providing the excellent care we would expect for our own families

The Royal Bournemouth and Christchurch Hospitals NHS
NHS Foundation Trust

Antenatal Care Pathway

Approval Committee	Version	Issue Date	Review Date	Document Author(s)
Maternity Clinical Governance and Risk Management Group	3.0	February 2015	February 2018	Pauline McGill
Maternity Clinical Governance and Risk Management Group	6.0	August 2018	August 2021	Clare Hogan Emma Twine

Version Control

Version	Date	Author	Section	Principle Amendment Changes
3.0	August 2012	Pauline Hawkes	All	Updated format Addition of appendix 1c Addition in Appendix 9 of Outpatient Risk assessment for Venous Thromboembolism
3.0	January 2013	Pauline Hawkes	Appendix 3 and 6	Updated with current changes in clinics
4.0	November 2014	Pauline Hawkes		Risk assess for use of aspirin Addition of plotting of SFH on customized growth chart Addition of carbon monoxide monitoring at booking Addition of identification of babies at risk of exposure to tuberculosis Addition of identification of women at risk of exposure to varicella Addition of appendices 3a and 3b- BCG referrals Addition of appendix 6a- referral to midwife counselor Appendix 8b- Sunshine Team referral updated Reference list updated Clarification of place of birth where there is a low Hb. Appendix 1d Vitamin D supplementation At booking if BMI is over 30 Pertussis vaccination Flu vaccination
5.0	February 2015	Pauline Hawkes	All	Updated to reflect the intrapartum NICE Guidance (2014)

6.0	May 2018	Clare Hogan & Emma Twine	All	Updated as per new service specifications Removed appendix 3 of clinics and consultant specialties Updated appointments and leaflets given Updated medical examination criteria Updated associated policies Updated referral forms for consultant and sunshine Updated social risk assessment Updated aspirin guidance
7.1	March 2018	J. Sheppard	Section 3, 5 & 6 and Appendix 6c	Updated letter to GP for Aspirin Prescription Updated RBH banner Updated section 5.0 and 6.0 Updated section 3.0 regarding Aspirin guidance

Contents

Table of Contents

1.0 Introduction

Pregnancy is a normal physiological process and as such, any interventions offered should have known benefits and be acceptable to pregnant women. This guideline therefore outlines best practice for baseline clinical care for pregnancy.

Maternity Matters (DoH 2007) outlines that women should be the focus of maternity care with an emphasis on providing choice, easy access and continuity of care. Care during pregnancy should enable a woman to make informed decisions, based on her needs, having discussed matters fully with the professionals involved. Key aspects of care valued by women are respect, competence, communication, support and convenience provided by a small group of people (Redshaw et al 2004).

2.0 Objective / Policy Statement

This guideline has been written to assist midwives in the routine care of women in the antenatal period.

3.0 Procedures

Women Centered Care and Informed Decision Making

Women, their partners and their families should always be treated with kindness, respect and dignity (NICE 2008). The views, beliefs and values of the woman, her partner and her family in relation to her care and that of her baby should be sought and respected at all times. Women should have the opportunity to make informed decisions about their care and treatment, in partnership with health care professionals. If women do not have the capacity to make decisions, then staff should refer to Department of Health Guidelines (DoH 2001 and 2007).

Informed decision making involves reasoned choice based on relevant information about the advantages and disadvantages of all the possible courses of action, including taking no action. It requires that the individual has understood both the information provided and the full implications of all the alternative courses of action available.

Information for Women

Giving pregnant women relevant information to allow them to make informed decisions remains a challenge to all health care professionals (NICE 2008). At each antenatal appointment, midwives should offer consistent information and clear explanations and provide women with an opportunity to discuss issues and ask questions.

Antenatal information should be given to women by a midwife according to the following schedule in Appendix 1. Written information should be given to the women in accordance with the table in Appendix 1a. All discussions and provision of information, both verbal and written **must** be clearly documented in the hand held notes.

Provision and Organisation of Care

Midwife Led Care

Midwife led care should be offered to women with an uncomplicated pregnancy. Routine involvement of obstetricians in the care of a woman with uncomplicated pregnancy at

scheduled times does not appear to improve the perinatal outcomes compared with involving obstetricians when complications arise (NICE 2008).

In order to promote choice, antenatal appointments should be offered at locations to suit women and be conducive to privacy and the opportunity to discuss sensitive issues such as domestic abuse or safeguarding concerns.

Healthy women with uncomplicated pregnancies should be offered appointments to a recommended schedule (see Appendix 2). This schedule is printed in the maternity handheld notes, see Appendix 5.

Consultant Led Care

The assessment of women who may or not need additional care during pregnancy is based on identifying those in whom there may be maternal or fetal conditions associated with a higher incidence of maternal or perinatal death or morbidity. The needs of each pregnant woman should be assessed at the first appointment and reassessed throughout the pregnancy because new problems can arise at any time.

Women identified as being at risk of developing problems in the pregnancy or birth Appendix 4), will need referral to a Consultant Obstetrician. This should be done using the referral form in Appendix 6. Following referral, the Consultant Obstetrician will reply to the midwife with a management plan for pregnancy and birth, which may be to remain under midwifery led care. In addition to having appointments with the Consultant Obstetrician, the woman will also be offered appointments with a midwife according to the schedule in Appendix 2.

Appendix 3 outlines the Consultant Led Clinics and allocation of midwifery teams.

It may also be appropriate to refer women to an anaesthetist, for the following reasons:

- **Medical Conditions:** Any moderate to severe organ dysfunction, e.g. cardio respiratory disease, CNS disease etc., including those stabilised by medication.

- **Musculo-skeletal Conditions:** Any moderate to severe back problems or previous surgery to the spine.

- **Haematological:** Any history of congenital or acquired blood dyscrasias or the regular use of medications likely to affect the coagulation system, e.g. low molecular weight Heparin, Warfarin.

- **Anaesthetic Problems:** Any history of anaesthetic problems including drug reactions, failed intubation, scoline apnoea, malignant hyper pyrexia, previous dural taps etc.

- **Failure of analgesia or anaesthesia:** Any patient with particular problems with analgesia or anaesthesia during a previous pregnancy who wishes to discuss it further with an anaesthetist, eg partially effective or failed epidurals / spinals.

- **BMI** > 40 at booking

See Appendix 7 for further information and referral form.

Fundal Height Measurement

Fundal height measurement should be done as part of routine antenatal care from 25 weeks gestation, using a non-elastic tape measure and plotted on the customised growth chart.

Method for Fundal Height Measurement

Explain the procedure to the woman and gain her verbal consent

- Wash hands
- Have a non- elastic tape measure to hand
- Ensure the mother is comfortable in a semi-recumbent position with an empty bladder
- Expose enough of the abdomen to allow thorough examination
- Ensure the abdomen is soft non- contracting
- Perform abdominal palpation to enable accurate identification of the uterine fundus
- Use the tape measure with the centimetres on the underside to reduce bias
- Secure the tape measure at the fundus with one hand
- Measure from the top of the fundus to the top of the symphysis pubis
- The tape measure should stay in contact with the skin
- Measure along the longitudinal axis without correcting to the midline
- Measure only once
- Record the metric measurement and plot it on the customised antenatal growth chart

Referrals for further investigation

Midwives should refer for ultrasound biometry, amniotic fluid assessment, +/- Doppler flow:

- If first fundal height measurement plots below 10th centile on the customised antenatal growth chart
- If based on consecutive measurements, growth is static, or there is concern about it being slow because it does not follow the slope of the curves on the chart

- If based on consecutive measurements there is concern about excessive growth because of the steepness of the curve.

- A first measurement above the 90th centile line **does not** need referral for scan for query LGA, unless there are clinical concerns – e.g. polyhydramnios

Follow up

- Normal USS- revert to serial fundal height measurement

- Abnormal - refer for urgent obstetric review

- A first measurement above the 90th Centile **does not** need referral for scan for LGA unless there are clinical concerns e.g. polyhydramnios

Booking appointment

Elements of the Booking Appointment

Booking appointment should:
- Be carried out by 8-10 weeks of pregnancy
- Pre-existing type 1 and type 2 diabetics should be booked by the Diabetes Specialist Midwives in ANC

A booking pack is required, which contains:
- Hand held notes
- Appropriate blood forms, including Family Origin Questionnaire (FOQ)
- Scan forms
- Information pack (see appendix 1a)
- Consent form for screening (see appendix 11)

Midwives should:
- Inform women that the estimated date of delivery (EDD) is calculated by using the scan dates not the last menstrual period date (LMP)
- Give appropriate information (see appendix 1)
- Identify women who may need additional care (see Appendix 4) and referral to a consultant obstetrician for opinion on care pathway or place of birth (see Appendix 6)
- Identify women at risk of developing venous thromboembolic disorder (VTE) see appendix 9) and refer accordingly
- Risk assess women for the use of aspirin. Booking midwife to complete and send Aspirin letter to GP if woman is high risk for Aspirin (see appendix 6c)
- Identify babies at risk of exposure of tuberculosis (see Appendix 3a) and complete relevant paperwork (see appendix 3b)
- If appropriate, review the health records from previous pregnancies. This may involve requesting health records from other Trusts.
- Refer women who may need additional midwifery support due to social circumstances (see appendices 8, 8a and 8b).
- Ensure HV is informed of these women by copying the referral form to the HV and GP

All women should be monitored for carbon monoxide using a calibrated CO monitor

- Refer women who need help to quit smoking (see appendix 1b)
- Ask about mood to identify possible depression (see Perinatal Mental Health Pathway)
- Refer women for midwife counseling as appropriate (see appendix 6a)
- Identify women for whom there are safeguarding concerns (See Maternity Safeguarding Guideline) and make reasonable inquiry of the mother or father, where known, to identify the father's GP with a view to sharing information with professionals as require.
- Identify women who are experiencing domestic abuse (See Domestic Abuse Guideline)
- Identify women who have had genital mutilation
- Identify women who would decline blood and blood products (see appendix 1c)
- Identify women who are at risk of exposure to varicella virus (chickenpox)
- Check blood group and rhesus D status
- Offer screening for haemoglobinopathies, anaemia, red cell alloantibodies, hepatitis B virus, HIV, and syphilis.
- Offer screening for asymptomatic bacteriuria
- Offer Combined/Quadruple Screening screening for Down's, Patau's and Edward's syndromes.If this screening is declined, offer a dating scan
- Offer ultrasound screening for structural anomalies
- Measure body mass index (BMI), actually weighing and measuring women. Self reported weight should **not** be used (CEMACE 2010)
- Take blood pressure (BP), and test urine for proteinuria
- Screen for gestational diabetes using risk factors (see Diabetes in Pregnancy Guideline)
- Inform the health visitor of the pregnancy by sending her a copy of the referral form and ensure that the woman is aware that the health visitor will contact her during thepregnancy.
- Encourage women to have the flu vaccination at any stage of pregnancy during flu season
- Encourage women to have the pertussis vaccination after 16 weeks of pregnancy
- Sign FW8 form for free prescriptions and dental care in pregnancy and for 1 year postpartum
- Sign Healthy Start Vouchers for those who are entitled
- Assess dosage of folic acid that is recommended and advise supplementation until 12 weeks of pregnancy
- Assess dosage of vitamin D dosage that is recommended and advise supplementation for duration of pregnancy and breastfeeding
- Discuss NHS guidelines on healthy eating in pregnancy

The following written patient information should be given: (see Appendix 1a)

- Screening Tests for You and Your Baby (also available in easy read versions as well as different languages via the gov.uk website)
- Vaccinations in Pregnancy Leaflet
- Dorset Breastfeeding Guide
- CO Monitoring card

Women Who Book Late

Women who are referred to the Maternity Service after 10 weeks gestation should be seen within 2 weeks of referral. Midwives must ensure that all referrals are copied to the health visitor and GP.

Medical Examination

Women born in a country where there is no effective medical screening in childhood, including auscultation of the heart should be referred to the General Practitioner (GP) to have a medical history taken and clinical assessment of their overall health (RCOG, 2011).

Appointment at 16 weeks gestation

The next appointment should be scheduled at 16 weeks to:

- Review, discuss and record the results of all screening / blood tests undertaken
- Confirm estimated date of delivery (EDD) from scan and ensure that this is documented in the hand held records
- If appropriate refer for Anti-D (see Guideline on Anti-D)
- Reassess planned pattern of care, identify and refer women who may need additional care (see Appendix 6, 8and 8b)
- Investigate a haemoglobin level of less than 110g/l (see Guideline on Anaemia in Pregnancy)
- Measure BP and test urine for proteinuria
- Review the customized growth chart and ensure that the data entered has been correctly
- Give information (see section 4.2), with an opportunity to discuss issues and ask questions including discussion of anomaly scan and parent education.
- Refer women for midwife counseling as appropriate (see appendix 6a)
- Encourage women to have the flu and pertusiss vaccination
- Ensure maternity exemption card has been received
- Discuss fetal movements

Appointment at 18-20 weeks gestation

If the woman chooses, an ultrasound scan should be performed for the detection of structural anomalies (see guideline on Screening for Fetal Anomalies). For a woman who is found to have a placenta over the cervical os at this time, another scan at 36 weeks should be offered.

Following the USS, a customised growth chart will be produced using the following information:

- EDD
- Height
- Weight
- Details of previous babies
- Ethnicity

Two copies of the customised antenatal growth chart will be printed:

- One filed in the hand held maternity notes with the USS result
- One filed in the Health Records

Appointment at 25 weeks gestation

This appointment should only be offered to primiparous women.

- Reassess planned pattern of care, identify and refer women who may need additional care (see Appendix 6, 8and 8b)
- Measure and plot the symphysis-fundal height on the customised growth chart
- Measure BP and test urine for proteinuria
- Give information (see section 4.2) with an opportunity to discuss issues and ask questions
- Ensure that results for screening for Infectious Diseases are filed in notes
- Refer women for midwife counseling as appropriate (see appendix 6a)
- Encourage women to have the flu vaccination and pertussis vaccination

Appointment at 28 weeks gestation

- Reassess planned pattern of care, identify and refer women who may need additional care (see Appendix 6, 8and 8b)
- Offer a second screening for anaemia and atypical red cell alloantibodies
- Ensure that an appointment for Rhesus negative women who wish Anti-D is booked (see guideline on Anti-D)
- Measure BP and test urine for proteinuria
- Measure and plot the symphysis-fundal height on the customised growth chart
- Give information (see section 4.2) with an opportunity to discuss issues and ask questions
- Ensure that results for screening for Infectious Diseases are filed in notes
- Refer women for midwife counseling as appropriate (see appendix 6a)
- Encourage women to have the flu vaccination
- Encourage women to have pertussis vaccination
- Check parent education booked

Appointment at 31 weeks gestation

This appointment should only be offered to primiparous women.

- Reassess planned pattern of care, identify and refer women who may need additional care (see Appendix 6, 8and 8b)
- Measure BP and test urine for proteinuria
- Measure and plot the symphysis-fundal height on the customised growth chart
- Give information (see section 4.2) with an opportunity to discuss issues and ask questions
- Review, discuss and record the results of the screening tests undertaking at 28 weeks gestation
- Reassess planned care pathway, identifying and referring women who may need additional care in pregnancy or birth (see Appendix 6 and 8)

- Ensure that results for screening for Infectious Diseases are filed in notes
- Refer women for midwife counseling as appropriate (see appendix 6a)
- Encourage women to have the flu vaccination
- Encourage women to have pertussis vaccination

Appointment at 34 weeks gestation

- Reassess planned pattern of care, identify and refer women who may need additional care (see Appendix 6, 8and 8b)
- Measure BP and test urine for proteinuria
- Measure and plot the symphysis-fundal height on the customised growth chart
- Give information (see section 4.2) with an opportunity to discuss issues and ask questions
- Review, discuss and record the results of the screening tests undertaking at 28 weeks gestation
- Ensure that results for screening for Infectious Diseases are filed in notes
- Refer women for midwife counseling as appropriate (see appendix 6a)
- Encourage women to have the flu vaccination
- Encourage women to have pertussis vaccination
- Offer low risk women this appointment at the birth centre

Appointment at 36 weeks gestation

- Reassess planned pattern of care, identify and refer women who may need additional care (see Appendix 6, 8and 8b)
- Measure BP and test urine for proteinuria
- Measure and plot the symphysis-fundal height on the customised growth chart
- Check position of baby
- (ECV) if confirmed (see guideline on ECV)
- Review ultrasound report if placenta extended over the os at 20 week scan
- Discuss breast feeding technique (see Dorset Breast Feeding Guideline)
- Give information (see appendix 1 and 1a), with an opportunity to discuss issues and ask questions.
- Ensure 'Birth Choices' page is completed in hand held notes
- Ensure that results for screening for Infectious Diseases are filed in notes
- Refer women for midwife counseling as appropriate (see appendix 6a)
- Encourage women to have the flu vaccination
- Encourage women to have pertussis vaccination
    - All women should be monitored for carbon monoxide using a calibrated CO monitor

The following written patient information should be discussed if appropriate: (see Appendix 1a)

- Monitoring Your Baby's Heartbeat in Labour (in maternity handheld notes)
- Vitamin K (in handheld notes)
- Birth choices (in handheld notes)

Appointment at 38 weeks gestation

- Reassess planned pattern of care, identify and refer women who may need

additional care (see Appendix 6, 8and 8b)
- Measure BP and test urine for proteinuria
- Measure and plot the symphysis-fundal height on the customised growth chart
- Give information (see section 4.2), with an opportunity to discuss issues and ask questions. Information should include options of the management of prolonged pregnancy
- Ensure that results for screening for Infectious Diseases are filed in notes
- Refer women for midwife counseling as appropriate (see appendix 6a)
- Encourage women to have the flu vaccination
- Encourage women to have pertussis vaccination

Appointment at 40 weeks gestation

This appointment should only be offered to primiparous women.

- Reassess planned pattern of care, identify and refer women who may need additional care (see Appendix 6, 8and 8b)
- Offer membrane sweep
  - Measure BP and test urine for proteinuria
  - Measure and plot the symphysis-fundal height on the customised growth chart
  - Give information (see section 4.2), with an opportunity to discuss issues and ask questions. Information should include options of the management of prolonged pregnancy
  - Ensure that results for screening for Infectious Diseases are filed in notes
  - Refer women for midwife counseling as appropriate (see appendix 6a)
  - Encourage women to have the flu vaccination
  - Encourage women to have pertussis vaccination

Appointment at 41 weeks gestation

For all women who have not given birth by 41 weeks:

- Reassess planned pattern of care, identify and refer women who may need additional care (see Appendix 6, 8and 8b)
- Offer membrane sweep
- Offer induction of date and arrange date for 40+10-12 if woman wishes
- Measure BP and test urine for proteinuria
- Measure and plot the symphysis-fundal height on the customised growth chart
- Give information (see section 4.2), with an opportunity to discuss issues and ask questions. Information should include options of the management of prolonged pregnancy.
- Ensure that results for screening for Infectious Diseases are filed in notes
- Refer women for midwife counseling as appropriate (see appendix 6a)
- Encourage women to have the flu vaccination
- Encourage women to have pertussis vaccination

The following written patient information should be discussed and supplementary leaflet given if appropriate: (see Appendix 1a)

- Induction of Labour

4.0 Training

Staff receive training on the management of the management of all aspects of antenatal care in their midwifery training. Updates to the guideline will occur in line with National Policy and staff will be updated via team and unit meetings. Staff will receive training in the annual mandatory training as per training needs analysis.

5.0 Process for Monitoring Compliance with the Policy

All staff are expected to adhere to the guideline. The reason for any deviation from the guideline should be documented in the hand held and/or maternity case notes.

In conjunction with the Audit Department an audit of the maternity notes of women is carried out following any change in trends or changes in local/national guidelines.

The auditor is responsible for reviewing the audit results and developing appropriate action plans. The results of the audit and subsequent action plans are fed back through the following means:

- Presented at the Maternity Open Risk monthly meeting
- If applicable, to relevant staff through training and updates

Any action plans from the audit will be monitored through the Maternity Open Risk Meeting.

For risk reporting please see appendix 10.

6.0 Approval, Implementation & Review

Approval
This policy will be approved by the Maternity Open Risk Meeting Committee.

Implementation
Once approved, the policy will be published on the Trust intranet, under Maternity Policies and Guidelines.

Review
The Maternity Open Risk Committee is responsible for ensuring that the policy is updated every 3 years.

7.0 References

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Department of Health (2007) *Code of Practice accompanying the Mental Capacity Act* www.dca.gov.uk/mencap/bill-summary.htm

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Royal College of Obstetricians and Gynaecologists (2011) Good Practice No. 13 Cardiac Disease and Pregnancy www.rcog.org.uk

Royal College of Obstetricians and Gynaecologists (2014) Vitamin D in pregnancy Scientific Impact Paper www.rcog.org.uk

8.0 Associated Policies

- Routine postnatal care of the Mother and Newborn
- Normal Labour and Birth Guideline
- Missed Appointments
- Antenatal Screening for Down's, Edward's and Patau's Syndromes
- Antenatal Screening for Infectious Diseases
- Antenatal Sickle Cell & Thalassaemia Screening
- Anti-D Policy
- Maternity Guidelines for Maternal Mental healthMaternity Safeguarding Policy
- SOP - Documenting and Accessing Information on Medway for Women with Safeguarding and Complex Social Needs
- Diabetes in Pregnancy
- Domestic Abuse
- Management of Eclampsia
- Management of Severe Pre-eclampsia and Eclampsia Policy

- External Cephalic Version Protocol
- Reduced/Absent Fetal Movements Guidance
- Pre-labour Rupture of Membranes at Term
- Management of Substance Misuse in Pregnancy
- Vaginal Birth after Caesarean Section
- Screening and Treatment for Anaemia In PregnancyReferral for Fetal Anomaly Guideline
- Guidelines for Management of a Surrogate PregnancySOP for Antenatal Booking Bloods, Combined Screening and Quadruple Screening

8.09.0Consultation

Those listed opposite have been consulted and comments/actions incorporated as required.	List Groups and/or Individuals Consulted Clinical staff, RBH maternity

Appendix 1-Provision of Information

Information given at: **Referral and booking**	How	Further information for women	Translation	Additional needs
Folic acid supplementation	Verbal explanation	www.nhs. uk		
Food hygiene, including how to reduce the risk of a food acquired infection	Verbal explanation			
Lifestyle advice: • smoking cessation • implications of recreational drug use • alcohol consumption in pregnancy • domestic abuse • flu vaccination • pertussis vaccination	Verbal explanation and discussion	www.nhs. uk Patient information leaflets: NHS Vaccination in Pregnancy Leaflet •	Language line and www.nhs.uk/	Maternity Access and Advocacy Pack
All antenatal screening: • haemoglobinopathies • anomaly scan • Down's, Edward's and Patau's syndromes • Infectious diseases	Verbal explanation and discussion National Screening Committee Leaflet	www.nhs.uk/www.gov.uk Patient information leaflet: • Screening Tests for You and Your baby		
How the baby develops in pregnancy	Verbal explanation	www.nhs.uk/		
Nutrition and diet, including vitamin D supplementation for women at risk of vitamin D deficiency and details of the Healthy Start Programme	Verbal explanation and discussion	www.nhs.uk/Patient information leaflet: • Healthy Start www.healthystart.nhs.uk		

Place of birth options	Verbal explanation Written information in handheld notes	www.nhs.uk/ Birth place app		
Pregnancy care pathway	Verbal explanation and written information in hand held notes	www.nhs.uk/Appointments		
Parent education classes	Verbal explanation	• Maternity website: http://www.rbch.nhs.uk/our_services/clinical_services/maternity		
Information given by:	How	Further information	Translation	Additional

16 weeks		for women		needs
Anti D (if appropriate)	Verbal explanation	Patient Information leaflet: • Blood Group and Red Cell Antibodies in pregnancy	Language line and www.nhs.uk/	Maternity Access and Advocacy Pack
Information given by: **28 weeks**	How	Further information for women	Translation	Additional needs
Maternity Leave	Verbal explanation	Mat B1 form	Language line and www.nhschoices.uk	Maternity Access and Advocacy Pack
Breast feeding, regardless of the stated intended method of feeding	Verbal explanation	www.nhs.uk/Patient Information leaflet: • Dorset Breastfeeding Guide	Language line and www.nhs.uk/	Maternity Access and Advocacy Pack
Further discussion of all antenatal screening	Verbal explanation and discussion	www.nhs.uk/www.gov.uk Patient information leaflet: • Screening Tests for You and Your Baby		

Antenatal mental health issues	Verbal explanation and discussion			

Information given by: **36 weeks**	How	Further information for women	Translation	Additional needs
Preparation for labour and birth: • information about coping with pain in labour • the birth plan • monitoring the baby in labour • recognition of active labour • sign 'Birth Choices' form	Verbal explanation and discussion Written information in handheld notes	www.nhs.uk/	Language line and www.nhs.uk/	Maternity Access and Advocacy Pack
Postnatal care and care of the new baby	Verbal explanation and discussion	www.nhs.uk/		
Vitamin K prophylaxis	Verbal explanation and discussion	www.nhs.uk/		
Newborn screening tests	Verbal explanation and discussion	www.nhs.uk/www.gov.uk Patient information leaflet: • Screening Tests for You and Your baby		
Postnatal mental health issues	Verbal explanation and discussion	www.nhs.uk/Patient information leaflet: • Understanding postnatal Depression		
Information given by: **38 weeks**	How	Further information for women	Translation	Additional needs
Options for management of prolonged pregnancy, including membrane sweeping and induction of labour	Verbal explanation and discussion	www.nhs.uk/Patient information leaflets: • Inductionof Labour	Language line and www.nhs.uk/	Maternity Access and Advocacy Pack

Appendix 1a- Patient Information Leaflets

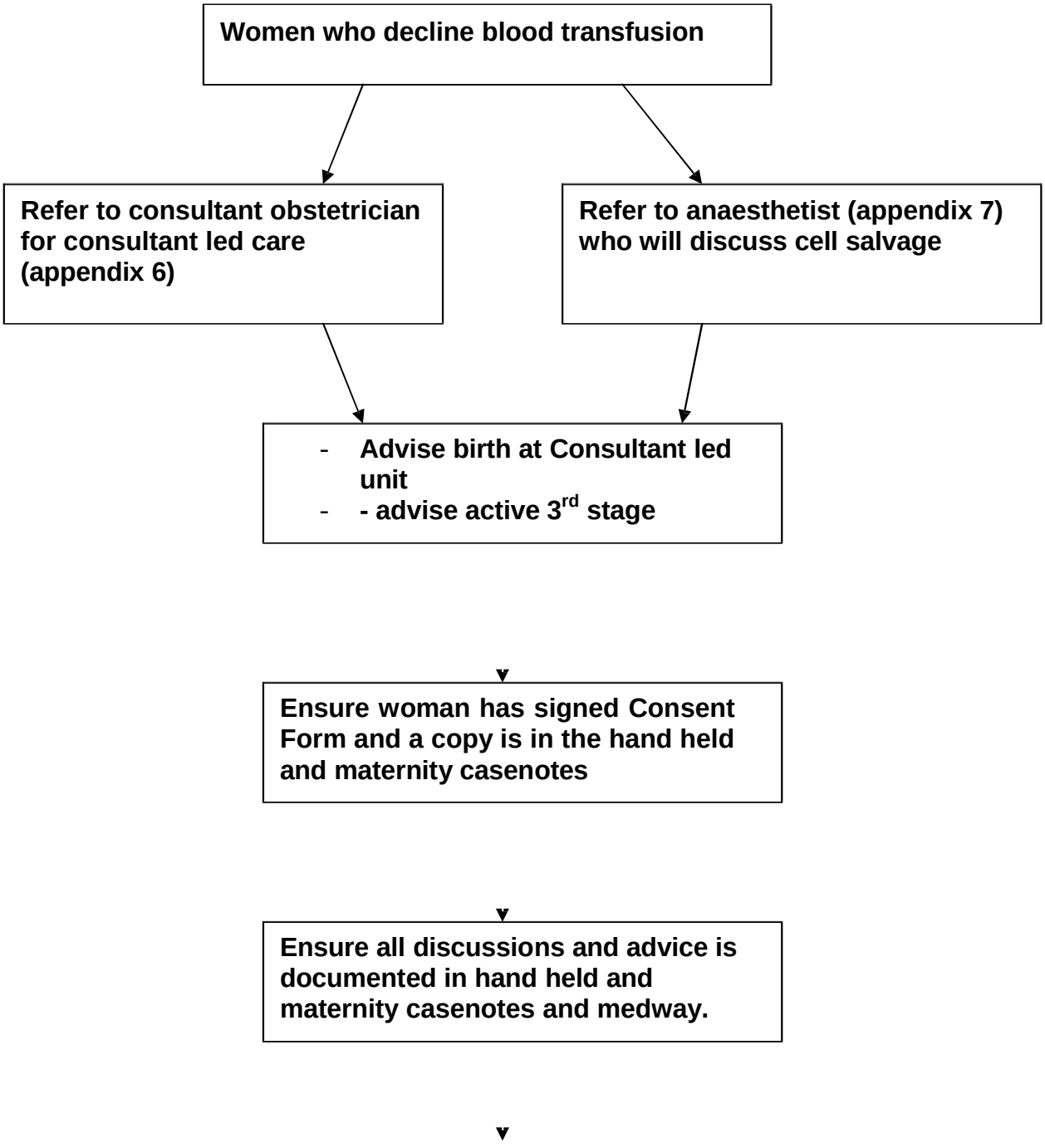
Appointment	Patient Information Leaflets to be Given
Booking	• Screening Tests for You and Your Baby • Healthy Start • Public Health England Vaccinations in Pregnancy • The Early Years Handbook – Bournemouth Borough Council • Bournemouth SureStart Centres – Low mood • RBCH Maternal Request for Caesarean Section • CO Monitoring • Dorset Breastfeeding Guide • Vaccinations in Pregnancy
	•
28 weeks	• Dorset Breastfeeding Guide • MaTB1
	•
41 weeks	• Induction of Labour

Appendix 1b- Quitting Smoking

Midwives should:

- Assess the woman's exposure to tobacco smoke through discussion and use of a Carbon monoxide test.
- Provide information about the risks to the unborn child of smoking when pregnant and the hazards of exposure to secondhand smoke for both mother and baby. Information should be available in a variety of formats.
- Explain about the health benefits of stopping for the woman and her baby. Advise her to stop – not just cut down.
- Explain that it is normal practice to refer all women who smoke for help to quit and that a specialist midwife or adviser will phone and offer her support.
- Refer all women who smoke, or have stopped smoking within the last 2 weeks, to smoking cessation midwifery team
- If her partner or others in the household smoke, suggest they contact NHS Stop Smoking Services. If no one smokes, give positive feedback.
- At the next appointment, check if the woman took up her referral. If not, ask if she is interested in stopping smoking and offer another referral to the service.
- If she declines the referral, accept the answer in an impartial manner, leave the offer of help open.
- If the referral was taken up, provide feedback. Review at subsequent appointments, as appropriate.
- Where appropriate, for each of the stages above record smoking status, CO level, whether a referral is accepted or declined and any feedback given. This should be recorded in the woman's hand-held record.

Appendix 1c- Women who decline blood transfusion



Appendix 1d- Information regarding Vitamin D

In general, vitamin D 10 micrograms (400 units) a day is recommended for all pregnant women in accord with the national guidance. This should be available through the Healthy Start programme.

High-risk women are advised to take at least 25 micrograms (1000 units) a day (women with increased skin pigmentation, reduced exposure to sunlight, or those who are socially excluded or obese). The RCOG has highlighted the importance of addressing suitable advice to these women. The limitation to therapy compliance mostly relates to the calcium which has a side effect of tasting of chalk, rather than the vitamin D element of oral therapy. It is often more appropriate to give vitamin D alone for patient acceptability. However, this is limited by the availability of suitable agents; vitamin D cannot be prescribed at low doses without calcium. 800-unit formulations of cholecalciferol without calcium are available (e.g. Fultium-D3®, Internis, London; Desunin®, Meda, Bishop's Stortford, UK).

RCOG 2014

Appendix 2 Antenatal care

Gestation	Appt to cover	Location	By whom
By 8-10 weeks	• Completion (in full) of hand held records • Information giving (see Appendix 1) • Inform women that scan dates are calculated from EDD not LMP • Identify and refer women who need consultant led care • Identify antenatal depression • Identify women whom there are safeguarding concerns • Identify women who are experiencing domestic abuse • Identify women with FGM • Check CO level for all women, regardless of smoking status • Risk assess women for the use of aspirin • Identify babies at risk of exposure to TB • Identify woman at risk of exposure to varicella • Take blood for grouping, antibodies, infectious diseases • Offer referral for chlamydia screening to women under 25 • Take MSU • Offer screening for Down's, Edward's and Patau's syndromes • Offer ultrasound screening for anomalies • Measure BMI, BP and test urine • Screen for gestational diabetes	• GP surgery • Children's Centre Birth Unit	Midwife
Between 11+2 - 14+1 weeks	• Dating scan or combined screening	RBH ANC	Sonographer
16 weeks	• Review screening / blood tests • Confirm EDD from scan and document in hand held records • Reassess care pathway • Investigate Hb <110 • Measure BP and test urine • Information giving (see Appendix 1) • Ensure that results for all screening and other tests is filed in notes • Encourage women to have flu vaccination • Encourage women to have pertussis vaccination	• GP surgery • Children's Centre • Birth Unit	Midwife
18-20 weeks	Ultrasound scan for structural anomalies	RBH ANC	Sonographer

Gestation	Appt to cover	Location	By whom
25 weeks (primips only)	• Measure and plot SFH • Measure BP and test urine • Information giving (see Appendix 1) • Ensure that results for all screening and other tests is filed in notes • Encourage women to have flu vaccination	Choice of: • GP surgery • Children's Centre • Birth Unit	Midwife
28 weeks	• Screening for anaemia • Arrange Anti D for Rh neg women at 30 weeks • Measure and plot SFH • Measure BP and test urine • Information giving (see Appendix 1) • Ensure that results for all screening and other tests is filed in notes • Encourage women to have flu vaccination • Encourage women to have pertussis vaccination		
31 weeks (primips only)	• Measure and record SFH • Measure BP and test urine • Information giving (see Appendix 1) • Review tests taken at 28 weeks • Reassess care pathway • Ensure that results for all screening and other tests is filed in notes • Encourage women to have flu vaccination • Encourage women to have pertussis vaccination		
34 weeks	• Measure and record SFH • Measure BP and test urine • Information giving • Review tests taken at 28 week • Reassess care pathway • Ensure that results for all screening and other tests is filed in notes • Encourage women to have flu vaccination • Encourage women to have pertussis vaccination		

Gestation	Appt to cover	Location	By whom
36 weeks	• Measure and record SFH • Measure BP and test urine • Check position of baby • Offer ECV to appropriate women • Review USS if appropriate • Discuss breast feeding • Information giving (see Appendix 1) • Reassess care pathway • Ensure that results for all screening and other tests is filed in notes • Encourage women to have flu vaccination • Encourage women to have pertussis vaccination • Check CO level	Choice of: • GP surgery • Children's Centre • Birth Unit	Midwife
38 weeks	• Measure and record SFH • Measure BP and test urine • Information giving (see Appendix 1) • Reassess care pathway • Ensure that results for all screening and other tests is filed in notes • Encourage women to have flu vaccination • Encourage women to have pertussis vaccination		
40 weeks (primips only)	• Measure and record SFH • Measure BP and test urine • Information giving (see Appendix 1) • Reassess care pathway • Offer membrane sweep • Ensure that results for all screening and other tests is filed in notes • Encourage women to have flu vaccination • Encourage women to have pertussis vaccination		
41weeks	• Offer membrane sweep/further membrane sweep for primips • Arrange IOL • Measure and record SFH • Measure BP and test urine • Information giving (see Appendix 1) • Reassess care pathway • Additional membrane sweeps may be offered if labour does not start spontaneously • Ensure that results for all screening and other tests is filed in notes • Encourage women to have flu vaccination • Encourage women to have pertussis vaccination		

Appendix 3a Countries of birth of parent or grandparent that require BCG vaccination

Afghanistan Algeria Angola Armenia Azerbaijan Bangladesh Belarus Belize Benin Bhutan Bolivia Bosnia Herzegovina Botswana Brazil
Brunei Darussalam
Burkina Faso, Burundi Cambodia Cameroon Cape Verde
Central African Republic Chad
China Congo
Cote d'Ivoire
Democratic Reublic of the Congo
Democratic People's Republic of Korea
Dijibouti
Dominican Republic
Ecuador
El Savador Equatorial Guinea Eritrea
Ethiopia
Fiji
Gabon Gambia Georgia Ghana Greenland
Guam
Guinea Guinea-Bissau Guyana
Guam Haiti Honduras India Indonesia Iraq
Kazakhstan Kenya Kiribati Kyrgyzstan
Korea
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Lithuania
Libya
Lithuania
Macao
Madagascar Malawi Malaysia Mali Maldives
Marshall Islands Mauritania Micronesia (Federated States of)
Mongolia Morocco Mozambique Myanmar Namibia
Nepal Nauru Nicaragua Niger Nigeria
Northern Mariana Islands Pakistan
Palau Panama
Papua New Guinea Paraguay
Peru Philippines
Republic of Korea
Republic of Moldova
Romania
Russian Federation Rwanda
Sao Tome & Principe Senegal
Sierra Leone
Singapore Solomon Islands Somalia
South Africa
South Sudan
Sri Lanka Sudan Swaziland Tajikistan Thailand Timore-Leste
Togo Turkmenistan Tuvalu Uganda Ukraine
United Republic of Tanzania Uzbekistan Vanuatu Vietnam
Yemen
Zambia Zimbabwe

The Royal Bournemouth & Christchurch Hospitals NHS
NHS Foundation Trust
Maternity Unit
Castle Lane East, Bournemouth, BH7 7DW
Tel: 01202 704685

NEO-NATAL BCG CLINIC

REFERRAL FROM/DATE REFERRED	ORIGIN/NATIONALITY
DATE RECEIVED:	HOSPITAL NO:/NHS
GP NAME & ADDRESS	NAME: D.O.B: M / F ADDRESS POSTCODE
ANY OTHER LIVE VACCINES IN LAST 4 WEEKS including hepatitis YES / NO	
GENERAL HEALTH / CURRENT TREATMENTS:	TEL. APPOINTMENTS Sent ✓ OUTCOME 1 ……. ……. ☐ …….. 2 …….. ……. ☐ ……
COMMENTS:MOTHERS NAME/NHS NUMBER	

BCG CONSENT

I consent to my child receiving the BCG vaccination.
I have understood the verbal and written information given regarding the vaccination.

SIGNED: …… *DATE* ……
PARENT / GUARDIAN

ACTION:	
BCG VACCINATION GIVEN: YES / NO	*VACCINATION GIVEN BY* *SIGNED:* ……
LOT:	
EXPIRY:	
DATE:	***Midwife***

Appendix 4 Criteria for Women Who Require Additional Care in Pregnancy

Pregnant women with the following conditions will usually require additional care in pregnancy and should be referred to a Consultant Obstetrician:

- cardiac disease, including hypertension
- renal disease
- endocrine disorders or diabetes requiring insulin
- psychiatric disorders (being treated with medication)
- haematological disorders
- autoimmune disorders
- epilepsy requiring anticonvulsant drugs
- malignant disease
- severe asthma
- use of recreational drugs such as heroin, cocaine (including crack cocaine) and ecstasy
- HIV or HBV infection
- obesity (body mass index 30 kg/m_2 or above at first contact) or underweight (body mass
- index below 18 kg/m_2 at first contact)
- higher risk of developing complications, for example, women aged 40 and older, women who
- smoke
- women who are particularly vulnerable (such as teenagers) or who lack social support.
- Women who have experienced any of the following in previous pregnancies:
- recurrent miscarriage (three or more consecutive pregnancy losses or a mid-trimester loss)
- preterm birth
- severe pre-eclampsia, (H) hemolytic anaemia, (EL) elevated liver enzymes, and (LP) low
- platelet count (HELLP syndrome) or eclampsia
- rhesus isoimmunisation or other significant blood group antibodies
- uterine surgery including caesarean section, myomectomy or cone biopsy
- antenatal or postpartum haemorrhage on two occasions
- puerperal psychosis
- grand multiparity (more than 4 pregnancies)
- a stillbirth or neonatal death
- a small-for-gestational-age infant (below 5th centile)
- a large-for-gestational-age infant (above 95th centile)
- a baby weighing below 2.5 kg or above 4.5 kg
- a baby with a congenital abnormality (structural or chromosomal).

Table 1 Medical conditions indicating increased risk suggesting planned birth at an obstetric unit

Disease area	Medical condition
Cardiovascular	• Confirmed cardiac disease • Hypertensive disorders
Respiratory	• Asthma requiring an increase in treatment or hospital treatment • Cystic fibrosis
Haematological	• Haemoglobinopathies – sickle-cell disease, beta-thalassaemia major • History of thromboembolic disorders • Immune thrombocytopenia purpura or other platelet disorder or platelet count below 100,000 • Von Willebrand's disease • Bleeding disorder in the woman or unborn baby • Atypical antibodies which carry a risk of haemolytic disease of the newborn
Endocrine	• Hyperthyroidism • Diabetes
Infective	• Risk factors associated with group B streptococcus whereby antibiotics in labour would be recommended • Hepatitis B/C with abnormal liver function tests • Carrier of/infected with HIV • Toxoplasmosis – women receiving treatment • Current active infection of chicken pox/rubella/genital herpes in the woman or baby • Tuberculosis under treatment
Immune	• Systemic lupus erythematosus • Scleroderma
Renal	• Abnormal renal function • Renal disease requiring supervision by a renal specialist
Neurological	• Epilepsy • Myasthenia gravis • Previous cerebrovascular accident
Gastrointestinal	• Liver disease associated with current abnormal liver function tests
Psychiatric	• Psychiatric disorder requiring current inpatient care

Table 2 Other factors indicating increased risk suggesting planned birth at an obstetric unit

Factor	Additional information
Previous complications	• Unexplained stillbirth/neonatal death or previous death related to intrapartum difficulty • Previous baby with neonatal encephalopathy • Pre-eclampsia requiring preterm birth • Placental abruption with adverse outcome • Eclampsia • Uterine rupture • Primary postpartum haemorrhage requiring additional treatment or blood transfusion • Retained placenta requiring manual removal in theatre • Caesarean section • Shoulder dystocia
Current pregnancy	• Multiple birth • Placenta praevia • Pre-eclampsia or pregnancy-induced hypertension • Preterm labour or preterm prelabour rupture of membranes • Placental abruption • Anaemia – haemoglobin less than 85 g/dl at onset of labour • Confirmed intrauterine death • Induction of labour • Substance misuse • Alcohol dependency requiring assessment or treatment • Onset of gestational diabetes • Malpresentation – breech or transverse lie • Body mass index at booking of greater than 35 kg/m^2 • Recurrent antepartum haemorrhage • Small for gestational age in this pregnancy (less than fifth centile or reduced growth velocity on ultrasound) • Abnormal fetal heart rate (FHR)/Doppler studies • Ultrasound diagnosis of oligo-/polyhydramnios
Previous gynaecological history	• Myomectomy • Hysterotomy

Table 3 Medical conditions indicating individual assessment when planning place of birth.

Disease area	Medical condition
• Cardiovascular	• Cardiac disease without intrapartum implications
• Haematological	• Atypical antibodies not putting the baby at risk of haemolytic disease • Sickle-cell trait • Thalassaemia trait • Anaemia Hb 85-105g/litre
• Infective	• Hepatitis B/C with normal liver function tests
• Immune	• Non-specific connective tissue disorders
• Endocrine	• Unstable hypothyroidism such that a change in treatment is required •
• Skeletal/neurological	• Spinal abnormalities • Previous fractured pelvis • Neurological deficits
• Gastrointestinal	• Liver disease without current abnormal liver function • Crohn's disease • Ulcerative colitis

Table 4 Other factors indicating individual assessment when planning place of birth

Factor	Additional information
Cardiovascular	• Cardiac disease without intrapartum implications
Haematological	• Atypical antibodies not putting the baby at risk of haemolytic disease • Sickle-cell trait • Thalassaemia trait • Anaemia 85-105 g/L at onset of labour
Infective	• Hepatitis B/C with normal liver function tests
Immune	• Non-specific connective tissue disorders
Endocrine	• Unstable hypothyroidism such that a change in treatment is required
Skeletal/neurological/gastrointestinal	• Spinal abnormalities • Previous fractured pelvis • Neurological deficits • Liver disease without current abnormal liver function • Crohn's disease • Ulcerative colitis
Previous complications	• Stillbirth/neonatal death with a known non-recurrent cause • Pre-eclampsia developing at term • Placental abruption with good outcome • History of previous baby more than 4.5 kg • Or less than 2.5kg at term • Extensive vaginal, cervical, or third- or fourth-degree perineal trauma • Previous term baby with jaundice requiring exchange transfusion • Previous pre-term birth • Recurrent miscarriage (3 or more)
Current pregnancy	• Antepartum bleeding of unknown origin (single episode after 24 weeks of gestation) • BMI at booking of <18kg/m^2 • Blood pressure of 140 mmHg systolic or 90 mmHg diastolic on two occasions • Clinical or ultrasound suspicion of macrosomia • Para 4 or more • Recreational drug use • Under current outpatient psychiatric care • Age over 40 at booking • Smoker
Fetal indications	• Fetal abnormality

Previous gynaecological history	• Major gynaecological surgery • Cone biopsy or large loop excision of the transformation zone • Fibroids

Antenatal Appointments in Pregnancy

Midwife Led Care– women who are healthy and are at low risk of developing problems the pregnancy and birth are suitable for midwife led care.

Consultant Led Care– women who are at risk of developing problems during the pregnancy and birth will be advised to have this type of care. In addition having appointments with your midwife or GP (see below), you will also have appointments with an Obstetrician and possibly other specialists.

At each antenatal appointment, you should bring your hand held maternity records and a urine sample. The midwife will feel your tummy and listen to the baby's heartbeat. You should let your midwife know if you are feeling unwell or have any symptoms that you do not normally have.

Gestation	**Appointment at:**	**What happens**
8-10 weeks	Community Clinic	Referral and booking appt
11-14 weeks	Hospital	Scan and blood tests
16 weeks	Community Clinic	Results of screening tests Midwife will book Anti-D if appropriate
18-20 weeks	Hospital	Detailed scan
25 weeks*****	Community Clinic	Routine check
28 weeks	Community Clinic	Blood tests Anti D if appropriate Mat B1 (maternity leave form)
31 weeks*	Community Clinic	Routine antenatal
34 weeks	Community Clinic	Routine antenatal
36 weeks	Community Clinic	Routine antenatal
38 weeks	Community Clinic	Information re prolonged pregnancy and induction of labour
40 weeks*	Community Clinic	Routine antenatal
41 weeks	Community Clinic	Induction of labour arranged

***1st time mums only**

REFERRAL TO OBSTETRICIAN/ANTENATAL CLINIC

Date of referral: NAME:
Midwife name: DATE OF BIRTH:
GP Surgery: PMI/NHS NUMBER:

G ….. P ….. EDD …….. Gestation …… BMI …… Smoker Y / N Number per day ……

Delivery Date				
Gestation				
Delivery Type				
Weight /centile of baby				

REASON(S) FOR REFERRAL:

MEDICAL/ONGOING ISSUES	**PREVIOUS PREGNANCY**	**CURRENT PREGNANCY**
• BMI >35 …… <18 …… • Smoker ……. • Substance/Alcohol misuse ……. • Significant Mental Health/Social ……. • Hypertension …… • Renal ……. • HIV …… • Cardiac …….. • VTE/Haematology …… • Type I and II Diabetes …….. • Other significant clinical history ……	• Fetal loss …….. • Fetal medicine input …… • SGA …… • Preterm < 34/40 …….. • Obstetric Cholestasis …… • Pre -eclampsia …….. • HeLLP …… • Placenta Accreta …… • PPH >1.5 L …….. • Caesarean …….. • Other significant issue …….	• Age > 40 …… <16 …… • TWINS …….. • Low Papp A …… • IVF …….. • Placenta Praevia …… • Polyhydramnios …… • Obstetric Cholestasis …… • SGA …….. • LGA …….. • Breech/Transverse lie …… • Other ……
If this referral is for advice only please consider emailing – rbch.ancreferrals@nhs.net (this is checked Mon-Fri 9-5)		

OBSTETRICIAN/ANC MIDWIFE TO COMPLETE – Named consultant:

	Appointment required		**USS required with ANC appointment**(scan form required)		**Fetal medicine appointment required**		**Serial USS for growth only** (NO ANC appt req)	
	YES	NO	YES	NO	YES if yes please hand referral to ANSC	NO	YES if yes please hand scan form to USS dept	NO
Gestation								

Previous maternity notes required		**Medical notes required**		**Date requested**
YES	NO	YES	NO	

FEEDBACK/ADVICE:

Date and time of scan: Date and time of appt:

Appendix 6c - referral to GP for Aspirin

Dear Doctor,

Re: Name: ……

NHS No: ……

DOB: ……

EDD: ……

Please prescribe **75mg per day Aspirin from 12 weeks gestation until birth** for the above patient as per NICE guideline – Hypertension in Pregnancy, for the following reasons:

Moderate Risk Factors (Aspirin required if 2 or more)	
First Pregnancy	
Age ≥ 40 years	
Pregnancy Interval > 10 years	
BMI ≥ 35kg/m2 at First Visit	
Family History of Pre-Eclampsia	
Multiple Pregnancy	
High Risk Factors (Aspirin required if 1 or more)	
Hypertensive Disease During Previous Pregnancy	
Chronic Kidney Disease	
Autoimmune Disease such as SLE / APS	
Type 1, Type 2 Diabetes	
Chronic Hypertension	

Please ensure there are no contra-indications to Aspirin.

Many thanks

…… …… ……..
Signature Date Grade

Appendix 7

PMU Obstetric Anaesthetic Assessment Clinic Guidelines

AIMS:

1 To assess potential high risk women ante-natally where anaesthetic involvement may be needed either presently or in the future.

2 To give guidance and advice by obstetric anaesthetists so that a planned course of action is laid out for each individual patient.

CATEGORIES OF PATIENTS SUITABLE FOR REFERRAL

Medical Conditions: Any moderate to severe organ dysfunction, eg cardio respiratory disease, CNS disease etc, including those stabilised by medication.

Musculo-skeletal Conditions:- Any moderate to severe back problems or previous surgery to the spine.

Haematological:- Any history of congenital or acquired blood dyscrasias or the regular use of medications likely to affect the coagulation system, eg low molecular weight Heparin, Warfarin.

Anaesthetic Problems:- Any history of anaesthetic problems including drug reactions, failed intubation, scoline apnoea, malignant hyper pyrexia, previous dural taps etc.

Failure of Analgesia or Anaesthesia:- Any patient with particular problems with analgesia or anaesthesia during a previous pregnancy who wishes to discuss it further with an anaesthetist, eg partially effective or failed epidurals / spinals.

Obesity:- BMI > 40 at booking

Referrals should preferably be accompanied by a short note and the woman asked to bring her relevant notes, laboratory results and x-rays. (See over for referral pro-forma).

If possible, please refer to the appropriate anaesthetist working with the obstetricians during the day for continuity.

Day	**Cons Anaesthetist**	**Cons Obstetrician (am/pm)**
Monday	Alison McCormick	Rob Sawdy/ Tim Hillard
Tuesday	Michael Wee	Louise Melson/ Tyrone Carpenter
Wednesday	Helen Wise	Alex Taylor/ James Balmforth
Thursday	Dan Dalgleish	James Balmforth/ Mona Khadra
Friday	Sarah Berridge/ Caroline Fortescue (alt weeks)	Padma Eedarapalli/ Mona Khadra

REFERRAL PRO-FORMA FOR ANAESTHETIC ASSESSMENT

(Please see over for trigger list of conditions)

Date: …… Referred by: ……

Cons Obstetrician: …….. Designation……..

Referred to: …….. Poole/Bournemouth team (delete)
(Cons Anaesthetist)

Addressograph sticker

Patient's Name……

Address…….....Post code……..

DOB…….Hospital number……...

Parity…….....

EDD…….

Contact phone numbers: (please complete)
Home……..

Mobile…….....

Brief Summary of Problem: (if high BMI, please give current gestation)

Please Tick:

Investigations available: Δ X-rays: Δ

Letter from Other Specialists: Δ

ADDRESSOGRAPH

Appendix 8 Social Risk Assessment

Social Risk Assessment Form

EDD……

Midwife……

	Yes	No	Brief Details and action taken
Do you have any problems with your mobility, your sight, your hearing or any other disability?			
Do you have any dependents with a disability?			
Do you or your partner have any special learning needs?			
Do you currently have, or have you had, any severe mental illness such as schizophrenia, bipolar disorder, psychosis in the postnatal period or severe depression? Have you ever had treatment from a mental health team? Has anyone in your family had serious mental illness? Are you taking antidepressants at the moment?			
Does your partner currently have, or have they ever had, any severe mental illness such as schizophrenia, bipolar disorder or severe depression? Has your partner ever had treatment from a mental health team? Is your partner taking antidepressants at the moment?			
During the past month have you often been bothered by feeling down, depressed or hopeless? During the past month have you often been bothered by having little interest or pleasure in doing things? If yes: Is this something you feel you need or want help with?			
Do you use (or have used in the last two years) any non-prescription or recreational drugs? Have you ever had a problem with alcohol? How many units of alcohol pre pregnancy?(per week) How many units of alcohol now?(per week)			
Does your partner use (or have used in the last two years) any non-prescription or recreational drugs? Has your partner ever had a problem with alcohol?			
Do all your children live with you? If no, who do they live with?			
Does your partner have any children? Do they live with you? If no, where do they live Does he have contact with them?			
Name and Dates of birth of partners children			
Housing: Do you rent, own, social housing, homeless? No of adults in house and who			
Have you, your children or your partner, ever had any involvement with social services? If currently involved name of social worker			
Have you or your partner had any involvement with the police? If so details?			
	Yes	No	Brief Details and action taken

Have you ever been hit, punched, kicked or in any way abused by someone close to you? Have you been forced to do anything sexually that you did not want to do?			
Have your children ever been hurt by anyone close to you, or are you afraid they might be?			
Is there anything else you feel is important about your life that you would like to talk about?			
Have you or your partner been a victim or perpetrator of domestic violence?			
Have you had FGM, been cut or circumcised ? If under 18 do you have any Vaginal, tattoos or piercings			
How long have you lived in the UK? (is referral needed to home office?) Are you a refugee or Asylum seeker (If yes what is their residency status) Have you been trafficked into the country? If yes Country trafficked from?			
Under 20 years of age (Consider CSE) Name and age of partner			

Is a Sunshine referral needed? Please document and fill in online referral form

Referral Pathway to the Sunshine Team

Social Concerns identified that meet Sunshine team Referral Criteria. This can be completed by any professional. Women may move between criteria as pregnancy progresses so referrals to be completed as needs are identified.

Red	Amber	Green
Present Domestic violence Current social service involvement Present substance alcohol misuse Asylum seekers/refugees Current Mental health issues or significant history requiring specialist input Concealed pregnancy/late booker Homeless Teenage pregnancy 16 years and under or up to 20 complex social needs Known to Police	Women 17-20 years with additional support needs Mental health issues not requiring specialist treatment but additional support Learning, sensory and physical disabilities Housing issues/ not homeless Missed appointments (follow missed appointment policy) Looked after child (LAC) FGM (follow policy)	No complex needs at booking

Sunshine referral required: YES NO

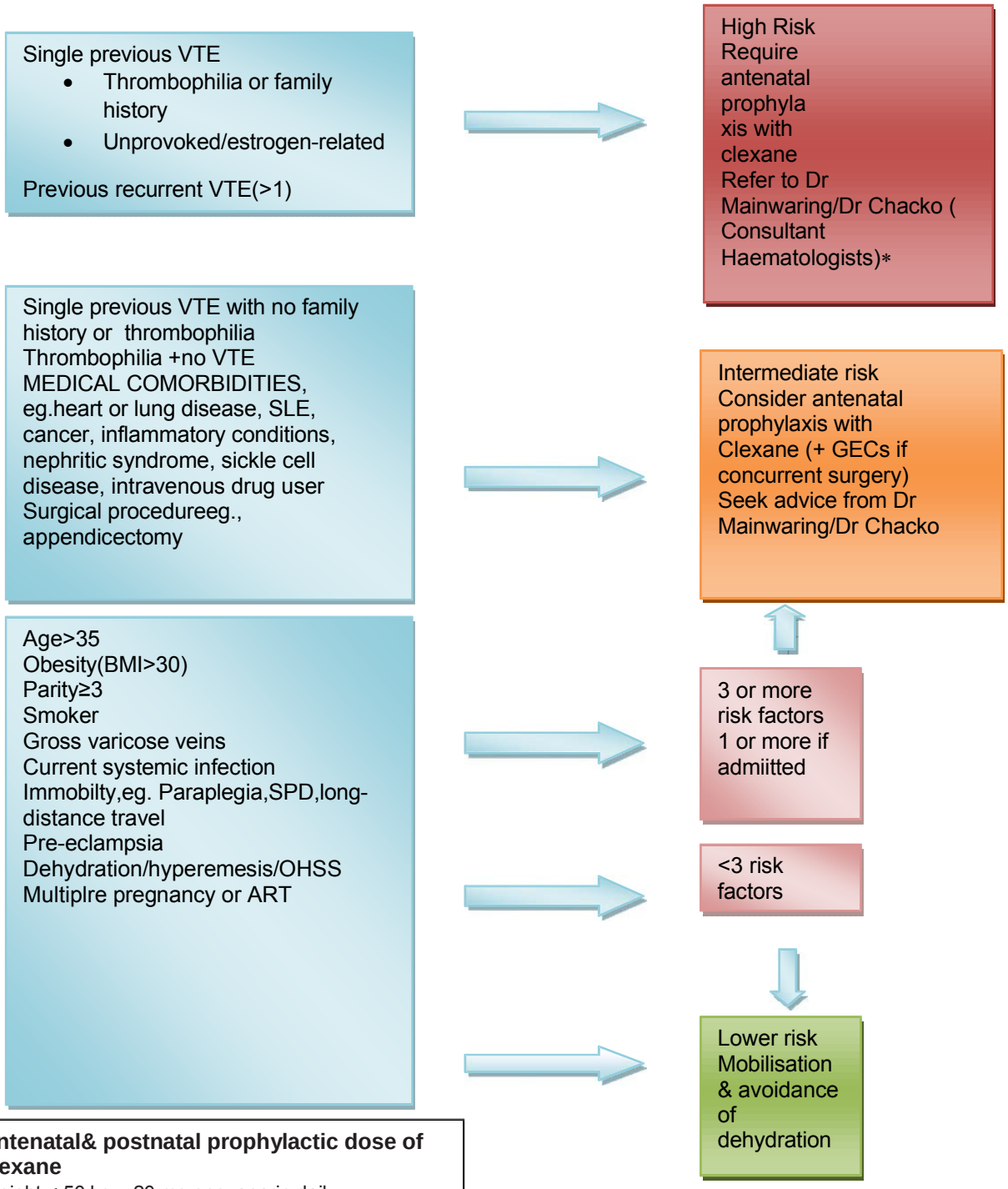
Date of referral to sunshine:

Midwife referring:

RED- Full antenatal and postnatal care by Sunshine team complete referral
Amber- Consider shared antenatal and Postnatal care with Community Midwife (consider referral to Early Help Family Support HUB)
Green - Full care by Community Midwife.

Appendix 9- Antenatal Risk Assessment VTE (adapted from RCOG&NICE)

Ensure that individual management plan is documented in the hand held and maternity casenotes.



Antenatal& postnatal prophylactic dose of clexane

Weight < 50 kg = 20 mg enoxaparin daily
Weight 50–90 kg = 40 mg enoxaparin daily
Weight 91–130 kg = 60 mg enoxaparin daily
Weight 131–170 kg = 80 mg enoxaparin
*Higher risk patient with previous spontaneous or recurrent VTEs, antithrombin deficiency may possibly require doses as high as 0.75 to 1 mg / kg twice daily

KEY:
ART = assisted reproductive therapy, BMI = body mass index (based on booking weight), gross varicose veins = symptomatic, above the knee or associated with phlebitis/oedema/skin changes, immobility = ≥ 3 days ,OHSS = ovarian hyperstimulation syndrome , PPH = postpartum haemorrhage, SLE = systemic lupus erythematosus, SPD = symphysis pubis dysfunction with reduced mobility, thrombophilia = inherited or acquired, long-distance travel = > 4 hours, VTE = venous thromboembolism GECs+ graduated elastic stockings

Outpatient Risk assessment for Venous Thromboembolism (VTE) in pregnancy

ADDRESSOGRAPH

Height……

Weight……..

BMI……

RISK ASSESS AT BOOKING and REASSESS WHENEVER CLINICAL SITUATION CHANGES

FOR ANY RISK IDENTIFIED: USE YELLOW ALERT STICKER AND PAGE 17 OF HAND HELD NOTES

Table 1

HIGH thrombotic risk if one or more ticks Refer to consultant clinic	*Bkg*	*20-30 wks*	*30-40 wks*		*Bkg*	*20-30 wks*	*30-40 wks*
Previous VTE				Antenatal thromboprophylaxis			
Known thrombophilia							

Table 2

Significant bleeding risk if one or more ticks Refer to consultant clinic	*Bkg*	*20-30 wks*	*30-40 wks*		*Bkg*	*20-30 wks*	*30-40 wks*
Uncontrolled BP (≥ 200/110)				Active bleeding			
Acute fatty liver/HELLP with low platelets				Thrombocytopenia (platelets ≤ 75)			
Inherited bleeding disorder							

Table 3

High thrombotic risk if ≥ 3 ticks Refer to consultant clinic **Low thrombotic risk** if <3 ticks	*Bkg*	*20-30 wks*	*30-40 wks*		*Bkg*	*20-30 wks*	*30-40 wks*
Age ≥ 35 yrs				Current infection			
Para 3 or more				Pre-eclampsia			
Obesity – BMI ≥ 30 **Reassess at 16/40 if 2 ticks at booking**				Prolonged bed rest, immobility ≥ 3 days			
Multiple pregnancy or Assisted Reproduction Treatment (ART)				Current hyperemesis, dehydration,			
Current smoker				Gross varicose veins			
Family history VTE				≥ 4 hrs travel within 2 weeks			

	Risk Level High/Low	**Print Name**	**Signature**	**Date**	**Referral Made** Yes/No
Booking Assessment					
20-30 week Assessment					
30-40 week Assessment					

See guideline & key overleaf **Community assessment to be done at 28wks and 34wks**

Further Reassessments (eg when clinical situation changes):

Date	**Risk Level High/Low**	**Print Name**	**Signature**	**Referral Made** Yes/No

KEY

LMWH = Low molecular weight heparin
Bkg = Booking visit
HELLP = syndrome with haemolysis, elevated liver enzymes and low platelet count

Please complete VTE risk assessment at booking appointment and refer to Consultant/Obstetric clinic if High Risk

If the booking assessment identifies 2 risk factors in Table 3, please reassess at the 16 week appointment to account for the BMI calculation. If this identifies a 3rd risk factor, treat as high risk and refer to consultant clinic

Reassess in each trimester or if clinical situation changes and refer as above

Tick all boxes that apply and make assessment accordingly

Appendix 10 – Maternity Incident Review Toolkit

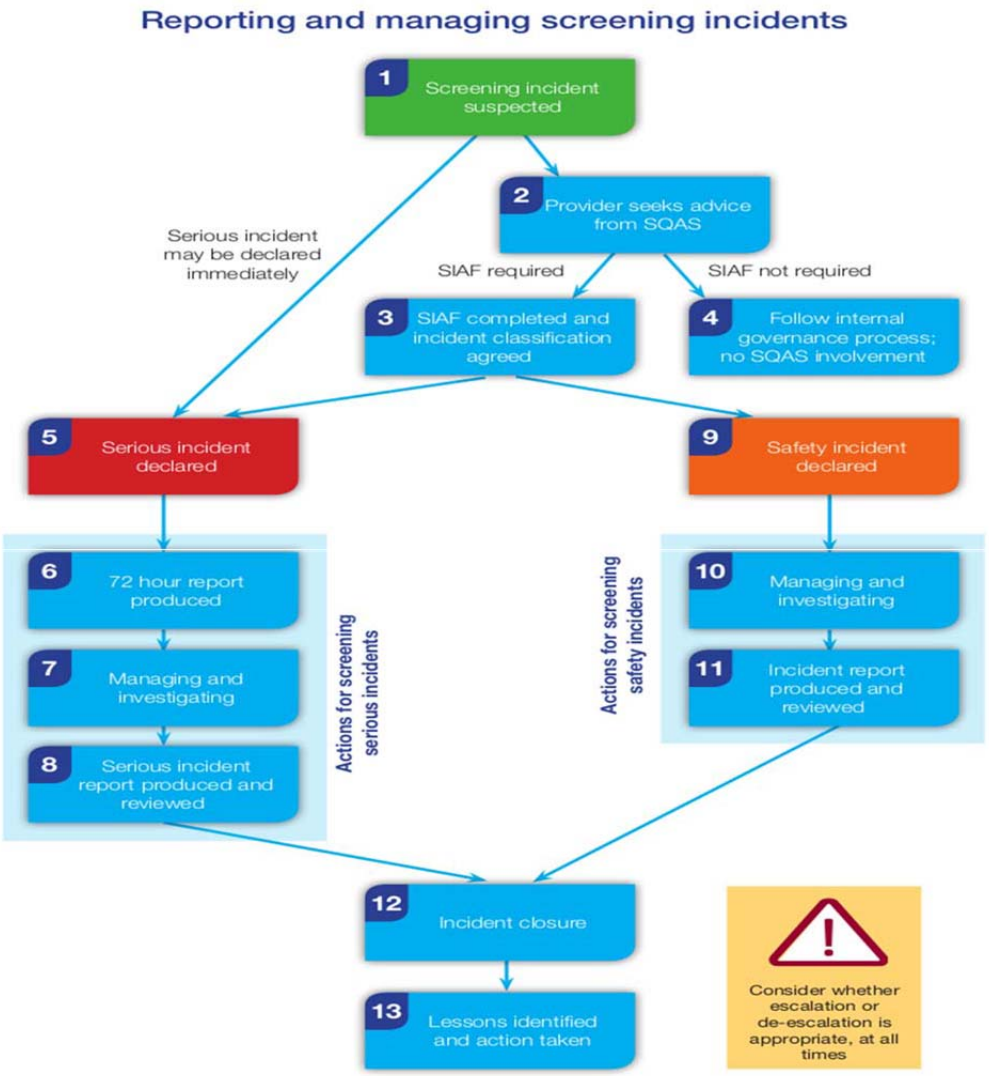
Ante-Natal Screening incidents – reporting and management process

Screening safety gets special attention because:

- the public rightly expects NHS screening to be high quality and safe
- the NHS invites apparently healthy people for screening – this creates an extra obligation to sort out quality problems
- lots of people can be affected by a screening incident because of the numbers screened
- if the screening is not up to standard, it can harm individuals and do more harm than good for the population
- NHS screening typically involves multiple clinical teams and organisations – screening incidents often affect the whole screening pathway
- we want to prevent the same incidents happening across the country

Reporting and managing screening incidents lead to national as well as local actions to improve services.

External reporting process



Ante-Natal Screening incidents – assessment form

Screening_incident___
assessment form 20

Internal reporting process

1. Complete LERN report on Datix system
2. Note reference number of LERN from acknowledgment email (for the assessment form)
3. Complete the Ante-Natal Screening incidents – assessment form (above) and save as a word document
4. Forward to Public Health England (PHE.SouthQA@nhs.net) **and** the screening and immunisations team (david.xxxxxxxx@xxx.xxx.) **from** antenatal.screening@nhs.net
5. Upload the completed from to the LERN record (contact Quality & Risk Team on Ex 4014 if you require help uploading)

Additional guidance

https://phescreening.blog.gov.uk/2017/08/21/managing-safety-incidents-guidance-update/

RCA, SI and Panel Toolkits

https://intranet.rbch.nhs.uk/index.php/quality-and-risk-management/serious-incident-and-rca-investigation-toolkit

Appendix 11 – Screening Consent Form

Your screening choices

Please fill in this form before attending the clinic.

Name:_____Date of Birth_____

Screening Tests	Yes I would like to have the test	No I do not want this test	I don't know I would like further information
Fetal anomaly scan (at 18 – 20 weeks and 6 days)			
Combined screening for Down's Syndrome (T21)			
Combined screening for Edward's & Patau's Syndrome (T18/T13)			
Quadruple Test for Down's Syndrome (T21) offered if >14+1 at scan or NT unobtainable			
Full blood count			
Inherited blood disorders (Sickle Cell/Thalassaemia)			
Blood group			
Hepatitis B			
Syphillis			
HIV			
Urine culture			

I have read the information provided in the *'NHS Screening Tests for you and your baby'* and I understand the reasons for these tests. I agree to his form being retained for hospital use.

Signed:_____Date_____