SCOPE DEFINITION

Guideline Title: *Rh D negative women and pregnancy*

Scope framework	
Population	*Which group of people will the guideline be applicable to?* • Pregnant women with an Rh D negative blood type
Purpose	*How will the guideline support evidence-based decision-making on the topic?* Identify relevant evidence related to: • Prevention of alloimmunisation to Rh D blood type • Recognition and referral of alloimmunised women
Outcome	*What will be achieved if the guideline is followed?* *(This is not a statement about measurable changes / not SMART goals)* Support: • Best practice management of women with Rh D negative blood type during pregnancy, labour and postpartum
Exclusions	*What is not included/addressed within the guideline* • Management of women with risk of alloimmunisation to antigens other than D • Routine antenatal, intrapartum and postpartum care • Ongoing care and management of the baby born to an Rh D negative woman • Management of established alloimmunisation • Care considered standard or usual as specified in the Queensland Clinical Guideline *Standard care*

Available from: www.health.qld.gov.au/qcg
Document Number: SC22.74-1-V1-R27
Effective date: May2027 | Review date: May 2027

Clinical questions

Question		Likely Content/Headings/Document Flow
Introduction		• Background: o Rh D negative blood type prevalence in Australian population o Risk of alloimmunisation o Role/mechanism of immunoprophylaxis o Clinical standards including informed consent
1.	What is Rh D alloimmunisation?	• Definitions/description • Pathogenesis • Prevalence
2.	What are the risk factors for alloimmunisation?	• Blood group of woman and fetus • Sensitising events
3.	What are the risks to the fetus/baby of an alloimmunised Rh D negative woman?	• Current pregnancy • Subsequent pregnancies
4.	How are women identified as being at risk of Rh D alloimmunisation?	• Routine initial blood tests o Blood group and antibody screening o Serologic partial D phenotype o Best practice blood tests–fetal RHD genotyping • Estimation of size of feto-maternal haemorrhage (FMH)–Kleihauer-Betke, flow cytometry • Postnatal cord or neonatal blood tests • Follow up testing
5.	How is Rh D alloimmunisation recognised?	• History, laboratory results • Referral
6.	What is the management of Rh D negative women who have a negative antibody screen for Rh D?	• Testing • Management if NIPT identifies likely Rh D negative fetus/baby
7.	What is the management of Rh D negative women if no NIPT for Rh D has been done, or if NIPT identifies an Rh D positive fetus/baby, or results are uncertain	• Routine antenatal immunoprophylaxis (28 and 34 weeks gestation) • Sensitising events o First trimester (before 13 + 0 weeks) o 13+0–19 + 6 weeks o From 20 + 0 weeks o FMH greater than or equal to 6 mL fetal red blood cell (12 mL whole blood) • Postnatally if: o Rh D positive baby o Rh D negative baby • Other: e.g. BMI greater than 30 kg/m^2
8.	What is the recommended use and administration of Rh immunoglobulin?	• Products: presentation, dose, volume, administration and indication (e.g. when intravenous administration required) • Safety • Consent
9.	What screening/testing does the baby born to a woman who is Rh D negative require at birth?	• Cord blood group • Direct antiglobulin titre

Potential areas for audit focus (to be refined during development)
Audit items will relate to the desired outcomes and the clinical questions

- Proportion of Rh D negative women who had antibody screening prior to 28+0 weeks gestation
- Proportion of Rh D negative women who receive routine Rh D immunoglobulin at or around 28 weeks gestation
- Proportion of Rh D negative women who receive routine Rh D immunoglobulin at or around 34 weeks gestation
- Proportion of Rh D negative women having sensitising event in pregnancy who have Rh D immunoglobulin dose administered within 72 hours
- Proportion of Rh D negative women who receive appropriate postpartum immunoprophylaxis