voluntary services over one to six community-based appointments with experienced perinatal mental health nurses while supporting and educating

GPs, midwives, child health nurses and obstetricians to provide evidence based care + Nurse prescriber as required

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Perinatal Wellbeing Referral Form

CONTINUE

Physiotherapy Services

Referrals can be sent via Medical Objects or MSH Smart Referrals to the Central Referral Hub.

Women's, Men's and Pelvic Health Physiotherapy -

Logan and Beaudesert Hospitals

Telephone: 3299 8858

Fax: 3299 8280

- Further enquiries: Melanie Walkenhorst - Clinical Lead Physiotherapist

Redland Hospital - Women and Birthing Physiotherapy Services

Physiotherapy & Nutrition and Dietetics

Telephone: 3488 3222

Fax: 3488 3223

- Further enquiries: Tracey Anderson – Physiotherapist

Outpatients	Inpatients
➢ AN/PN Classes	➢ Maternity ward
➢ AN/PN individual appointments *	➢ Post - Surgical
➢ Pelvic floor dysfunction	
➢ Pelvic health clinic	

* Limited individual appointments available therefore comprehensive referral outlining urgency/impact on ADL's is required to facilitate triage

CONTINUE

Community Midwifery Service

Community Midwifery Service - Extended Program Eligibility Criteria

- Support for vulnerable women and their babies up to twenty-eight days after birth.
- Primarily a service for women who have birthed at Logan/Beaudesert Hospital and reside in Logan or Beaudesert Hospital catchment area.
- Women and neonates who birth at other facilities may access the service at the discretion of the service and depending on service capacity.

- Women in the Redland Catchment will continue to be able to access 2-5 visits up until 7 days post birth
- Women and babies must be medically stable to be eligible for referral.
- Mainstream services should be the first referral point for additional support after birth of a baby (for example child health).

Eligibility criteria

Women and/or neonates who require additional support, that they are unable to access via mainstream services. This support may include:

- Complex feeding Support.
- Psycho-social support.
- Birth counselling/debriefing
- Jaundice reviews
- Wound reviews
- Newborn checks and weight review
- Safe Relationship Education/Review

Ineligibility criteria

- Women being cared for under Midwifery Group Practice or Private Practice Midwife - continue under MGP postnatally.
- Acutely unwell post-natal women and neonates.
- Women who do not meet safety risk screening criteria for home visits.
- Out of Logan/Beaudesert Hospital Home visiting catchment area

How to refer

- Referrals will be triaged within 24 hours of receipt.
- Referral can be made via the Central Referral Hub (clearly stating referral is for CMS) by sending a standard letter of referral.
- Logan Hospital Community Midwifery Service can be contacted on- 07 3089 2814 from 8am to 3pm seven days a week or via email at cms_ep@health.qld.gov.au.
- Beaudesert Midwifery Services contact: 07 5541 9144
- The team are available to assist General Practitioners with information on referral to the service or mainstream services that are available to families and provide ongoing collaborative care.
- Midwifery staff will liaise with the primary GP for any ongoing management plans.

Southern suburbs

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Beaudesert Mt Ommaney Springwood Wynnum	Acacia Ridge Coorparoo Cleveland Logan Central	Beenleigh Coorparoo Hillcrest Wynnum	Inala Jimboomba Mt Gravatt East Springwood	Cleveland Hillcrest Logan Central

Additional services for families

Community Child Health Drop-in Clinics

CONTINUE

Postnatal item numbers

16407

Postnatal professional attendance (other than a service to which any other item applies) if the attendance:

- (a)is by an obstetrician or general practitioner; and
- (b) is in hospital or at consulting rooms; and
- (c)is between 4 and 8 weeks after the birth; and
- (d) lasts at least 20 minutes; and
- (e)includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and
- (f)is for a pregnancy in relation to which a service to which item 82140 applies is not provided (participating RM)

Payable once only for a pregnancy

Fee: $71.70 **Benefit**: 75% = $53.80 85% = $60.95

16408

Home visit for woman who was admitted privately for the birth. Midwife (on behalf of and under the supervision of the medical practitioner who attended the birth) Obstetrician or GP can claim. 1-4 weeks post partum, at least 20 min duration

Fee: $53.40 **Benefit**: 85% = $45.40

More resources and links to view the most recent Alignment events at Logan/Beaudesert and Redland Hospitals can be found on the BSPHN Website at https://bsphn.org.au/support/for-your-practice/maternity-shared-care/

Important Referral information will also be kept up to date on the Metro South Health - "Refer Your Patient" Antenatal and Maternity webpages at https://metrosouth.health.qld.gov.au/referrals/antenatal

Please direct pregnant women and their families to information about Metro South Health Maternity Services at https://metrosouth.health.qld.gov.au/maternity-services

CONTINUE

Exam

Question

01/10

To achieve best practice communication and safe care, which of the following apply? (select one or more)

- [ ] GP's should promptly forward a referral on the Antenatal Referral template to the Central Referral Hub as early as practicable after initial screening tests are undertaken
- [ ] GP referrals should nominate their alignment status, and the woman's preferred model of care.
- [ ] All pathology and radiology results are to be copied to ANC and a printed copy given to the woman/placed in her PHR folder, along with a record of each antenatal visit.
- [ ] GPs are to advise the consultant obstetrician, registrar or Team Leader Midwife of adverse events
- [ ] Ethnicity and language spoken needs to be included on antenatal referrals to assist with triaging women to appropriate models of care, and support services.

Question

02/10

Which of the following public services are available to ALL women at Metro South Maternity Hospitals?

- Preconception Clinic
- Physiotherapy
- Midwifery Group Practice
- Dedicated assessment unit for early pregnancy problems e.g. bleeding but stable, pain
- Women are to be referred to the Booking Hospital Radiology Department for all their ultrasound scans

Question

03/10

Testing for Gestational Diabetes Mellitus in MSH involves which THREE of the following:

- [ ] First trimester OGTT for all women
- [ ] First trimester HbA1c or OGTT if >K12 for women at high risk of gestational diabetes
- [ ] OGTT for all women at 24-28 weeks unless they have already been diagnosed with diabetes
- [ ] Random venous plasma glucose testing in first trimester for all women with BMI >30
- [ ] Women who test positive for GDM are to be promptly advised of their results and referred directly back to ANC for review (including result with referral).

Question

04/10

Gestational Diabetes Management in MSH involves which TWO of the following:

(select one or more)

- [ ] Education sessions regarding GDM are undertaken in a one-on-one setting by Diabetic Educators and the Dietitian.
- [ ] Only women who require Insulin for GDM management need to be referred back to the High-Risk Antenatal Clinic.
- [ ] At Logan Hopital, a Midwife Navigator is available to assist women with GDM engaging with the extra care required and negotiating the care pathway.
- [ ] Postnatal follow up is to be arranged by the GP, with an OGTT at 6 weeks recommended, and ongoing monitoring by HBA1C every 1-3 years, and prior to, or early in subsequent pregnancies.

Question

05/10

Women who are receiving public antenatal care at a MSH Maternity Unit should be advised which TWO of the following:

- [ ] One -on-One Public physiotherapy appointments are limited to women with significant functional incapacity or severe symptoms.

- [ ] All women can be referred to a MSH dietitian.

- [ ] Women with urgent pregnancy related concerns (>K20) can be reviewed at the Maternity Assessment Centre (Logan/Redland) or at Birth suite in Beaudesert which is open 24/7

- [ ] Haemodynamically stable women with pain or bleeding at K<20 who require Obstetric review should be referred direct to ED.

Question

06/10

Which of the following need to be considered in women with BMI > 30 undertaking Shared Antenatal Care with their GP in MSH?

- GP's should recommend higher dose Folate supplementation(5mg) from preconception until at least 12 weeks of pregnancy.
- Baseline E/LFT's and urine protein: creatinine ratio should be measured at time of routine antenatal investigations in the first trimester
- BMI should be noted on the initial antenatal referral.
- Early use of low dose Aspirin from before 16 weeks should be considered in pre-eclampsia prevention
- All of the Above

Question

07/10

Which TWO of the following apply to women undertaking Shared Antenatal Care with their GP in Metro South? (select one or more)

- [ ] Abdominal Palpation and Fundal Height measurements should be undertaken at every antenatal visit after 24 weeks and documented in the Pregnancy Record.
- [ ] Ferritin testing is not necessary as long as Haemoglobin levels are being monitored.
- [ ] Women with BP > 140/90 should be sent home to rest and reviewed at their next scheduled visit.
- [ ] Haemoglobinopathy needs to be considered in women with RBC Microcytosis (<80), or with positive family history or ethnicity risks.

Question

08/10

Which of the following applies to women undertaking Shared Antenatal Care with their GP in Metro South ? (select one or more)

- [ ] Weighing women in pregnancy distresses them and should not be undertaken so as not to embarrass them, especially those who are overweight.

- [ ] Syphilis is uncommon and testing only needs to be undertaken in woman with at risk behaviours or in at risk cultural groups.

- [ ] "High Risk" detected on Fetal Anomaly Testing (CFTS or NIPT) should prompt discussion with the woman (+/- partner), and a phone discussion with the Obstetrician at the booking hospital re further assessment options, including referral to Mater Maternal-Fetal Medicine Unit.

- [ ] Weight trackers appropriate to a woman's prepregnant BMI can assist women and their GP monitor weight gain during pregnancy and adjust lifestyle measures accordingly.

Question

09/10

Which THREE of the following apply to women undertaking Shared Antenatal Care with their GP in Metro South? (select one or more)

- [ ] Deviations of more than 3cm from the expected fundal height measurement in the third trimester should prompt referral for an USS, and urgent review by the Obstetrician if IUGR is confirmed.
- [ ] Women who report a change in foetal movements should be asked to complete a Kick Chart and be reviewed by the GP within 24 hours.
- [ ] Specialised services are available at Logan Hospital to assist pregnant women who suffer Perinatal Mental Health concerns or are identified as substance users.
- [ ] Postnatal Community Midwifery care is available as a home visiting service for vulnerable women up to 28 days after birth.

Question

10/10

Which of the following services are available to support GPs at MSH? (select one or more)

- [ ] GPs can phone or email the GP Liaison Midwife/GP for advice on referrals and pathways for assessment, and available management guidelines to assist in the care of antenatal and postnatal women
- [ ] GPs can phone the obstetric registrar for advice and assistance with care of antenatal and postnatal women
- [ ] GPs can phone the consultant obstetrician for advice and assistance with care of antenatal and postnatal women
- [ ] GPs can access online education and resources at BSPHN Maternity Shared Care Program Page

Course completion

Congratulations! You have completed the online component of the GP Shared Care Online Bridging Program.

Your certificate of completion will be available in your Completed Learning.

Please click the Exit to close the course.

Feedback

Your feedback helps us to improve this program and is highly appreciated. You can provide feedback at the link below:

Maternity Shared Care Online Bridging - GP Feedback

Acknowledgements:

- Metro South Health and Hospital Service - especially the Primary Care Partnership Unit and the LEAPOnline team
- Brisbane South Primary Health Network (BSPHN)
- The Alignment Team at Mater Mothers' Hospital
- The >1600 GPs who have been through the MMH and MSH Alignment process and given us their feedback
- Dr Wendy Burton, GP and Maternity Lead, BSPHN

- Maternity Services at Logan/Beaudesert/Redland Hospitals for their clinical input and support