Clinical Practice Guideline Routine Pregnancy Care

Peninsula Care Goal Safe

Target Audience
Doctors (obstetricians, registrars, HMO), shared care practitioners (General Practitioners, Private Practice Midwives), hospital midwives, medical and midwifery students

Purpose
Pregnancy is a normal physiological process and any care offered should have known benefits and be acceptable to women.[1] Women should be the focus of maternity care, with an emphasis on providing choice, easy access and continuity of care. Care during pregnancy should support each woman to actively participate in decision making in a collaborative relationship with care providers[1].

This guideline should be used to support evidence-based pregnancy care so that clinicians are providing consistent advice to women.

Precautions
This guideline provides a framework for pregnancy care and may be all that is required for a woman experiencing a low risk pregnancy. Some women may have risk factors for complications identified at booking or during pregnancy and may require additional visits, investigations and treatment.

Each visit should be an opportunity to identify any existing or new issue that requires additional investigations, consultation, referral or transfer to a higher level of care.

Women of culturally and linguistically diverse populations should be offered an interpreter at every visit in accordance with Peninsula Health Interpreter Service guideline. Family members should not be used as interpreters.

Documentation
All women will be given a hand held Victorian Maternity Record (VMR) at booking. Documentation of each visit at Peninsula Health will occur on the Birthing Outcome System (BOS) and printed summaries will be attached to the VMR.

Specific requirements for individual care during the pregnancy should be noted and updated in the management section of BOS to facilitate consistency of information and continuity of care at each visit. Notes of specific requirements should also be made on the front cover of the VMR for the benefit of external providers.

If a woman telephones the Women's Health Unit or Women's Services for advice during pregnancy this should be recorded in the phone call section of BOS.

If a woman presents to the Women's Health Unit for assessment during pregnancy this should be recorded in the outpatient section of BOS.

In the community, notes about the consultation and copies of results need to be printed out and/or recorded in the VMR

Midwife Booking Appointment 10-14 weeks

- Review antenatal summary and complete antenatal assessment sections on BOS, including results of tests and investigations
- Identify EDB using Maternity e Handbook guideline in agreement with the woman Accurate pregnancy dating (estimated due date)
- Discuss model of care with the woman, noting any risk factors for obstetric consultation and referral as per Risk Assessment for Model of Pregnancy Care Advise confirmation of model of care will occur after first doctors visit.
- Ask the woman if she, her partner or her baby identify as Aboriginal or Torres Strait Islander – offer referral to Koori Maternity Service (KMS) and/or Aboriginal Healthy Start to Life Aboriginal Healthy Start to Life
- Open Antenatal visit tab and document observations and safer baby collaborative assessment and education
- Complete baseline vital signs *(refer for urgent obstetric review if hypertensive)* Hypertension in Pregnancy (Pre-Eclampsia & Eclampsia)
- 'Ask Advise Help' - Offer carbon monoxide analysis & document result in on BOS. If woman confirms she is currently smoking, offer QUIT referral and sensitively discuss increased risk of stillbirth offer Quit smoking for baby flyer and QUIT referral
- Ask each woman about other substance use & provide advice & offer referral to social work and/or Frankston and Mornington Drug and Alcohol Service (FaMDAS)
- Complete Edinburgh Postnatal Depression Score (EPDS) and follow pathway if score above 10 or risk of self-harm has been identified Perinatal Mental Health
- Within the psychosocial assessment field, note if there are considerations required for pregnancy, birth or post-natal care planning related to LGBTQIA+, surrogacy, adoption or other variations of family dynamics and refer to social work if required Surrogacy and or Adoption
- Within the psychosocial assessment field assess for risk of family violence Family Violence Response and Referral
- Weight is to be measured at first appointment (not reported pre pregnancy weight) and again at 28w and 32w. If BMI is over 35 or if other dietary issues are identified (low BMI, IBS, previous bariatric surgery) offer referral to antenatal nutrition class or individual dietician appointment as appropriate. If BMI 45 or over advise that transfer to tertiary centre for birth is required if BMI ≥50. Management of a woman with BMI ≥35 in pregnancy
- Discuss diet, exercise and healthy weight gain in pregnancy

BMI at Booking	Ideal Weight Gain in Pregnancy
< 18.5	12.5-18 kg
18.5 to 24.9	11.5-16 kg
25-29.9	7-11.5 kg
>30	5-9 kg

- Discuss nutrition in pregnancy including folate and iodine supplementation. Healthy eating for pregnancy
- Assess risk of Vitamin D deficiency and provide advice about supplementation as required Vitamin D Deficiency in Pregnancy & Breastfeeding.
- Assess for Fetal Growth Restriction and document risk level on BOS (procedures section in Antenatal Visit Tab) manage as per Management of the Small for Gestational Age or Growth Restricted Fetus and Indications for Antenatal Ultrasound CPGs. Sensitively educate each woman regarding her risks for FGR and stillbirth

<table>
<tr><th>Level 1</th><th colspan="2">Level 2</th><th>Level 3</th></tr>
<tr>
<td>No FGR risk factors identified[A]

One minor risk factor with normal clinical growth[A/B]

Note: more than 50% of FGR cases have no risk factors</td>
<td>2 or more minor risk factors
• Age ≥35yrs[B]
• Nulliparity[A]
• IVF singleton pregnancy[B]
• Aboriginal or Torres Strait Islander[A]
• Smoking ≤10/day
• BMI 30 to 34kg/m^2 [A/B]
• BMI < 18kg/m^2
OR
• Previous late (≥32/40) FGR or pre-eclampsia[B]

Advise low dose Aspirin 150mg nocte prior to 16/40 up to 36/40</td>
<td>Antenatal Complications
Suspected FGR/SGA (SFH>2cm behind projected fundal height, static growth, SFH<10th %)[B]

Arrange US fetal growth.
If growth normal but ongoing clinical suspicion, arrange FU growth assessment.</td>
<td>High Risk of Early FGR[C]

• Maternal age ≥40yrs
• Smoker >10/day, substance use
• Previous early (<32/40) FGR/SGA or pre-eclampsia
• PAPP-A <0.4 MoM
• Congenital CMV
• Pre-eclampsia or hypertension
• APH heavier than menstrual loss
• Previous stillbirth with FGR/SGA
• Maternal medical conditions (e.g. antiphospholipid syndrome, renal impairment, diabetes with vascular disease, chronic inflammatory conditions)
• BMI ≥35 kg/m^2 [A/B] *</td>
</tr>
<tr>
<td>Standardized serial SFH at each visit from 24/40
Plot SFH on growth chart</td>
<td colspan="2">US fetal growth at 28 and 34-36wks
Review model of care group (see CPG)</td>
<td>Advise low dose aspirin (150mg nocte) prior to 16/40 up to 36/40
Review model of care (see CPG)
US growth 4 wkly from 24/40
* BMI ≥35 see CPG US growth/AFI/Doppler 28, 32, 36 weeks</td>
</tr>
</table>

*If low dose aspirin is started before 16/40 in high risk women, the rate of FGR can be halved [10].

Escalate immediately to obstetric staff if FGR risk is level 2 or 3 for consideration of commencement of low dose aspirin (LDA) 150mg nocte **prior to 16w**

- Assess oral health and offer referral to Community Dental if the woman has a health care card or review in private dental clinic
- If the woman is continuing care in Enhanced Maternity Clinic (EMC) provide information about 20-22 week morphology ultrasound and request on EMR (Clover)
- If the woman is rhesus negative blood type, discuss prophylactic Anti-D and complete consent form (MR553120) Anti-Rh (D) Immunoglobulin Antenatal and Post Natal Administration
- Review results of investigations and consult or refer for medical review as required. Provide a pathology or imaging request for outstanding investigations
- Promote immunisation during pregnancy

Routine Pregnancy Investigations

Investigations	Rationale
Blood group and Antibodies	Maternal Rh status for presence or risk of isoimmunisation Prevention of haemolytic disease of the newborn Anti-RH (D) Immunoglobulin Antenatal and Post Natal Administration
FBE (consider ferritin if risk factors for iron deficiency anaemia)	Anaemia and haemoglobinopathies in pregnancy - consider ferritin if Hb <110g/L and haemoglobin electrophoresis and DNA analysis if MCV <80 fL and /or MCH ≤29pg[4] Iron Deficiency Anaemia in Pregnancy, Intrapartum and Postpartum
Hepatitis B, Hepatitis C, HIV, Rubella, Syphilis	Infectious disease screening impacting maternal / fetal or newborn health (ordering of HIV and Hepatitis C screening requires an accredited midwife or doctor for counselling)
Midstream Urine for MC&S	Asymptomatic bacteriuria – increased risk of maternal and neonatal infection and preterm birth
Combined First Trimester Screening or Non-invasive prenatal testing (NIPT) (cfDNA) or, if not done offer Second Trimester Maternal Serum Screening	Risk assessment for trisomy 21, 18 and 13 requires maternal blood collected between 9+0 and 13+6 weeks (ideally around 10 weeks) and Ultrasound between 11 and 13+6 (detection rate 85-93%, likely to be an out of pocket expense) or Risk assessment for trisomy 21, 18 and 13 and sex chromosome aneuploidies. Currently the most accurate test available. Cost can be high. Ultrasound at around 12 weeks is still recommended to exclude structural abnormalities or, if not done offer Blood collected between 14+0 and 20+6 weeks. Risk assessment for trisomy 21,18, and 13 and neural tube defects by analysing maternal serum levels of alpha-fetoprotein, free bHCG, unconjugated oestriol and inhibin A Prenatal Screening Tests

Conditional Pregnancy Investigations

Investigation	Rationale
Early Oral Glucose Tolerance Test (OGTT) Diabetes in pregnancy	Increased risk of Gestational Diabetes (GDM): BMI > 30 Family history of diabetes (1st degree relative with DM or sister with GDM) Previous GDM Previous macrosomia (>4500gm or >90th centile) Elevated booking BGL Multiple Pregnancy Polycystic Ovarian Syndrome (PCOS) Maternal age of 40 years or over Corticosteroid or antipsychotic medication Previous perinatal loss Women with ethnicity of increased risk (Asian, Indian subcontinent, Aboriginal, Torres Strait Islander, Pacific Islander, Maori, Middle Eastern, African)
Chlamydia and Sexually Transmitted Infection (STI) testing	Offer to at risk populations (women 25 years or younger, multiple sexual partners)

Education and health promotion to be offered at midwifery booking appointment

- Discuss and offer childbirth education, dietitian classes (encourage early booking)
- Discuss risk factors for FGR
- Advise maternity ward tour times and contact number
- Discuss and offer mindful moves
- Discuss infant feeding preferences, offer health promotion about benefits of breastfeeding
- Discuss common symptoms of early pregnancy, for example nausea and vomiting Nausea and Vomiting in pregnancy
- Discuss concerns about birth, consider referral to perinatal emotional health service Perinatal Mental Health
- If previous birth was a caesarean section, discuss birth options and offer information leaflet

Booking information for all pregnant women refer to website	
Having a baby at Frankston Hospital	Healthy eating for pregnancy
Taking care of yourself during pregnancy	Your pregnancy- what to expect
Healthy relationships and pregnancy	Protect your baby – whooping cough
Healthy teeth healthy pregnancy	Vaccinate against Flu
Your baby's movements matter	Beyond Blue Emotional health and wellbeing – dads, partners other carers
Beyond Blue Emotional health and wellbeing – pregnant women new mums	Length of stay 6-24hrs Multigravida 6-48 hrs Primigravida – discuss MHITH and MHC
Vitamin K for newborn babies	Newborn Hepatitis B

Additional information as appropriate	
Quit and carbon monoxide analysis	Second hand smoke & your children
Rh(D) consumer information	Responsible pet ownership - We are family
Frankston & Mornington Drug and Alcohol Service (FaMDAS)	Koori Maternity Service
Next birth after caesarean section	Aboriginal Healthy Start to Life
PANDA - Anxiety & Depression in Pregnancy & Early Parenthood	Information about your score on the Edinburgh Postnatal Depression Scale
Expecting Twins	Gathering support (family violence)
Love or control? Abuse in same sex relationships	Side Sleeping if woman is private or non-hospital care

Documentation in BOS

- Complete all tabs in the Antenatal Assessment section of BOS including adding booking as an Antenatal Visit.
- Psychosocial notes can be completed for confidential information.
- Confirm model of care.
- Initiate management plan if required

Documentation in VMR

- Complete page one of VMR
- GPs and VMOs to complete medical screen in VMR and ensure copies of investigations are included in maternal hand held file and documented
- Print booking summary from BOS and attach to page two of VMR

Encourage the woman to book the remainder of her appointments at the completion of the booking visit to facilitate continuity of care. Request interpreter if needed.

First Obstetric Visit 14-16 weeks

(To be undertaken by hospital obstetric doctor or VMO. If late booking >15w must be attended within 1 week of booking appointment)

1. Review history
   - Health and wellbeing assessment
   - Confirm Estimated Date of Birth (EDB) using Accurate pregnancy dating (estimated due date)
   - Review results of investigations ordered at last visit – refer to diabetes clinic if OGTT positive
   - Review risk level for fetal growth restriction and manage according to Management of the Small for Gestational Age or Growth Restricted Fetus and Indications for Antenatal Ultrasound

Level 1	Level 2		Level 3
No FGR risk factors identified[A] **One minor risk factor with normal clinical growth[A/B]** **Note: more than 50% of FGR cases have no risk factors**	**2 or more minor risk factors** • Age ≥35yrs[B] • Nulliparity[A] • IVF singleton pregnancy[B] • Aboriginal or Torres Strait Islander[A] • Smoking ≤10/day • BMI 30 to 34kg/m^2 [A/B] • BMI < 18kg/m^2 **OR** Previous late (≥32/40) FGR or pre-eclampsia[B] *Advise low dose Aspirin 150mg nocte prior to 16/40 up to 36/40*	**Antenatal Complications** • Suspected FGR/SGA (SFH>2cm behind projected fundal height, static growth, SFH<10th %)[B] Arrange US fetal growth. If growth normal but ongoing clinical suspicion, arrange FU growth assessment.	**High Risk of Early FGR[C]** • Maternal age ≥40yrs • Smoker >10/day, substance use • Previous early (<32/40) FGR/SGA or pre-eclampsia • PAPP-A <0.4 MoM • Congenital CMV • Pre-eclampsia or hypertension • APH heavier than menstrual loss • Previous stillbirth with FGR/SGA • Maternal medical conditions (e.g. antiphospholipid syndrome, renal impairment, diabetes with vascular disease, chronic inflammatory conditions) • BMI ≥35 kg/m^2 [A/B] *
Standardized serial SFH at each visit from 24/40 **Plot SFH on growth char**	US fetal growth at 28 and 34-36wks Review model of care group (see CPG)		*Advise low dose aspirin (150mg nocte) prior to 16/40 up to 36/40* Review model of care (see CPG) US growth 4 weekly from 24/40 * BMI ≥35 see CPG US growth/AFI/Doppler 28, 32, 36 weeks

*If low dose aspirin is started before 16/40 in high risk women, the rate of FGR can be halved [10].

- 'Ask Advise Help' Provide smoking cessation and substance misuse advice and support if applicable

2. Physical assessment

- Cardiovascular and respiratory systems, abdomen and thyroid. Offer additional investigations and procedures e.g. additional fetal surveillance to monitor fetal growth restriction if a low PAPP-A is identified, thyroid function testing, cervical screening,
- Blood pressure *(refer for urgent obstetric review if hypertensive)* Hypertension in Pregnancy (Pre-Eclampsia & Eclampsia)
- Review model of care assigned by booking midwife following physical assessment and refer to obstetric care as required
- BMI if not recorded
- Cervical screening

3. Discuss and offer investigations

- Offer second trimester Maternal Serum Screening if no first trimester aneuploidy screening done
- Provide referral for second trimester ultrasound for fetal number and morphology and placental location – consider uterine artery Doppler measurement at this ultrasound in the presence of maternal risk factors level 3 for fetal growth restriction
- Influenza vaccination

4. Provide education and information

- As required

5. Document in BOS – 'Antenatal Visit' tab

- Document physical check
- Amend management plan if required
- Print visit summary and put in VMR (VMO document in VMR)

Midwife or Doctor 20-24 weeks

(Hospital or community visit if shared care or VMO)

1. Review history
    - Health and wellbeing assessment
    - Review results of investigations ordered at the last visit
    - 'Ask Advise Help' about smoking behaviour and or substance use. Provide encouragement, support, advice and referral to QUIT if applicable, document on BOS (Procedure / Treatment section on antenatal visit tab). Ask about and substance misuse provide advice and referral if applicable.
    - Follow up referrals from previous visit
2. Physical assessment
    - Blood pressure *(refer for urgent obstetric review if hypertensive)* Hypertension in Pregnancy (Pre-Eclampsia & Eclampsia)
    - Urinalysis if BP is elevated
    - Abdominal Examination/ Palpation and measurement of SFH from 24 weeks' gestation. Plot measurement on My Baby's Growth chart and in BOS, explain expected trajectory to the woman, encourage her to have her baby's growth plotted each visit. Reassess and document FGR risk encourage her to bring growth chart to each episode of pregnancy care
    - Consider urinalysis if suspicion of UTI or in the presence of elevated blood pressure
    - Discuss diet and exercise recommendations for pregnancy
    - Offer measurement of maternal weight
3. Discuss and offer investigations advise to have 1 week prior to next visit (28 weeks)
    - Gestational diabetes testing (Oral Glucose Tolerance Test), full blood examination (FBE) and ferritin level if low at booking
    - Blood group and antibodies
4. Provide education and information
    - Rh (D) immunoglobulin 625 IU (if Rhesus D negative)
    - Confirm booking for childbirth education
    - Influenza vaccination
    - Pertussis vaccination – recommended between 20-32w
    - Discuss and offer 'Your baby's movements matter' consumer information, document in Procedure/ Treatment section of 'Antenatal Visit' Tab
5. Document in BOS – 'Antenatal Visit' tab
    - Amend management plan if required
    - Print visit summary and put in VMR (GP or VMO document in VMR)

Midwife or Doctor 28 weeks

(Hospital or community visit if shared care or VMO)

1. Review history
   - Health and wellbeing assessment
   - Review results of investigations ordered at the last visit (OGTT, blood group and antibodies, FBE) – refer to diabetes clinic if OGTT positive
   - Offer carbon monoxide analysis. 'Ask Advise Help' about smoking behaviour and or substance use. Provide support and encouragement offer advice and referral to support services if applicable and document on BOS (Procedure / Treatment) section of Antenatal Visit Tab)
2. Physical assessment
   - Blood pressure *(referral for medical review if hypertensive* Hypertension in Pregnancy (Pre-Eclampsia & Eclampsia)
   - Urinalysis if BP is elevated
   - Enquire about fetal movements discuss and document in BOS (procedures section on Antenatal Visit Tab) discussion about importance of fetal movements and when to seek help Decreased Fetal Movements
   - Auscultate the fetal heart rate
   - Perform abdominal palpation Abdominal Examination/ Palpation . Document SFH on maternal My Baby's Growth Chart and on BOS. Review against previous measurements noting consistency of growth trajectory and SFH measurement against gestation – Review FGR risk assessment level and if level 2 or 3 review management plan and requirements. Refer for obstetric review if growth trajectory has slowed altered and/or SFH is equal to or more than 3cm below gestation as per Management of the Small for Gestational Age or Growth Restricted Fetus and Indications for Antenatal Ultrasound CPGs. Order ultrasound for fetal growth surveillance for 32 weeks if indicated on clinical assessment or documented in management plan. Follow up appointment should be with senior obstetric staff to review ultrasound report
   - Measure maternal weight – note BMI change
3. Discuss and offer investigations
   - Review pathology results for blood group and antibody screen
   - If the woman is Rhesus D negative, offer and administer Rh (D) immunoglobulin (D) Immunoglobulin Antenatal and Post Natal Administration
   - Review OGTT result and refer to diabetes clinic if required
   - Check immunization status for influenza and pertussis

     Consider and discuss iron supplementation if haemoglobin is low Iron Deficiency Anaemia in Pregnancy, Intrapartum and Postpartum

4. Provide education and information
   - Safe Side Sleeping
   - Gestational diabetes education as required
   - Your baby's movements matter
   - Recommend pertussis vaccine for parents and others who may be in contact with the baby within the first 3 months of life

Second trimester information as appropriate	
Your baby's movements matter	Safe Side Sleeping
Rh(D) consumer information if required	Protect your baby – whooping cough
Purchasing a rearward facing child restraint	

5. Document in BOS – 'Antenatal Visit' tab
   - Amend management plan if required
   - Print visit summary and put in VMR (GP or VMO document in VMR)

Midwife or Doctor 32-34 weeks

(hospital or community visit if shared care or VMO)

1. Review history
    - Health and wellbeing
    - Review results of investigations ordered at the last visit including OGTT, fetal growth
    - 'Ask Advise Help' about smoking behaviour and other substance use if applicable. Offer support, encouragement and advice if applicable
    - Follow up referrals from previous visit
2. Physical assessment
    - Blood pressure *(referral for medical review if hypertensive)* Hypertension in Pregnancy (Pre-Eclampsia & Eclampsia)
    - Urinalysis if BP is elevated
    - Enquire about fetal movements discuss and document in BOS (procedures section on Antenatal Visit Tab) discussion about importance of fetal movements and when to seek help Decreased Fetal Movements
    - Auscultate the fetal heart rate
    - Perform abdominal palpation Abdominal Examination/ Palpation Document SFH on maternal My Baby's Growth Chart and on BOS. Review against previous measurements noting consistency of growth trajectory and SFH measurement against gestation – Review FGR risk assessment level and if level 2 or 3 review management plan and requirements. Refer for obstetric review if growth trajectory has slowed, altered and/or SFH is equal to or more than 3cm below gestation as per Management of the Small for Gestational Age or Growth Restricted Fetus and Indications for Antenatal Ultrasound CPGs
    - Measure maternal weight – Note BMI change
    - Check immunization status for influenza and pertussis
3. Discuss and offer investigations
    - Full blood examination (FBE) if low at 28 weeks
4. Order ultrasound for placental location if low on second trimester scan of Placenta Praevia Placenta Accreta and Vasa Praevia
5. Provide education and information
    - Rh (D) immunoglobulin 625 IU (if Rhesus D negative) recommend second dose Anti D at 34w (or 6 weeks after first dose) (D) Immunoglobulin Antenatal and Post Natal Administration
    - Confirm booking for childbirth education
    - Influenza vaccination
    - Discuss birth planning including options for pain relief offer Managing your labour – information about how to manage pain in labour consumer information Water Birth / Immersion in Water During Labour and Birth

- Perineal protection during second stage
- Maternity falls prevention
- Offer 'Your baby's movements matter' consumer information and encourage women not to delay contacting Women's Health Unit if they experience concern about a change in their baby's pattern of movements.

6. Document in BOS – 'Antenatal Visit' tab
   - Update management plan if required
   - Print visit summary and put in VMR (GP or VMO document in VMR)

Midwife or Doctor 35-36weeks

(hospital or community visit if shared care or VMO)

1. Review history
   - Health and wellbeing assessment
   - Review results of investigations ordered at the last visit
   - 'Ask Advise Help' Offer smoking cessation and substance use advice and support if applicable
   - Follow up referrals from previous visit *(including growth scan if applicable)*Advise cessation of low dose aspirin (if commenced for FGR risk 2 or 3) at 36w
2. Physical assessment
   - Blood pressure *(referral for medical review if hypertensive)* Hypertension in Pregnancy (Pre-Eclampsia & Eclampsia)
   - Urinalysis if BP elevated
   - Enquire about fetal movements Decreased Fetal Movements
   - Auscultate the fetal heart rate
   - Perform abdominal palpation Abdominal Examination/ Palpation Document SFH on maternal My Baby's Growth Chart and on BOS. Review against previous measurements noting consistency of growth trajectory and SFH measurement against gestation – Review FGR risk assessment level and if level 2 or 3 review management plan and requirements including ultrasound for fetal growth surveillance for 36 weeks if indicated on clinical assessment or documented in management plan. Follow up appointment should be with senior obstetric staff. Refer for obstetric review if growth trajectory has slowed, altered and/or SFH is equal to or more than 3cm below gestation as per Management of the Small for Gestational Age or Growth Restricted Fetus and Indications for Antenatal Ultrasound CPGs If malpresentation is suspected, refer for obstetric review External Cephalic Version and counselling for mode of birth Vaginal Breech Birth
   - Offer to measure maternal weight
3. Discuss and offer investigations

- Full blood examination (FBE) if haemoglobin was low at 28 weeks to be done prior to 36-week visit
- Check date of previous Anti D administration and if required, advise and offer Rh (D) immunoglobulin 625 IU if Rhesus D negative (D) Immunoglobulin Antenatal and Post Natal Administration
- Offer perianal swab for group B streptococcus (GBS) screening unless planning a caesarean birth, or there is a history of GBS bacteriuria in current pregnancy or previous baby with invasive GBS Group B Streptococcus

4. Provide education and information

- Infant feeding
- Your baby's movements matter - encourage women not to delay contacting Women's Health Unit if they experience concern about a change in the pattern of their baby's movements.
- Every week counts information for fetal neurodevelopment and optimal timing of birth
- Postnatal mental heath
- Reducing the risks of Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Death in Infancy (SUDI)
- Newborn screening tests
- Discuss birth planning including options for pain relief, perineal protection, Water Birth / Immersion in Water During Labour and Birth
- Vitamin K and Hepatitis B for baby
- Keeping your baby safe in hospital
- Psychosocial support in the postnatal period including Maternal and Child Health Nurse, GP, PANDA, Beyond Blue, COPE
- Discuss Induction of labour information and decision making tool if a recommendation for induction of labour is likely <39w

Third trimester information as appropriate	
Your baby's movements matter	Red nose – safe sleeping
Rh(D) consumer information if required	Red nose – safe wrapping
Your baby's hearing screen	Newborn Screening for the health of your baby
Water birth information	Third stage management
Keeping your baby safe in hospital	Vitamin K prophylaxis
Every Week Counts	Induction of labour information and decision making tool
Managing your labour	Tips for successful breastfeeding
Breastfeeding support service	

5. Document in BOS – 'Antenatal Visit' tab

- Update management plan if required
- Print visit summary and put in VMR (GP or VMO document in VMR)

Midwife or Doctor 37-38 weeks

(hospital or community visit if shared care or VMO)

1. Review history
    - Health and wellbeing assessment
    - Review results of investigations and referrals ordered at the last visit *(including growth scan if applicable)*
    - 'Ask Advise Help' Offer smoking cessation and substance misuse advice and support if applicable
2. Physical assessment
    - Blood pressure *(referral for medical review if hypertensive)* Hypertension in Pregnancy (Pre-Eclampsia & Eclampsia)
    - Urinalysis if BP is elevated
    - Enquire about fetal movements Decreased Fetal Movements Auscultate the fetal heart rate
    - Perform abdominal palpation Abdominal Examination/ Palpation note liquor volume, fetal lie, and ask if the woman feels her baby is growing. Document SFH on maternal My Baby's Growth Chart and on BOS. Review against previous measurements noting consistency of growth trajectory and SFH measurement against gestation – Reassess FGR risk l and if level 2 or 3 review management plan. Refer for obstetric review if growth trajectory has slowed, altered and/or SFH is equal to or more than 3cm below gestation Management of the Small for Gestational Age or Growth Restricted Fetus and Indications for Antenatal Ultrasound CPGs
    - Discuss options for birth timing or increased fetal surveillance if FGR level 2 or 3 using induction of labour decision making tool Induction of Labour Indications and Booking Process
    - If malpresentation is suspected refer for obstetric review
    - Offer to measure maternal weight
    - Offer vaginal examination and 'stretch and sweep' from 38w to reduce likelihood of prolonged pregnancy[5] Prolonged pregnancy
3. Discuss and offer investigations
    - Discuss optimal birth timing for women with additional risk factors for stillbirth (e.g. FGR level 2 or 3 gestational diabetes requiring insulin, extremes of maternal age, previous adverse outcome, South Asian ethnicity) Induction of Labour Indications and Booking Process
    - Consider twice weekly AFI and CTG from 39 weeks for women of South Asian, Middle Eastern and African ethnicity (India, Pakistan, Sri Lanka, Bangladesh, Bhutan, Nepal, Maldives, Afghanistan) due to the increased risk of late term stillbirth in this cohort[7,8,9].
    - Discuss management of prolonged pregnancy
4. Provide education and information

- Discuss GBS results and implications for birth Group B Streptococcus Rupture of Membranes at Term
- Discuss birth planning including options for pain relief offer Managing your labour – information about how to manage pain in labour consumer information, perineal protection and Water Birth / Immersion in Water During Labour and Birth,
- Infant feeding
- Discuss postnatal check and contraception planning
- Your baby's movements matter - encourage women not to delay contacting Women's Health Unit if they experience concern about a change in the pattern of their baby's movements.
- Keeping your baby safe in hospital

5. Document in BOS – 'Antenatal Visit' tab
   - Update management plan if required
   - Print visit summary and put in VMR (GP or VMO document in VMR)

Midwife or Doctor 39-40 weeks

(hospital or community visit if shared care or VMO)

1. Review history
    - Health and wellbeing assessment
    - Review results of investigations ordered at the last visit *(including fetal wellbeing scans if applicable)*
    - 'Ask Advise Help' Offer smoking cessation and substance misuse advice and support if applicable
    - Follow up referrals from previous visit
2. Physical assessment
    - Blood pressure *(referral for medical review if hypertensive)* Hypertension in Pregnancy (Pre-Eclampsia & Eclampsia)
    - Urinalysis if BP is elevated
    - Enquire about fetal movements Decreased Fetal Movements
    - Perform abdominal palpation Abdominal Examination/ Palpation note liquor volume, fetal lie, and ask if the woman feels her baby is growing. Document SFH on My Baby's Growth Chart and on BOS. Review against previous measurements noting consistency of growth trajectory and SFH measurement against gestation – Review FGR risk assessment level and if level 2 or 3 review management plan. Refer for obstetric review if growth trajectory has slowed, altered and/or SFH is equal to or more than 3cm below gestation. If fetal growth restriction is suspected discuss optimal time of birth (ideally prior to 40 weeks) to reduce risk of stillbirth and consider additional surveillance to ensure fetal wellbeing if the woman declines induction of labour
    - Auscultate the fetal heart rate
    - Discuss birth timing or increased fetal surveillance if FGR level 2or 3 or if low risk Prolonged pregnancy management using induction of labour decision making tool Induction of Labour Indications and Booking Process
    - Refer for obstetric review if growth trajectory has slowed, altered and/or SFH is equal to or more than 2cm below gestation Management of the Small for Gestational Age or Growth Restricted Fetus CPG
    - If malpresentation is suspected refer for obstetric review
    - Offer to measure maternal weight
    - Offer vaginal examination and 'stretch and sweep' [5] Prolonged pregnancy
3. Discuss and offer investigations
    - Arrange postdates fetal surveillance of twice weekly AFI and CTG from 41+3 weeks Prolonged Pregnancy
    - Consider twice weekly AFI and CTG from 39 weeks for women of South Asian, Middle Eastern and African ethnicity (India, Pakistan, Sri Lanka, Bangladesh, Bhutan,

Nepal , Maldives, Afghanistan) due to the increased risk of late term stillbirth in this cohort[7,8,9,]

- Provide education and information on Induction of labour and if suitable Going home after balloon cervical ripening catheter
- Your baby's movements matter - encourage women not to delay contacting Women's Health Unit if they experience concern about a change in the pattern of their baby's movements.
- Discuss birth planning including options for pain relief offer Managing your labour – information about how to manage pain in labour consumer information Water Birth / Immersion in Water During Labour and Birth
- Infant feeding

4. Document in BOS – 'Antenatal Visit' tab
   - Update management plan if required
   - Print visit summary and put in VMR (GP or VMO document in VMR)

Midwife or Doctor 41-42 weeks

(senior obstetric doctor if woman has chosen shared care)

1. Review history
   - Health and wellbeing assessment
   - Review results of investigations ordered at the last visit *(including AFI and CTG)*
   - 'Ask Advise Help' Offer smoking cessation and substance misuse advice and support if applicable
   - Follow up referrals from previous visit
2. Physical assessment
   - Blood pressure *(referral for medical review if hypertensive)* Hypertension in Pregnancy (Pre-Eclampsia & Eclampsia)
   - Urinalysis if BP elevated
   - Enquire about fetal movements Decreased Fetal Movements
   - Auscultate the fetal heart rate
   - Perform abdominal palpation Abdominal Examination/ Palpation note liquor volume, fetal lie, and ask if the woman feels her baby is growing. Document SFH on My Baby's Growth Chart and on BOS. Review against previous measurements noting consistency of growth trajectory and SFH measurement against gestation – Refer for obstetric review if growth trajectory has slowed, altered and/or SFH is equal to or more than 3cm below gestation
   - Review FGR risk l and if level 2 or 3 review management as most 'at risk' babies should have had IOL offered by this time. Refer for obstetric review if growth trajectory has slowed, altered and/or SFH is equal to or more than 2cm below

gestation Management of the Small for Gestational Age or Growth Restricted Fetus and Indications for Antenatal Ultrasound CPGs

- If malpresentation is suspected refer for urgent obstetric review

3. Discuss and offer investigations
   - Offer vaginal examination 'stretch and sweep.' Discuss timing of birth and offer induction of labour for post-dates between 41.3 and 42 weeks gestation using induction of labour decision making tool Induction of Labour Indications and Booking Process
   - Arrange fetal surveillance, twice weekly AFI and CTG to commence at 41.3 weeks Prolonged pregnancy
   - If the woman declines induction of labour and wishes her pregnancy to continue beyond 42 weeks, refer to obstetric care for ongoing fetal surveillance and birth planning
4. Provide education and information
   - Your baby's movements matter - encourage women not to delay contacting Women's Health Unit if they experience concern about a change in the pattern of their baby's movements.
   - Discuss birth planning including options for pain relief offer Managing your labour – information about how to manage pain in labour consumer information Water Birth / Immersion in Water During Labour and Birth
   - Discuss (using BRAIN acronym) and offer induction of labour. Provide education and information on Induction of labour and if suitable Going home after balloon cervical ripening catheter
5. Document in BOS – 'Antenatal Visit' tab
   - Update management plan if required
   - Print visit summary and put in VMR (VMO document in VMR)

Key Aligned Documents

Abdominal Examination/ Palpation
Aboriginal Healthy Start to Life
Adoption
Advanced Maternal Age
Anti-RH (D) Immunoglobulin Antenatal and Post Natal Administration
Collection of Urine Specimens
Continuity of Care Experience (COC) for Midwifery Students
Decreased Fetal Movements
Diabetes in pregnancy
Family Violence Response and Referral
Fetal Diagnostic Service
Group B Streptococcus

Healthy Mothers Healthy Babies Service Guide
Hypertension in Pregnancy (Pre-Eclampsia & Eclampsia)
Indications for Antenatal Ultrasound
Induction of Labour Indications and Booking Process
Induction of Labour – Cervical Ripening Balloon Catheter
Intrauterine Fetal Death and Stillbirth
Interpreter Service
Iron Deficiency Anaemia in Pregnancy, Intrapartum and Postpartum
Management of a woman with BMI > 35 in pregnancy
Management of Placenta Praevia Placenta Accreta and Vasa Praevia
Management of the Small for Gestational Age or Growth Restricted Fetus
Management of Vulnerable Babies, Children, and Young People at Risk of Harm
Models of Antenatal Care Referral Criteria for Obstetric Review
Nausea and Vomiting in pregnancy
Pain relief in labour
Peninsula Health Guide to Antenatal Ultrasound Assessment
Perinatal Mental Health
Pre-labour Rupture of Membranes at Term
Prenatal Screening Tests
Prolonged pregnancy
QUIT services guide
Supervision of Students (Nursing, Midwifery and Paramedicine) During Clinical Placement
Surrogacy
Vaginal Birth After Caesarean (VBAC)
Vaginal Breech Birth
Vitamin D Deficiency in Pregnancy & Breastfeeding
Water Birth / Immersion in Water During Labour and Birth
Adoption Act 1984 (Vic)
Assisted Reproductive Treatment Act 2008 (Vic)
Births, Deaths and Marriages Registration Act 1996 (Vic)
Status of Children Act 1974 (Vic)

Evaluation

Regular document revision, revision of incidents and near misses identified at incident review committee and / or review of relevant VHIMS/RiskMan Reports.

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