Clinical Guideline for: Antenatal Booking and subsequent Antenatal Appointments and Risk Assessment

For use in:	Maternity Services
By:	Midwives
For:	Antenatal Booking and subsequent Antenatal Appointments and Risk Assessment
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If Yes - does the strategy/policy deviate from the recommendations of NICE? If so why?	No

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5	26/06/2020	New template	Pam Sizer, Midwifery Matron; Liz Chalk and Sue Frost, Ruth Todd, Kate Hales
6	22/03/2021	Addition of Vitamin D supplementation	Pam Sizer, Midwifery Matron; Liz Chalk and Sue Frost, Ruth Todd, Kate Hales
7	25/06/2021	Addition of risk assessments and Personalised Care Plans (PCP) see Trustdocs ID: 18780	Pam Sizer, Midwifery Matron; Liz Chalk and Sue Frost, Ruth Todd, Kate Hales
7.1	07/03/2022	Appendix 2 amended	As above
7.2	10/03/2022	Minor changes to page 14	As above

This is a Controlled Document

Printed copies of this document may not be up to date. Please check the hospital intranet for the latest version and destroy all previous versions.

Scope

This guideline gives guidance to midwives on how to book a pregnant woman, instigate the appropriate antenatal care pathway and any information needed to be given to pregnant women throughout their pregnancy.

This guideline makes recommendations for women and people who are pregnant. The guideline uses the term women throughout, for simplicity, but this should be taken to include people who do not identify as a woman but who are pregnant, in labour and during the postnatal period. When discussing care with a person who does not identify as a woman, please ask them their preferred pronoun and then ensure this is clearly documented within their pregnancy records to inform all health professionals.

Data Protection Act (DPA) 2018 (General Data Protection Regulation – GDPR) Legislation

This Trust has a duty under the DPA 2018 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before processing begins. In many cases we may need to obtain consent: this must be explicit, informed and documented clearly.

For more information about your obligations under DPA 2018 please see Information Governance Policy Trustdocs Id: 725.

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Background

To maintain optimum health during pregnancy, ensure a safe delivery of mother and baby and facilitate a positive experience; antenatal care should be provided by a small group of health professionals with whom the woman feels comfortable. There should be continuity of care throughout the antenatal period. All women should be given relevant and up-to-date information enabling informed choice, taking into account their individual risk and as a minimum, in accordance with schedule of routine antenatal care.

The environment in which antenatal appointments take place should enable women to discuss sensitive issues such as domestic violence, sexual abuse, psychiatric illness and recreational drug use

Recommendations

- Antenatal care should be readily and easily accessible to all pregnant women and sensitive to the needs of individual women and the local community. It should enable all pregnant women to have their first full booking visit and personal maternity record completed by 10 weeks of pregnancy.
- If the woman is presenting at 10 weeks or beyond, she should be seen within 2 weeks for booking and a timely and appropriate appointment should be made for screening and a hospital appointment, should it be required.
- All pregnant women will be allocated to a named midwife within a local community team.
- The midwife will discuss the pathway of antenatal care and provide the woman with the relevant information ensuring accurate documentation. Where possible the relevant leaflet should be viewed and explained (Appendix 1).
- The Midwife will obtain a full history at booking, and this will form the basis upon which the risk assessment is performed.
- The midwife will discuss the booking bloods, urine tests and explain the available maternal and neonatal screening.
- All care will be fully recorded in personal maternity record, where appropriate and stored securely on the local electronic maternity system. Women will be given a shortened paper version.
- The woman's lifestyle, social history and mental health should be thoroughly but sensitively explored.
- The needs of each woman should be risk reassessed at each on-going appointment.
- Women should be supported in their personalised birth choices. A personalised care plan (PCP) will be given to women at booking. Information and support should be given throughout pregnancy to enable the capture and recording of conversations, discussions and agreed outcomes in a way which makes sense to women.

Risk assessment:

Clinical Risk Assessment – is a systematic process which includes screening tests and investigations to assist the healthcare provider, in discussion with the woman,

in determining the potential clinical risk factors. This mechanism or tool assists with the planning of holistic care. It is a dynamic process used throughout the whole pregnancy journey which starts at booking, and risk assessed at each follow-up visit or attendance until the pathway of care has been completed.

- The aim is to identify those women who have or may develop factors that could adversely affect the pregnancy outcome.

- Risk factors may be singular or a combination of medical, surgical, mental health, obstetric (maternal and / or fetal), social circumstances or lifestyle. These are all questions that are mandatory at each AN contact on E3

Recommendation One

Antenatal care should be readily and easily accessible to all pregnant women and sensitive to the needs of individual women and the local community. It should enable all pregnant women should have their first full booking visit and personal maternity record completed by 10 weeks of pregnancy.

Booking for midwifery care at NNUH can occur via the following routes:

- Woman presents at GP surgery.
    - On confirmation of pregnancy, the woman is advised to complete the self-referral for pregnancy form via www.nnuh.nhs.uk. Information should be available within GP surgeries that will signpost women to self-refer via the NNUH Internet site. Receptionists within these centres should redirect women to the Internet site or direct to Medicom Midwifery Triage where self-referral can be supported and booking process can be arranged.
    - Additionally, all GP surgeries display posters which redirect women to the self-referral form. She may then contact a midwife through Medicom Midwifery Triage or her GP Surgery in order to arrange a booking appointment with the midwife.
- Women requests booking via Maternity Website.
    - Following completion of self-referral, and prior to clicking ‘send’ women will be sign-posted to contact Medicom Midwifery Triage to arrange a booking appointment. When a referral has been received, an appointment is made with the woman’s named midwife to ensure that her booking appointment and completion of records is achieved before 10 weeks of pregnancy. The link to the self-referral form is available at www.nnuh.nhs.uk and social media platform www.JustOneNorfolk.org
    - At all contacts the electronic records and hand-held notes, including a personalised care plan (PCP), should be thoroughly completed at the relevant sections.
    - The booking scan referral request will be triggered when the electronic Antenatal Booking Pathway has been completed and 2x green ticks are present.
    - The Community Midwife or Specialist Midwife will undertake the antenatal booking and risk assessment to determine the booking category and antenatal care pathway.

Recommendation Two

If the woman is presenting at 10 weeks or beyond, she should be seen within 2 weeks for booking and a timely and appropriate appointment should be made for screening and a hospital appointment, should it be required.

- Woman presents at GP surgery.
    - On confirmation of pregnancy, the woman is advised to complete the self-referral for pregnancy form via www.nnuh.nhs.uk Information should be available within GP surgeries that will signpost women to self-refer via the NNUH Internet site. Receptionists within these centres should redirect women to the Internet site or direct to Medicom Midwifery Triage where self-referral can be supported and booking process can be arranged. Once it is established the woman is 10 weeks or more the first booking visit is arranged by the Medicom midwife to take place within 2 weeks and with the named midwife wherever possible.
- Women requests booking via Maternity Website.
    - Following completion of self-referral, and prior to clicking 'send' women will be sign-posted to contact Medicom Midwifery Triage to arrange a booking appointment. An appointment is made with the woman's named midwife to ensure the first booking visit is arranged to take place within 2 weeks.
    - Information on the booking process is available at http://www.nnuh.nhs.uk/maternity-self-referral-form/ and social media platform www.JustOneNorfolk.org

Recommendation Three

All women will be allocated a named midwife within the local midwifery team.

- At the time of making arrangements for the first booking visit, the woman will be given details of her named midwife and associated team. This will be allocated according to the woman's registered GP surgery.
- The women will be given details of:
    - Local midwifery team arrangements and contact details.
    - Out of hours arrangements for contacting the service in an emergency.
- Prior to the booking appointment the woman should be directed to pregnancy information, which may be in electronic format. This should include National Institute for Health and Care Excellence (NICE) Routine Antenatal Care for Healthy Pregnant Women Guidance, Screening Tests for You and Your Baby.

Recommendation Four

The midwife will discuss the pathway of antenatal care and provide the woman with the relevant information ensuring accurate documentation. Where possible the relevant leaflet should be viewed and explained.

- The initial contact with the Community Midwife can be via a telephone consultation for some women. This enables initial information to be discussed and for the woman to be directed to appropriate electronic information on screening and antenatal care prior to the face-to-face consultation. Women who have known or

highlighted issues including, but not exclusive of; non-English speaking, safeguarding issues, vulnerabilities such as learning disabilities, should be offered a full face-to-face booking appointment.

- At the face-to-face booking visit the Community Midwife will discuss the pathway of antenatal care including the proposed schedule of visits as set out in 'Antenatal care for uncomplicated pregnancies' (NICE 2008).
- The pregnancy pack will be given if not received prior to this appointment and relevant leaflets given and explained.
- Ensure Antenatal Care Schedule attached to records and that woman knows when and where she will be seen for ongoing care and, if necessary, how to book subsequent appointments.
- Ensure a PCP is given to the woman with an explanation of its use.

Recommendation Five

The Midwife will obtain a full history at booking, and this will form the basis upon which the risk assessment is performed.

- Suitability for Midwifery Led Care and place of birth options should be discussed and documented in all records. This should take into account risk assessment for suitability of low or high-risk care:
- Initial risk assessment.
    - Confirm that the woman has received all pre booking information.
    - Complete all antenatal risk assessments within the handheld and electronic notes. Refer appropriately when a risk has been identified (Appendix 2).
    - Take a booking blood pressure and advise a daily dose of Aspirin 150mgs if risk factors are identified.
    - Women should be advised to take a vitamin D supplement (10 micrograms of vitamin D per day).
    - Thyroid Function Test (TFT) to be taken with booking bloods for those with known thyroid conditions. Check results within 7 days and if TFT abnormal then inform the patients GP. The woman will also require a routine referral to Maternal Medicine Consultant Clinic.
    - Take a midstream urine (MSU) and send for 'Routine Antenatal Urinalysis'.
    - The woman's height and weight measurements must be recorded. The Body Mass Index (BMI) calculated and documented in all records. Referral should be in accordance with the guideline on 'The Management of Women with Obesity During Pregnancy' Trustdocs Id: 880.
    - Record if the woman smokes, and if YES refer to Stop Smoking Services.
    - Complete Carbon Monoxide (CO) monitoring for all women and continue to monitor CO results at each contact. Referral should be accordance with guideline on 'Antenatal Pathway for women who smoke and for CO monitoring in pregnancy' Trustdocs Id: 15956.
    - The woman's view on the use of blood products must be recorded and a referral made to Consultant Antenatal Clinic if she intends to decline blood products, in

accordance with guideline on 'Obstetric Haemorrhage for women who decline blood and blood products' Trustdocs Id: 851.

- Record the Lead Professional in all records, together with the continuity of carer team if on this pathway.

- The midwife will indicate the need for an Obstetric appointments and reason for referral in all records.

Recommendation Six

The midwife will discuss the booking bloods, urine tests and explain the available maternal and neonatal screening.

- Complete the Family Origin Questionnaire in full for haemoglobinopathy screening, including discussing relevant generations.
- At booking take bloods with consent for ABO Group, Full Blood Count (FBC), Rhesus factor, HIV, Hepatitis B and Syphilis. Consideration should be given for gestation dependant bloods. An MSU is to be taken for Aysymptomatic Bacteriuria (ASB). In light of failing to obtain blood samples and referring the woman to another health practitioner, it is the midwife's responsibility to follow up the woman's blood results.
- Information on optional screening should be discussed. If the woman opts for screening this should be clearly documented on the booking section of Euroking. The decision to have the test therefore has to be made prior to booking the dating scan.
- If Trisomy screening is requested and the woman is eligible (less than 20 weeks gestation at the dating scan), screening will be offered and performed at the scan. Refer to guideline on 'Antenatal Screening for Trisomy 21, Trisomy 18 and Trisomy 13' Trustdocs Id: 836.
- If the woman books too late to perform ultrasound screening or if the nuchal translucency or screening has been unsuccessful, the QUAD test should be offered by the community midwife.
- Where possible, the 16-week antenatal check should be a woman only appointment. Where possible discuss domestic abuse and mental health assessments and any reason for referral in a sensitive manner.
- At 16 weeks inform the woman of her antenatal screening results and document the results of all screening tests in all records.
- At 25- or 28-week antenatal appointment check the customised growth chart for accuracy and review to ensure correct pathway is being followed. A change in pathway may be necessary if small for gestational age has been identified in previous births.

Recommendation Seven

All care will be fully recorded in personal maternity record, where appropriate and stored securely on the local electronic maternity system. Women will be given a shortened paper version.

To ensure there is continuity of care and involvement of the woman and the family, each aspect of her care will be explained and communicated among those involved in the provision of her care including clear and concise documentation at every stage Nursing and Midwifery Council (2018) The Code; Professional standards of practice and behaviour for nurses, midwives and nursing associates https://www.nmc.org.uk/standards/code/

Recommendation Eight

The woman's lifestyle, social history and mental health should be thoroughly but sensitively explored.

- At the booking appointment the midwife should explore the woman's lifestyle and social history. This should include both current and past history and involvement with social care.
- The exploration of history should also include the partner and that of the wider family including any care packages for children of either parent.
- The lifestyle and emotional wellbeing of the woman should be explored at each clinical contact and documented clearly in all records.
- Professional curiosity should not stop following the booking appointment but should continue throughout all contact with the family.
- At each contact complete the mental health assessment, document in all records and follow the appropriate care pathway.
- If any other vulnerabilities are identified refer to the relevant guideline and ensure Consultant input has been requested, where appropriate:
    - Antenatal and Postnatal Mental Health Trustdocs Id: 879.
    - Female Genital Mutilation Clinical Policy Trustdocs Id: 11407.
    - Care of Vulnerable Women in Pregnancy Trustdocs Id: 10046.
- Should the woman have additional needs e.g., English not first language, then the midwife should ensure support is obtained from translation services and where possible leaflets provided in format which meets individual needs such as first language, braille.
- Vulnerable groups such as teenagers, the homeless and asylum seekers have access to Skylark Team and should have consideration for increased midwifery contacts wherever possible.
- At the end of the booking appointment the midwife should ensure that the woman has contact telephone numbers for the service, a plan of care and a date for her next appointment.
- Handheld notes and a PCP are given to the women on the completion of this appointment.

Recommendation Nine

The needs and risks of each woman should be reassessed at each on-going appointment

- Women with uncomplicated pregnancies should be informed of the NICE Antenatal Appointment Schedule:

  - Primigravida women: minimum of 10 appointments, excluding scans.
  - Multigravida women: minimum of 7 appointments, excluding scans.
  - At least one antenatal and one postnatal visit should be undertaken and the home address.
- At each follow-up appointment, consistent information with clear explanations should be given and women should have the opportunity to discuss and ask questions.refer to PCP . Women should have the opportunity to discuss their birth choicepreferences including place of birth and have an opportunity to discuss them with appropriate referral for support as required.
- Order Anti-D at 16-week appointment unless *ffDNA* indicates otherwise.
- Referral to the Health Visiting team should occur via the joint monthly meetings.
- The Pre-birth Protocol should be used when assessing all women and not just in cases where Safeguarding concerns have already been identified. The Pre-birth Protocol can be accessed at: https://www.norfolklscb.org/about/policies-procedures/5-21-pre-birth-protocol/.

At Appointments

- Complete a full clinical antenatal risk assessment and record in all records.
- At 16 weeks direct women to the RCOG information leaflet on 'Your baby's movements in Pregnancy' and record discussion in all records.
- The fundal height measurement should be measured in whole cm and plotted (X) on the customised growth chart in the handheld records from 25 weeks for all women who are not having serial scans. The Assessment of Fetal Growth Guideline should be followed at each contact Trustdocs Id: 8882.
- At 28 weeks take blood samples for Antibody Screening and FBC.
- At 28 weeks a discussion re fetal movement patterns and actions to be taken when concerned should be documented in all future contacts.
- At 28 weeks offer prophylactic Anti-D Rhesus to Rhesus negative women where *ffDNA* is not known.
- At 36 weeks commence birth plan discussions and direct to relevant information on Trust website.
- At 40 weeks offer a membrane sweep to all women prior to offering Induction of Labour pathway.

During Third Trimester

- Women should be encouraged to consider their birth choices preferences, including place of birth, and have an opportunity to discuss them.
- Regularly promote antenatal education / Pathway to Parenting / informative web pages and group specific sessions.
- Women who chose to birth at home should have a risk assessment and home visit at 36 weeks gestation (Appendix 3). This should include assessment of access, adequate telephone/mobile phone access. Any clinical concerns should be

discussed including any possible actions / recommendations / outcomes that may occur if any deviations from normal labour are detected. Refer to Planned Homebirth Management Guideline Trustdocs Id: 805.

Recommendation Ten

Women should be supported in their personalised birth choices

Women should be able to make decisions about the support they need during birth an where they would prefer to give birth, whether this is at home, in a midwife-led unit or in an obstetric unit, after full discussion of the benefits and risks associated with each option (Better Births 2016).

- Suitability of midwifery-led care and place of birth options should be discussed and documented in all records.
- Confirm that the woman has been given and read 'Choosing Where to have Your Baby' leaflet Trustdocs Id: 4067.
- The woman should be informed that the place of birth may change as clinical needs change.
- Women should be informed that there is a possibility that her first choice in place of birth may not be accommodated if activity is high at the time of her labour.
- For complex homebirth care planning, the midwife should contact her team leader in the first instance for support.
- For women that are having an unplanned homebirth following a labour assessment and have no completed risk assessment, the midwife facilitating the care should undertake a full risk assessment at the time and clearly document in the electronic records.
- If any risks are identified during the intrapartum period which a midwife determines that the type of care being requested could cause risk to her or her baby, then she should discuss the woman's wishes with her, provide detailed information relating to her requests, options available for care including alternatives, and outlining potential risks so that the woman is able to make a fully informed decision.
- If a woman declines alternative advice, during labour urgent referral to the Delivery Suite Co-ordinator or Manager on Call, and Consultant Obstetrician is recommended for senior midwifery and obstetric advice and ongoing support to the woman. The midwives have a duty of care and must continue to provide support to the woman. Consider seeking support from a Professional midwifery advocet as required after each event.
- If the woman requests that you provide care that does not meet recommended guidelines or pathways, ensure that you very clearly document the reason for care outside of guidelines in all records and escalate to line manager/Matron for further advice.

Unforeseen Circumstances

In the event of poor connectivity resulting in inability to access electronic records at the time of appointment/delivering care, midwives must complete Euroking paper proforma's at time of appointment. The information must be entered electronically as soon as in an area where connectivity has been resumed.

In the event of any unforeseen global, regional or local crisis, the schedule of care may change in line with national and/or regional guidance which may include reversion to telephone and virtual consultations instead of face-to-face appointments. Careful consideration will be given to NICE, RCOG and RCM guidance and will be based on the current available evidence at the time to ensure the safest and appropriate care in maintained.

All women will be informed of these changes via Trusts, Local maternity Partnerships and midwifery social media platforms.

Summary of Development and Consultation Process Undertaken before Registration and Dissemination

This guideline was initially written by Pam Sizer, Midwifery Matron and has been subsequently updated by Community Midwifery Team Leaders. Input has been obtained from members of the Guidelines Committee which includes clinically based midwives, senior midwives and Obstetric colleagues. This guideline was approved by the Director of Midwifery and Directors of Clinical Governance.

Distribution list

Community Team Leaders
Head of Midwifery
Clinical Midwives
Trust Intranet

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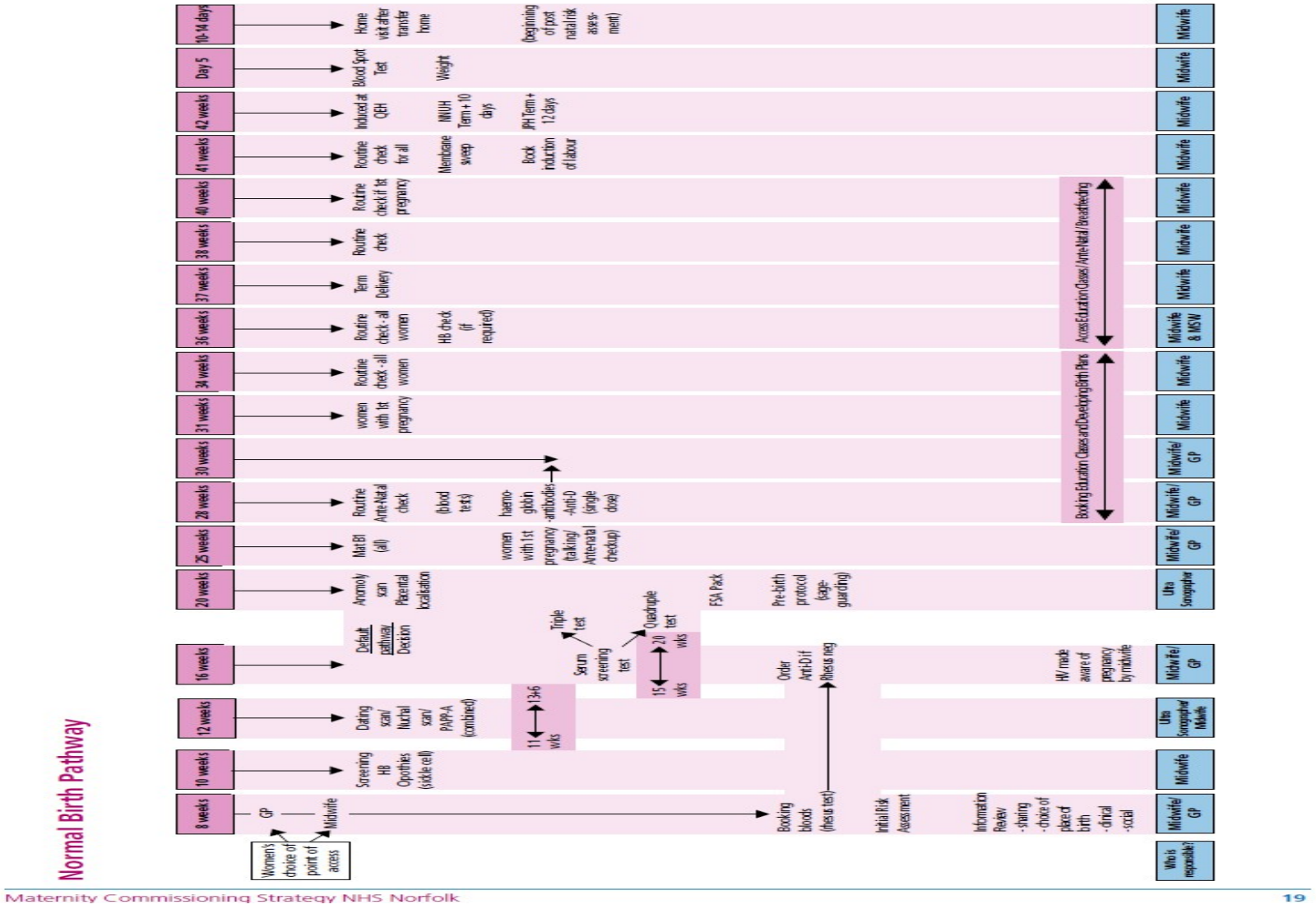
Appendix 1 – Maternity Pathway



Antenatal Appointments (Schedule and Content)

How many weeks you should be when you are seen (approximately)	Seen By / Who Needs Seeing	Purpose Below are examples of what the midwife will discuss during your visit
Booking visit This should be completed by 9 weeks howeverwe appreciate that sometimes this is not possible, therefore the midwife will aim to complete the booking by the end of your 12th week of pregnancy	Midwife All women	A full booking history will be taken. The midwife will complete/send the booking form and give you your maternity hand-held records Discuss your choice for place of birth, concerns and preferences Discuss and provide information leaflets regarding screening tests; HIV, Hepatitis B, Syphilis, Thalassaemia & Sickle Cell screening (FOQ). Discuss/obtain consent for routine blood tests (Full blood count, Group, antibodies), Discuss & offer Combined Screening (a scan plus Nuchal measurement) Record your baseline observations including BMI, blood pressure & Urinalysis Discuss smoking, CO monitoring, diet, alcohol, dental care, folic acid, vitamin D, prescribed and non-prescribed drugs **Other 'risks' may be highlighted during your appointments which may require support from other health professionals**
11 – 14	USS Dept All women	Routine 'dating' scan +/- Combined Screening (NT) *(Please note there is a charge for all scan photos)*
16	Midwife All women	Discuss/confirm your agreed date for delivery following your scan Discuss any maternity benefits and/or grants. Review and record your blood tests and discuss results/future tests Record your Blood pressure (BP), urinalysis, discuss baby movements Discuss/organise Anti-D if you are Rhesus negative and a Glucose Tolerance Test (GTT) if required Discuss P2P and Flu / Whooping Cough vaccines **Organise a Quadruple test for screening (if applicable)**
Approximately 20 weeks	USS Dept All women	Routine fetal anomaly scan – this checks the anatomy of the baby in more detail; heart, growth, fluid around the baby and placenta location
25	**1st baby** Midwife	Review and discuss your scan results. A full antenatal examination and assessment checking; BP, urinalysis, height of your uterus, amount baby is moving and your psychological health & wellbeing Discuss infant feeding Discuss/issue any relevant benefit forms including your Mat B1 form
28	Midwife All women	Full antenatal examination / assessment (as above). Discuss infant feeding. Repeat your FBC +/- antibody screen. **Administration of Anti-D injection if you are Rhesus negative** This should be given between 28 – 32 weeks.
31	**1st baby** Midwife	Full antenatal examination / assessment (as above) Review and record any blood results, discuss results and any future tests. Discuss infant feeding and preparation for birth
34	Midwife All women	Full antenatal examination / assessment (as above) Arrangements for a home visit at 36 weeks if you are planning a homebirth. Talk about labour / skin to skin contact / birth plan / any concerns. Complete infant feeding checklist.
36	Midwife All women	Full antenatal examination/assessment (as above) Confirm place of birth – discuss childcare, transport, birthing support FBC / MRSA screening if required We need to confirm the position of the baby at this time and if it does not appear to be 'head down' a presentation scan will be arranged
38	Midwife	Full antenatal examination/assessment (as above) Discuss labour and membrane sweep. If this is your first baby you will be offered a membrane sweep at your next appointment after 40 weeks
40	**1st baby** Midwife	Full antenatal examination/assessment (as above) Offer a membrane sweep, discuss induction of labour.
41	Midwife All women	Full antenatal examination/assessment (as above) Offer a membrane sweep Your induction of labour appointment will be booked for Term +10 to 14

Women with a complicated pregnancy may need to see the obstetrician/midwife more frequently. This will be discussed with you by your midwife or doctor.

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Appendix 2: Consultant Speciality Clinic Days

Monday (AM) Ms Beth Revell (BJR) Skylark Team & Perinatal Mental Health	Vulnerable women & FGM: • Learning Difficulties, • Severe Postnatal Depression, • Puperal or Psychosis, • Psychiatric disorders, (mod/severe) • Drug / Alcohol abuse • Age 19 or younger at EDD
Monday (PM) Mr Lartey (JPL)	Pre-term labour & Infectious diseases: • Anyone who needs cervical length or suture, • Late miscarriage, • Prev PPROM • HIV, Hep B/C • Current Bacterial vaginosis ≤16/40
Tuesday (AM) Ms Gibson (ABG) & Mr Sveronis (Locum)	General Obstetrics: • Jehovah Witness • ↑TRA • Anaemia, sickle cell thalassemia disease thrombocytopenia • Previous poor outcome (HIE)/Neonatal Death. • Recurrent 1st trimester miscarriage. • Current PET/SGA • ↑Maternal age at EDD
Tuesday (PM) Ms Nirmal (DMN)	Birth choices: • BAC, • Traumatic delivery, • 3rd degree tears (if has been advised) • 4th degree tears • Fistula
Wednesday (AM) Mr Bircher (CWB) & Ms Haestier (ACH)	Raised BMI • BMI 35 -39.9 seen in ANC with dating scan • BMI 40 + seen in ANC with dating scan
Wednesday (PM) Ms Partridge/Mr Lartey (FHH)	Gestational Diabetes
Wednesday (PM) Ms Gibson (ABG)	Rainbow Clinic: Previous SB
Thursday (AM) Mr Smith (RPS) & Mr Cameron (MJC)	• Multiple Pregnancy, genetics & FMU • Rhesus isoimmunisation or significant blood group antibodies
Ms Partridge (GCP) & Ms Remadevi (Locum)	Epilepsy
Thursday (PM) Ms Partridge & McKelvey (ACM)	Pre-existing Diabetes – Type 1, Type 2, Pump etc.
Friday (AM) Ms Harlow (FHH), Mr McKelvey (ACM) & Mr Lartey (JPL)	Maternal Medicine: • Cardiac disease, • Neurology disorders (exception Epilepsy) • Renal disorders including urology problems • Pre-pregnancy hypertension, • Autoimmune disorders including Rheumatology & inflammatory bowel disease. • Endocrine disorders, • Respiratory Disease, • Malignant disease, • Other Haematological disorders, • Severe pre-eclampsia or HELLP in previous pregnancy.

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Appendix 3

D

Homebirth Risk Assessment

Patient Identifier Label

Date of 36 week visit: *dd/mm/yyyy* **……..**

Expected date of delivery: *dd/mm/yyyy* **…….**

Partners name				
Home telephone number				
Call restrictions?/network coverage	Details:			
Mobile number				
GP telephone number				
GP code				
Community Midwife				
Midwifery team				
Blood Group				
Rhesus factor				
Most recent Hb	Result		Date taken *dd/mm/yyyy*	
Previous obstetric history				
Current pregnancy details				
High / Low risk (homebirth criteria)				
Consent for student	Yes ☐ No ☐		*If no add details*	

Home birth requirement list given?	
Detailed directions to premises obtained / issues with postcode.	

Print name		Signature	
Date *dd/mm/yyyy*		Designation	

Patient Identifier Label

	Tick when discussed	Risk Factors Yes / No	Comments
Birth Preferences Water birth requested? Pain relief preferences? Use of complimentary therapies?			
Baby monitoring in labour			
Third stage of labour Physiological Active management			
Environmental Factors: Is there adequate heating and lighting? Is there good access to the premises? Stretcher access out of the birth room? Is there adequate mobile phone signal?			
Social Issues Safeguarding issues? Social Services involvement?			
Personal Safety issues: For Mother/Baby? For Staff?			
Contact arrangements Own midwife not always on duty midwife availability e.g. sickness – simultaneous home births Distance / time to hospital Weather conditions Midwives response time Limitations of service			

Print name		Signature	
Date *dd/mm/yyyy*		Designation	

Patient Identifier Label

	Tick when discussed	Risk Factors Yes / No	Comments
Management of emergencies / transfer to hospital Why transfer may be necessary Complications in labour • Mother e.g., slow progress • Baby – problems with heart rate Complications after birth • Mother - e.g., PPH • Baby – resuscitation Equipment available Limitations of staff – e.g., cannulation Response times – e.g., paramedic – transfer to hospital times Care of other children Directions to hospital			
Information leaflets / signpost to NNUH website. Vitamin K IM/oral - If oral preparation is parental choice, the community MW to ensure this has been arranged.			
Special requests Birth plan discussed? Any other questions or concerns?			
Examinations / Assessments Following Delivery VTE risk assessment NIPE Pre and post Ductal O2 saturations Hearing Screening			

Discussed and acknowledged homebirth check list		Yes ☐ No ☐			
Mother's Name		Date *dd/mm/yyyy*		Signature	
Midwife's Name		Date *dd/mm/yyyy*		Signature	

Clinical Guideline for: Antenatal Booking and subsequent Antenatal Appointments and Risk Assessment

Booking Process Quick Reference Guide

- On confirmation of pregnancy, woman contacts GP surgery and given relevant midwifery team contact number.
- Advised to complete online form at www.nnuh.nhs.uk

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- Offered Booking Appointment between 7-9 weeks gestation
- Completed in 2 parts

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Part 1

- Telephone consultation
- Risk assessment completed
- Consultant led care (CLC) or Midwife led care (MLC)
- E3 completed
- Appointment booked for Part 2
- Notes completed and taken to base ready for appointment

Part 2

- Face to face and prior to scan
- Height, weight, BMI, B/P, U/A
- Discussion and consent for combined screening
- Discussion and consent for blood tests
- Hand held records given

All other appointments arranged as per Antenatal schedule either by NNUH (CLC patients) or via case loading midwife

Clinical Guideline for: Antenatal Booking and subsequent Antenatal Appointments and Risk Assessment

Appendix 4

‘Your Personalised Care Plan’ - Trustdocs Id: 18780