Guideline for managing Antenatal Care		Barnsley Hospital NHS NHS Foundation Trust	
Author:	Guideline group Maternity Guideline Group	Reference number:	
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Introduction

Rationale

Saving mothers lives identifies that around 20% of women who died from direct or indirect causes either booked for maternity care after 20 weeks gestation or missed over four routine appointments, did not seek care at all or concealed their pregnancies. This guideline describes the process for ensuring that women book in the appropriate timescales and receive antenatal care which is appropriate to their individual circumstances. It describes the process for follow up of women who miss antenatal appointments.

Scope

This guidance applies to all staff working within the Maternity service and Community at BHNFT

Principles

To ensure that women who choose to have their babies at BHNFT receive care that is evidence based and follows best practice guidance

Guideline Outline

Antenatal Appointments

Antenatal Appointments should take place in a location that women can easily access. The location should be appropriate to the needs of the woman. Each antenatal appointment should have structure and focus incorporating routine tests and providing an opportunity for discussion, enabling women to make informed choices. Women should feel able to discuss sensitive issues and disclose problems.

In an uncomplicated pregnancy there should be 10 appointments for nuliparpous women and 7 appointments for parous women. The risk assessment and plan of care will be reviewed and updated at each contact.

Low Risk Antenatal Pathway. P= Primigravida M= Multigravida.

VISITS	GESTATION	CARE AND ADVICE GIVEN
1 P & M	1ST Trimester Following confirmation of pregnancy- before 12 weeks of pregnancy or within 2 weeks of referral	• Obtain history/complete booking form • Complete family origin questionnaire and take all booking bloods if required • Commence mental health screening – refer to mental health pathway • Early identification of appropriate risk criteria and care path way • Discussion of options for care and place of birth with woman • Baseline assessment (BP, pulse, Urinalysis) • Assessment of pregnancy/Abdominal palpation • Ensure women have appropriate written information, including antenatal classes • Brief discussion of screening programmes – refer to antenatal screening pathway • Brief introduction to the benefits of breast feeding including workshops. • Information to include where women will be seen and who will undertake care • Discussion of folic acid supplementation and the maintenance of adequate vitamin D stores during pregnancy • Ask domestic violence questions. • Discuss maternity benefits. • Document professional lead, agreed plan of care and place of care
2 P & M	10 – 13 +6 weeks Dating scan appointment (Optimum time 12 weeks)	• Optional confirmation of gestation by ultrasound • Investigations: FBC, Group & antibody screen, Rubella, Treponema, Hep B, HIV and haemoglobinopthy screening and Family origin questionnaire. • MSU testing for asymptomatic bacteriuria, BP • Offer first trimester screening (11+2 – 14+1 weeks gestation). • Height, weight and BMI – If BMI > 35 complete Obesity risk assessment form. • Thromboprophylaxis risk assessment – complete TRAF form • Domestic violence questions asked if not already done. • Generate a growth chart.
3 P & M	14-20 weeks Optimum time 15 weeks	• Offer Quad test (14+2- 20 weeks gestation) if first trimester screening is not performed • BP and urinalysis • Review and record screening test results.
	18- 20+6weeks A+ P Scan appointment	• Offered optional anatomy scan • Abnormalities from the scan to be acted upon
4 P	24 - 25 weeks	• BP and urine for proteinuria. • Ensure growth chart is in records. • Confirmation of blood and scan results • Discuss RAADP in Rhesus Negative women – Give leaflet - ***Order Anti D to BHNFT ANC*** - ***Contact 432239 who will send appointment for woman to***

VISITS	GESTATION	CARE AND ADVICE GIVEN
		attend BHNFT for Anti D • Discussion regarding arrangements for the preparation of parenthood • Discussion regarding symptoms of pre ecclampsia • Review mental health pathway
5 P & M	28 weeks	• BP and urine for proteinuria • Antenatal assessment + plot fundal height on graph • Repeat Rhesus & FBC (Document on request form if any Anti D has been given) • Discuss Vitamin K, Labour & 'Skin to Skin' • **Attend ANC for Anti D** No need for Group and antibody screen unless out of area booking / DNA's to be reported to CMW to arrange urgent appointment to administer Anti D. Record administration in woman's handheld records and hospital notes • Ensure growth chart is in records of all women. • Out of area bookings ensure antenatal check is performed.
6 P	32 weeks	• Antenatal assessment + plot fundal height on graph • Review and record blood results taken at 28weeks • Review of feeding plans • Review if women need additional care
7 P & M	34 weeks	• Antenatal assessment + plot fundal height • BP and urine for proteinuria • Review, discuss and record results of screening test undertaken at 28 weeks; • Provide information on recognition of active labour and coping with contractions in labour • Review birthplan and formulate plan of care for delivery
8 P & M	36 weeks	• Antenatal assessment + plot fundal height on graph • FBC • Assessment of presentation is performed abdominally • Abnormal presentations refer for management plan • Reinforce breast feeding information as detailed in the UNICEF 'Baby friendly initiative' • If not discussed before provide information on Vitamin K, newborn screening tests, care of new baby, postnatal self care and awareness of baby blues and postnatal depression • MRSA Swabs
9 P & M	38 weeks May be offered	• Antenatal assessment + plot fundal height on graph • Review plan of care for delivery • Discuss options for the management of prolonged pregnancy / leaflet
10 P	40	• Antenatal assessment + plot fundal height on graph • Give information including further discussion regarding prolonged labour
11 P & M	41 weeks	• Antenatal assessment + plot fundal height on graph • Offer membrane sweep • Discuss and arrange date for induction
12 P & M	42 weeks	• Women who decline induction of labour offer increased antenatal monitoring

High Risk Antenatal Pathway.

Women with the following conditions identified at the risk assessment will be placed on the high risk antenatal pathway. **Women will attend the following antenatal clinics according to clinical need.** Document the lead professional on the front of hand held records and in the hospital notes.

Medical history	**Consultant clinic**	**Combined Endocrine Clinic**	**Comments / actions**
Thyroid disease		√	
Diabetes		√	
Known haemoglobinopathies	√		
Epilepsy	√		Complete audit form refer to SJW clinic Wednesday morning for review by Epilepsy lead midwife
Cardiac disease including hypertension	√		Refer to cardiologist as necessary
Any auto immune disorders	√		
Chronic renal disease	√		
Skeletal deformities	√		
Severe asthma	√		If not on regular treatment can book for Midwifery led care
Any psychiatric illness	√		Mental condition to be assessed and documented frequently – mental health pathway
Malignant disease	√		
HIV / Hepatitis B Infection / Syphillis	√		

Previous Obstetric history:	**Consultant clinic**	**Combined Endocrine Clinic**	**Comments**
Still birth or neonatal death	√		Offer meeting with bereavement MW
Pregnancy loss after 14 weeks	√		
Baby below 2.5kgs or above 4.5kg SFGA below 5th Centile LFGA above 90th Centile	√		Offer GTT if previous baby 4.5kg or above
Delivery < 35 weeks	√		
Shoulder dystocia	√		
3rd / 4th degree tear	√		
A child with a congenital abnormality (structural or chromosomal)	√		
Pre-eclampsia	√		
Rhesus isoimmunisation or other significant blood group antibodies	√		
Uterine surgery including LSCS, myomectomy, cone biopsy or any	√		IF VBAC agreed document in all records

Previous Obstetric history:	Consultant clinic	Combined Endocrine Clinic	Comments
uterine abnormality			
Antenatal or Postnatal haemorrhage on two occasions	√		
Grand multiparity (more than 4 births)	√		

Other history & present pregnancy	Consultant clinic	Combined Endocrine Clinic	Comments
Multiple pregnancies	√		Monochorionic twins to be seen by SJW / NK Dichorionic twins can be seen at any consultant clinic.
Assisted conception	√		
IUCD in situ	√		
Recurrent bleeding or significant area of bleeding detected on USS	√		
Alcohol or substance misuse	√		
Primip age 35 or above	√		
Multips Maternal age 40+ at delivery?	√		Offer screening visit Consider more frequent BP monitoring
Teenage pregnancy	√		Book under RKR and refer to Teenage specialist midwife
BMI ↓ 18	√		
BMI ↑ (35)	√		Arrange GTT at 28 weeks for all BMI's ↑ 30 Consider more frequent BP monitoring
Raised systolic BP160 mm/Hg	√		
Group B strep infection in this pregnancy / other child	√		
Safeguarding, domestic violence issues.	√		

<u>Process for ensuring women have a booking visit by 12 weeks gestation</u>

All women who present for antenatal care require a full booking history and hand held records completing by 12 weeks of pregnancy.

Community

- Community midwives are linked to a GP practice and carry their own caseload They will collect details of the new referrals on a regular basis
- Pregnant women can self refer to the Community Midwife if they so wish.
- The midwife will arrange a time with the woman to undertake a booking history before 12 weeks and record it in the hand held records

Hospital

- Women who book at Barnsley Hospital for delivery but have an out of area GP are referred directly to antenatal clinic in the hospital.
- An appointment will be generated from antenatal clinic for a booking history to be undertaken before 12 weeks gestation

Process for ensuring women who book later than twelve weeks are seen within two weeks of referral

Community

- The community midwife will ensure that women who are already 12 weeks pregnant or more are seen within two weeks of referral to Maternity services for a booking appointment.

Hospital

- Women who book at Barnsley Hospital for delivery but have an out of area GP are referred directly to antenatal clinic in the hospital.
- If the woman is twelve weeks gestation on referral an appointment will be generated from antenatal clinic for a booking history to be undertaken within two weeks of referral.

Clinical assessment at the first hospital visit of migrant women who have not had a full medical examination undertaken.

Women who have not previously had a full medical examination in the United Kingdom will require booking for shared care to ensure a medical examination is completed. A medical assessment and clinical assessment of the woman's overall health will be made for migrant women using interpreter services if needed.

Process for arranging the availability of health records from all previous pregnancies for review by clinicians.

Community midwives have access to the woman's records at the GP surgeries where they work. They will review previous records and incorporate into the current pregnancy notes any relevant:

- Medical / surgical conditions,
- Obstetric problems,
- Mental health
- Social / lifestyle problems

If the community midwife does not have access to these records she will complete a Medical Records Check Request form and send to the GP surgery to request further information and update the current records when it is received. If a response is not received from the GP the Consultant in charge of the woman's care will be informed and they will request the information again.

At the first hospital appointment the woman's previous medical / obstetric records will be obtained and are reviewed by the clinicians. If the previous records are not available e.g. if the woman booked at another hospital, a written request for the information will be made. A further appointment for the woman is generated to review the information and discuss the further plan of care If the information has not been received a further request for information is made. The current records are updated to ensure that the women follow the correct antenatal pathway.

Process for the follow up of women who do not attend for any antenatal appointment.

The healthcare professional will:

- Attempt to contact the woman and arrange a further mutually satisfactory appointment.
- If they fail to contact the woman they will send out another appointment.
- They will document in the patient records that the woman 'Did not attend' (DNA'S) and details of the next appointment arranged.

In addition to this at the third missed appointment:

- The community midwife will also arrange a home visit to encourage the woman to access antenatal care and assess the woman. She will contact the hospital to update the woman's Hospital notes with the further plan of care agreed with the woman.
- For community appointments the GP will be informed to encourage the woman to access care.
- For hospital missed appointments the notes will then be reviewed by the appropriate consultant who will write to the woman's GP alerting him to her failure to access care.

Risk Assessment.

A risk assessment will be undertaken as a minimum at booking during the antenatal period and an individual management plan formulated. (N.B. If the woman is an out of area booking the risk assessment will be completed at the first hospital visit).

The risk assessment will be reviewed at each antenatal contact and the management plan will be amended as risks are identified. The following criteria will be reviewed:

- Previous medical conditions including anaesthetic and psychiatric history.
- Factors from previous pregnancies
- Mental Health factors
- Social factors including Safeguarding and Lifestyle history
- Identification of women who refuse of blood and blood products
- Assessment of appropriate place to deliver

In addition at first hospital visit the following assessment is undertaken:

- Aspirin requirements.
- Obesity – GTT requirements and specialised equipment requirements.

- Thromboembolic disease – VTE risk assessment.

Process for referral following risk assessment

When risks are identified the woman will be referred to the appropriate clinician for review. The woman will be given an appointment to attend antenatal clinic or the antenatal day unit under the care of the allocated obstetrician.
Any changes in lead professional will be recorded in the hospital and hand held records and changed electronically on the hospital computer system. The Consultant will be informed using the designated referral form.

If risks are identified requiring referral to other agencies or members of the multidisciplinary team e.g. social services / physiotherapists, the appropriate referral form will be completed and details documented in the antenatal management plans.

Process for referral back to Midwifery Led Care

The woman can be referred back to midwifery led care following a specific event if warranted by the review of the risk assessment. This decision is taken by the most senior professional involved in the care at the time. The change in lead professional will be recorded in the hospital and hand held records and changed electronically on the hospital computer system.

Documentation requirements

- The booking history and risk assessment will be documented in the green hand held records and the management plan will be completed and updated as appropriate.
- For out of area women the booking and risk assessment will be documented in the antenatal care plan in the hospital records and the management plan amended as appropriate.
- Identification of women who refuse blood products will be documented on the green hand held records.
- Obesity and VTE risk assessment forms will be completed and filed in the hospital notes with the antenatal care plan.
- Aspirin requirements will be assessed and documented on antenatal care plan in the hospital records
- Changes in lead professional will be documented in the antenatal care plan in the hospital records and on the front of the hand held records.

When management plans are formulated or amended both the hospital and hand held records will be updated.

Roles and Responsibilities

All staff working on the Maternity unit and in Community are responsible for ensuring this guidance is followed.

Midwives are responsible for:

- Ensuring that women are booked before twelve weeks and a risk assessment undertaken.
- Ensuring that women referred after twelve weeks gestation have a booking appointment within two weeks.
- Review previous health records and update the current pregnancy records.
- Review risk assessment and management plans and amend as appropriate.
- Where records are not available to request information from the GP
- Follow up women who do not attend for appointments and document action taken for missed appointments.

Medical Staff are responsible for:

- Ensuring that migrant women have a medical assessment undertaken.
- Where records are not available to request information from the GP or other hospitals.
- Review risk assessment and management plans and amend as appropriate

Equality and Diversity statement

Women's and Children's Services are committed to ensure that both current and potential service users and their families will not be discriminated against on the grounds of religion, gender, race, sexuality, age, disability, ethnic origin, social circumstance or background. The principles of tolerance, understanding and respect for others is central to what we believe and central
to all care provided.

Audit / Monitoring

Booking / missed appointments and antenatal risk assessment will be audited in line with the annual audit programme, as agreed by the CSU. The guideline will be audited, as a minimum, on a three-year basis. The results will be reviewed and presented to the multidisciplinary audit meeting. Any deficiencies will be actioned via the audit action plan to try and improve safety and learn from previous mistakes. The audit action plan will be reviewed at the monthly risk management meetings on a quarterly basis and monitored by the risk midwife to ensure that improvements in care are made.

Any adverse incidents relating to antenatal care will be monitored via the incident reporting system. Any problems will be actioned via the case review and Root cause analysis action plans. The action plans are monitored by the risk midwife to ensure that improvements in care are made. The trends and any root cause

analysis are discussed at the monthly risk meetings to ensure that appropriate action has been taken to maintain safety.
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Dissemination and Access

An electronic copy is available on the Intranet and via the Practice Facilitator Midwife

Training

Training will be given as documented in the Maternity Training Needs Analysis. This is updated on an annual basis.

Review

This guideline will be reviewed in three years of authorisation. It may be reviewed within this period if there are any reports, new evidence, guidelines or external standards suggesting that guideline review is required

References:

Confidential Enquiry into Maternity and Child Health. (2003-2005). Saving mother's lives: reviewing maternal deaths to make motherhood safe
Saving mothers lives 2003 – 2005 Confidential Enquiry into Maternal and Child Health

National Institute for Health and Clinical Excellence. Antenatal Care: Routine care for the healthy pregnant woman 62 March 2008.

NHS Litigation Authority, Clinical Negligence Scheme for Trusts (Maternity), Clinical Risk Management Standards. (2009/10). Standard 4, Criterion 1 and 3

Glossary of Terms

BHNFT – Barnsley Hospital NHS Foundation Trust
DNA – did not attend
CEMACH – Confidential Enquiry into Maternity and Child health
GP – General Practitioner
NHS – National Health Service
NICE – National Institute for Clinical Excellence

Appendices

Appendix 1 – Hospital Clinic Times

Appendix 1

Hospital Clinic Times

Consultant	Special interest	Day and time
Mr. Raychaudhuri	Teenagers Teenage specialist midwife clinic Twins DA / DC	Monday 1.30pm – 5pm
Dr Khanem	Feto maternal medicine Twins DA / DC / MA / MC	Tuesday 1.30pm – 5pm
Mr. Whittaker	Feto maternal medicine Epileptic lead midwife available Twins DA / DC / MA / MC	Wednesday 9am -12.30
Mr. Sharma	Substance misuse + midwife specialist clinic Twins DA / DC	Wednesday 1.30pm – 5pm
Mr. Sankar	Twins DA / DC	Alternate clinics: Monday 9am – 12.30pm Friday 9am- 12.30pm
Shared consultant clinics	Combined Endocrine clinic: Obstetrician, Endocrinologist, Diabetes specialist nurse, Dietician combined clinic	Thursday 10am – 12.30 DSN an midwife 1.30 pm – 5pm. *Any endocrinology history 1.30pm – 2.30pm*
Midwife only clinics	Routine antenatal / Anti D	Monday 9am – 12.30
	Scans & Bookings	Tuesday 9am – 12.30
	Routine antenatal / Anti D	Thursday 9am – 12.30
High risk / Invasive clinic	High risk pregnancies	Friday 9am – 12.00

Obstetric Guideline Checklist

Guideline for Booking Appointments	**Lead Professional** Gill Jepson	**Review Date** May 2015

Formatting	Included/attached
Headings	included
Quality Impact Statement	included
References	included

Consultation Process	Date Disseminated/Presented	Relevant information
Initial circulation to Guideline Group and relevant parties (draft 1)		
Amended draft sent to development lead		
Final Draft presented to Guideline Group for ratification	29/05/12	Ratified 29/05/12
Amended/final Draft presented to Women's Governance group for Ratification	11/ 06/2012	Ratified 11/06/12

Archiving	Date of distribution	Date of Archiving
Distribution and Retrieval	11/06/12	11/06/12

Training Package devised	Date	
Training Package Delivered	Date	

Audit/ Monitoring	Method	Date Commenced	Date Completed
Audit Process			
Monitoring process			