Antenatal Care Schedule at Royal Prince Alfred Hospital

This schedule of visits has been reworked to ensure appropriate, timely and safe provision of antenatal care to pregnant women and people. It is important to recognise that the structure of antenatal care needs to facilitate social support of pregnant women/people as they move toward birth as well as requirements for pregnancy and psychosocial monitoring by maternity clinicians. This schedule should be regarded as a 'baseline'. Pregnant women/people who need more social support or who need a heightened level of medical surveillance will need to have supplementary visits – which can be determined on an individual basis by their clinician/s.

- Clinical Practice Guidelines – Pregnancy Care. The Australian Government (2020).

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Low to Moderate Risk Antenatal Schedule of Visits for Shared Care or Midwifery Models at Royal Prince Alfred Hospital

Colour code: General Practitioner (GP) visits
Hospital visits
Ultrasounds (USS)
Notes

Gestation	Actions to be completed at each visit
6-10 weeks GP	GP visit to confirm pregnancy. • Booking bloods (Blood group and antibody screen, Full Blood Count, Hep B, Hep C, HIV, VDRL (syphilis serology), Rubella, HBEPG for thalassaemia), midstream urine for culture and microscopy (MC&S), dating USS (other tests may be offered e.g., Varicella, serum ferritin, vitamin D) • Risk assessment and referral to hospital once pregnancy viability is confirmed (e.g after the dating scan or around 8 weeks gestation). • Refer all women/people for Combined First Trimester Screening (cFTS) / Non-Invasive Pregnancy Testing (NIPT) (optional or risk based) and Fetal Anomaly Scan (FAS)– see comment 1. • Order early Glucose Tolerance Test (eGTT) 16-20 weeks gestation for high-risk pregnant women/people where appropriate. • Discuss smoking/vaping and offer NRT or support where required. • Discuss influenza vaccine and Covid-19 vaccine - see comment 3. • Discuss reproductive carrier screening if not completed prior to conception. • Referral to RPA Fetal Medicine Unit (FMU) for cFTS,+/- NIPT and FAS by e referral – engaged outpatient.
12 – 14 Weeks Midwife (MW)	• 45-minute booking visit and cFTS • Confirm the correct GP is listed in eMR • Complete all sections of the Antenatal Booking History (**Note:** social history, psychosocial assessment, domestic violence screening and pregnancy intention score will be completed at second visit). • Discuss smoking and vaping in pregnancy. Offer Carbon monoxide (Smokelyzer) monitoring – see comment 4. • Start/update yellow card, review booking bloods, order missing/ additional serology (ensuring blood group and antibody screen is completed at RPA) and morphology USS/FAS, determine pregnancy category as per Australian College of Midwives (ACM) National Guidelines for Consultation and Referral (NMGCR). • Review cFTS and medical history before discussing pregnancy care options and referring to an appropriate model of care. • Complete Antenatal Venous Thromboembolism (VTE) Risk Assessment. • If high risk for diabetes, counsel and provide referral for 16-20 week eGTT if not provided by GP. • Discuss and offer “Get Healthy in Pregnancy (GHiP)” if appropriate. • Follow up and confirm preferences relating to recommendations for vaccinations during pregnancy.

	• If psychosocial concerns are apparent, then referral to social work, mental health, drug and alcohol or perinatal coordinator should be facilitated as early as possible.
	
	cFTS Results
	• Risk of aneuploidy calculated by sonographers
	• Check fetal anatomy
	• NIPT suggested if cFTS risk of aneuploidy is > 1 in 1000 (pregnant woman/ person pays for NIPT, available through hospital at cost)[2]
	• For women at risk of preeclampsia (if greater than 1 in 100) or fetal growth restriction (if greater than 1 in 150 or risk factor based):
	  ○ Initiate aspirin therapy at a dose of 150 mg daily. Although aspirin therapy is typically initiated in the Fetal Medicine Unit, it is essential to emphasize its importance to the woman and ensure they understand the need to continue the treatment.
	• If risk of preeclampsia or growth restriction is greater than 1 in 20 (and woman not already referred to alternate high-risk clinic) refer to Tuesday HDP clinic within 2 weeks.
	• If risk of preeclampsia or growth restriction is 1 in 20 to 1 in 50:
	  ○ Women allocated to a continuity care model, should have an appointment with the lead obstetric consultant to develop a pregnancy care plan and arrange ultrasound referrals.
	  ○ Women NOT allocated to a continuity model should be referred to the Tuesday HDP Clinic.
	• If high risk for preeclampsia 1 in 50 to 1 in 100 or high-risk fetal growth restriction 1 in 50 to 1 in 150:
	  ○ Women allocated to a continuity care model, should have an appointment with the lead obstetric consultant to develop a pregnancy care plan and arrange ultrasound referrals.
	  ○ Women NOT allocated to a continuity model should be referred to the Rapid Access Clinic within 2 weeks, to discuss results, develop a pregnancy care plan and arrange ultrasound referrals.
	• If first trimester screening for preeclampsia and fetal growth restriction not available, triage woman by medical history / BP and give high-risk women aspirin 150mg daily.

16-18 weeks MW	• Second 45 minute MW visit to complete remainder of Antenatal Booking History • Routine antenatal visit (maternal BP and fetal heart rate) • Complete: Women's Health History, breast assessment, social history, psychosocial assessment (including domestic violence and Edinburgh Depression Scale), pregnancy intention score, review results from tests ordered in initial booking • Discuss and offer cervical screening test (CST) if due (trained clinician or self-collect). • Discuss relevant birth/parenting/breastfeeding classes and encourage booking. • Review early GTT results if applicable.

	• Next appointment will be with either the midwife, GP or high-risk clinic depending on NMGCR category and previous consultation with obstetric team. • Women/pregnant people choosing GP Antenatal Shared Care should have midwife visits booked at 30, 37 and 40 weeks. Additional hospital visits can be booked as needed. • Referral to psychosocial intake meeting as appropriate
19-22 weeks	Fetal anomaly scan (FAS) • Scan only, no visit
23-24 weeks GP / MW / O&G	• Routine antenatal visit (fetal heart rate, symphyseal-fundal height and BP) • Review FAS • Offer pertussis (Boostrix) and Influenza[2] vaccination where relevant • Infant/Breast feeding discussion • Discuss and provide referral form for 26-28 week pathology (GTT, FBC, VDRL, blood group and antibody screen). • Assess wellbeing and consider repeating EDS for women with a score >12 at earlier screen
28-30 weeks MW	• Routine antenatal visit • Review results of 26-28 week pathology • Discuss safer baby bundle (side sleeping, fetal movements, smoking/vaping) • Offer Carbon monoxide (Smokelyzer) monitoring. • Discuss pregnancy progress / birthing discussion / breastfeeding • Arrange Anti-D for pregnant women/ people who are RhD negative, ideally this should be at approx. 28 weeks (Note: women requiring Anti D will need to be seen at RPA) • Give GPSC pregnant women/ people form for LVS and 36 week USS if required. FBC and Serum Ferritin ('ferritin') as required. • Assess wellbeing and consider repeating EDS for women with a score >12 at earlier screen
3 weekly GP / MW	• Routine antenatal visits • Arrange Anti-D for pregnant women/ people who are RhD negative at approximately 34 weeks (Note: women requiring Anti D will need to be seen at RPA)
36-37 weeks MW / O&G	• Routine antenatal visit • Order FBC if indicated by 28 week pathology results and LVS • Review and discuss birth preferences, including Hep B/Vit K/3rd stage of labour, strategies preferred for labour, mode of birth and labour onset. • Complete consent for women having a planned caesarean or IOL • +/- USS or bedside scan confirming presentation. • Visits from this point will continue at 1-2 week intervals, depending on risk factors, parity and preference • Pregnant women/ people with history of caesarean section will see obstetric team through BAC or other specialist obstetric clinic. • Women with pregnancy/medical complications where IOL may be recommended prior to 39weeks, should be seen by the obstetric team so that IOL consent can be completed

1-2 weekly MW/O&G/ GP	• Routine antenatal visit • Review birth preferences, LVS, pathology and ultrasound results. • For women having a planned IOL, complete consent approx. one week in advance. IOLs can be booked up to 10 days in advance.
40 weeks MW	• Routine antenatal visit. • Discuss and offer membrane sweep • If planned vaginal birth and IOL is appropriate: discuss, offer, consent and book postdate IOL for 41+ weeks
41 weeks MW / O&G	• Routine antenatal visit • Discuss and offer membrane sweep • Growth and wellbeing scan, aim for 40^{+6} - 41^{+1} weeks • If appropriate, complete written consent for postdates IOL • Arrange CTG by 41^{+3} weeks. This could be the pre-cervidil CTG for women/people being induced. • Anyone choosing to continue their pregnancy should be recommended for twice weekly CTG and AFI.

Comments:

1. **Combined first trimester screening (cFTS)**

cFTS has proven to be an effective method for identifying women at risk of developing early-onset pre-eclampsia (PET) and fetal growth restriction (FGR). High-risk women benefit from starting aspirin before 16 weeks of pregnancy. Research suggests that aspirin can reduce early-onset pre-eclampsia by approximately 80%, lower the incidence of small-for-gestational-age (SGA) babies (<10th percentile) by about 40% for those born before 37 weeks, and by about 73% for those born before 32 weeks.

cFTS is recommended as the first-line screening tool and should not be replaced by non-invasive prenatal testing (NIPT), as NIPT does not include a structural scan or assess the risk of pre-eclampsia and FGR.

2. **NIPT**

If first trimester screening returns a low-risk for aneuploidy (higher than 1 in 1000 but lower than 1 in 300) then NIPT may be considered for further reassurance but the test is not available through Medicare. If the woman wants NIPT we can organise it via the fetal medicine unit at RPA. For women who take this option, the detection rate for trisomy 21 is expected to increase to 97% compared with 90% for first trimester screening alone.

3. Influenza Vaccine in Pregnancy

Influenza vaccine is recommended for every pregnancy and can be administered at any gestation. If a woman/pregnant person has been vaccinated with the previous season's vaccine, they should be offered a second vaccine in the same pregnancy with the new vaccine when once it is available. If the influenza vaccine has been given in the weeks and months prior to conception, it should still be offered during the pregnancy. Influenza vaccines can be administered at the same time as the COVID and pertussis vaccines.

4. Smoking/vaping cessation and the Smokerlyzer

The Smokerlyzer measures the level of expired carbon monoxide in the breath and is now used as a screening, and reduction/cessation tool throughout pregnancy. It should be offered to all pregnant women/people at their initial booking in visit and at all subsequent visits for those who disclose smoking/vaping. For non-smokers/vapers, this is repeated at 28-30 weeks gestation.

EDUCATION POINTS:

BP

Women who have not been able to access preeclampsia screening or who have screened as high risk will require more frequent monitoring of blood pressure than what is provided in the above antenatal schedule. A referral or plan for individual schedule should occur at initial appointment. High risk >1:50: eligible for referral to the HDP clinic.

FAS (morphology scan)

RPA recommends this scan routinely occurs at 19-22 weeks. Please request cervical measurement and for the sonographer to stipulate whether a transvaginal (TV) or transabdominal (TA) scanning has been used. If the TA measurement is <35mm, a TV scan is required. If the TV measurement is <25mm, the pregnant woman/ person requires referral to the Preterm Birth Clinic at RPA as soon as possible.

CONSULTATION

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Staff Specialists, RPA
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