NORTHERN IRELAND HEALTH AND SOCIAL CARE
MATERNITY SERVICES
CORE PATHWAY FOR ANTENATAL CARE
May 2016

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The Project Team wish to thank all who participated in the development of this pathway which included;

Women
Midwives
General practitioners
Obstetricians

PURPOSE OF CORE PATHWAY ANTENATAL CARE

The Northern Ireland Maternity Strategy (DHSSPS, 2012) launched in July 2012 has a six year implementation period. There are a total of 22 objectives in which a number (1;2;10;12&16) address woman's choice, accessibility of services and who is best placed to be the lead maternity professional. The purpose of this pathway therefore is to address these objectives and to outline evidence based care for women whose pregnancy follows the path of normality. Women who follow this pathway will have their maternity care led by a midwife as first point of contact for all maternity problems. However the lead professional for all other aspects of care they may require will continue to be their General Practitioner (GP). As the GP will continue to have long term responsibility for women before, during and after pregnancy, it will be essential that all aspects of maternity care are effectively and promptly communicated to her GP.

RATIONALE

The Maternity Strategy states 'midwives will be the lead professional for all healthy women with straightforward pregnancies'. It is therefore anticipated that *all women,* provided that it is their choice, will have early contact with a midwife. The midwife will risk assess in partnership with women reviewing options of care and will ensure close liaison with the local general practitioner throughout the woman's pregnancy.

For women with complex pregnancies the midwives will work as the key coordinators of care within the multidisciplinary team, liaising closely with obstetricians, general practitioners, health visitors/public health practitioners, family nurse partnerships nurses and maternity support workers/maternity care assistants.

In the course of this core pathway the midwife will inform women of the range of options best suited to meet their individual needs. The pathway will guide the woman and her midwife on the care required at each antenatal visit and if at any stage the woman's pregnancy deviates from straightforward, a discussion will ensue with the woman and she will be advised of referral to the most appropriate professional to assess her needs and a decision therefore will be required to be made in writing as to what pathway the woman will chose to take for the rest of her care.

HOLISTIC CARE

Prospective parents are partners with Health and Social Care (HSC) staff in maternity care. They must be given the right information about how they can help themselves and their baby to stay healthy before and during pregnancy, and in the postnatal period. Early assessment in pregnancy, informed choices for parenting education and location of birthplace of the baby, relevant to individual needs, are of crucial importance to both women and their partners. This pathway will therefore inform women and their partners of what care to expect from the midwife during the duration of her antenatal period.

COMMUNICATION PATHWAY TO GENERAL PRACTITIONERS

Primary care professionals, particularly general practitioners (GPs) and health visitors are also partners in maternity care. A communication pathway has been developed so that all professionals clearly understand respective roles and responsibilities and that there is two-way sharing of information. The use of the maternity hand-held record (MHHR) will be key to the coordination of the communication processes, a shorter version of this pathway will be included in it. In addition to the communication pathway, at the back of this pathway a referral letter has been adapted as a good practice tool. This is to ensure the right information on the need for transfer of care from one lead maternity professional to another is documented.

NI MATERNITY SYSTEM (NIMATS)

NIMATS has and will continue to be reviewed and updated to ensure it is ‘fit for purpose’. All prospective parents’ details are taken at the 'Booking Visit'. This visit will identify a number of key aspects that need to be included in the overall holistic care that will include social factors such as those identified through the routine enquiry questions.

RISK ASSESSMENTS

Risk assessment starts at the first contact and continues throughout the antenatal period. Women with straightforward pregnancies will have midwives as their lead maternity professionals. At the back of this pathway 'risk assessment tools' have been included which should be used as good practice to guide the lead professional in the assessment of risks. Venous Thromboembolism (VTE) risk assessment tool and Gestational Diabetes risk assessment tools are already included in the maternity hand-held record for

reference and completion by the lead professional. In addition, some women have rhesus negative blood therefore routine antenatal anti-D prophylaxis (RAADP) is recommended as a treatment option for all pregnant women who are rhesus D (RhD) negative and who are not known to be sensitised to the RhD antigen (NICE TA156, 2008). Anti-D immunoglobulin can be given as a single dose of 1500 IU either at 28 weeks.

CAVEATS

For those women with more complex pregnancies, consultant obstetricians will be the lead maternity professionals. Women whose pregnancies are complicated by pre-existing medical or mental health conditions should be immediately referred to appropriate specialist clinics where both care for their medical condition and their obstetric care can be optimised. Referral to specialist services should be made by telephone and in writing using the HART Tool, it should be made clear that the woman is pregnant. This core pathway will underpin their care in addition to the planned care in relation to their individualised needs. All referrals, discussions and findings should be documented in the MHHR.

GUIDELINES AND AUDIT IMPLEMENTATION NETWORK (GAIN) GUIDELINES ON CRITERIA FOR ADMISSION TO MIDWIFE LED UNITS & NORTHERN IRELAND NORMAL BIRTH CARE PATHWAY

The Maternity Strategy outlined that women will be supported to make an informed decision about their place of birth by providing a balanced description of the benefits and risks of the different types of maternity settings. This will include information on midwife-led units, homebirth and consultant-led units for all women their partners and professionals providing maternity care. GAIN Guidelines on criteria for admission to Midwife Led Units has been launched and available at http://gain-ni.org/images/Uploads/Guidelines/GuidelinesFINAL.pdf

In addition, a Northern Ireland Antenatal Care Pathway has been developed and will be used by midwives in providing care for women with straightforward pregnancies to ensure continuity of evidence based care.

KEY ASPECTS OF CARE WHICH ARE IMPORTANT TO CONSIDER AT EACH VISIT

Follow the NICE (2014) Clinical Guideline 62 (some pointers)

- ✓ Lead professional should offer **consistent information and clear explanations,** and should provide pregnant women with an opportunity to discuss issues and encourage them to ask questions
- ✓ A system of clear referral paths should be established so that pregnant women who require additional care are managed and treated by the appropriate specialist teams when problems are identified
- ✓ Blood pressure measurement and urinalysis for protein should be carried out at each antenatal visit to screen for pre-eclampsia
- ✓ At the first contact with a healthcare professional, women should be given information about the purpose and implications of the anomaly scan to enable them to consider and make an informed decision as to whether or not to have the scan
- ✓ Gestation Related Optimal Weight – (GROW) - Customised growth charts are produced for every pregnant woman in Northern Ireland following her dating scan and secured in her Maternity Hand Held Record (MHHR). The charts are used to plot both Fundal height measurements obtained during clinical examination and estimated fetal weight (EFW) following an ultrasound examination. They are customised to each individual taking into account the height, weight, ethnicity, parity of the woman. Birth weights of previous children should be inputted to identify previous problems with growth, but this does not affect the centiles produced.

Additional points to remember

- To avoid preventable deaths, the benefits of influenza and whooping cough (pertussis) vaccinations for pregnant women should be promoted and the vaccine/s should be offered as appropriate
- If a woman repeatedly (≥ three times) presents to the general practitioner, or community midwife or alternatively repeatedly (≥ three times) makes self-referrals to the obstetric triage or day assessment unit this should be considered a 'red flag' and warrant a thorough assessment of the woman
- To inform the woman:- *If you notice your baby is moving less than usual or if you have noticed a change in the pattern of movements, it may be the first sign that your baby is unwell and therefore it is essential that you contact your local maternity unit immediately so that your baby's wellbeing can be assessed*

EARLY PREGNANCY APPOINTMENT - (before 10weeks)

Referral by	Assessed By	This early appointment will be to:	Tick when complete or note when not
Self-referral by women Or GP	Midwife	✓ Meet and build relationships ✓ Give pregnancy book and discuss early pregnancy aspects within book such as: I. Folic acid, including correct dose, vitamin D II. Minor disorders of pregnancy III. Public Health issues; smoking-including carbon monoxide monitoring, alcohol, drugs, prescribed and non-prescribed, healthy eating/foods to avoid, regular gentle exercise IV. Discuss benefits of receiving influenza and whooping cough (pertussis) vaccinations ✓ Discuss choices for antenatal care, midwife led, consultant led, consultant shared or group based care and education, and who will be the lead professional for care plus provide contact details ✓ Initiate discussion about place of birth to include Homebirth, Midwife Led Unit (MLU), Hospital ✓ If interested in MLU give GAIN Guidelines for Admission to MLU maternity care user leaflet ✓ Verify demographic details in order to generate NIMATS number and the Maternal Hand Held Record (MHHR) discuss content of same ✓ If seen by Midwife first - notification of pregnancy to GP (appendix 4) ✓ Prepare woman what to expect at her 'Booking' visit ✓ Discuss appointment schedule ✓ Commence discussions regarding building relationships with baby, infant mental health	

SIGNATURE _____**DATE**_____

'BOOKING VISIT' FOR ALL WOMEN before 12+6 weeks

Referral by	Assessment By	OPPORTUNITIES TO DISCUSS AND ASSESS THE FOLLOWING WITH THE WOMAN THIS APPOINTMENT IS TO:	Tick when complete or note when not
By Midwife or GP	Midwife	✓ Continue to build relationship between the woman and her midwife ✓ Confirmation of pregnancy via Dating / Viability Scan (by an appropriate health professional) ✓ Maternal weight and height should be measured at the booking appointment, and the woman's body mass index calculated ✓ Clinical Examination - measure blood pressure and test urine for proteinuria (NICE CG62) ✓ Give early pregnancy advice in conjunction with pregnancy book including: o Smoking – including Carbon Monoxide monitoring o Healthy eating/foods to avoid, regular gentle exercises o Alcohol, drugs, prescribed and non-prescribed o Folic Acid completed at 12 weeks (unless history of neural tube defect, diabetes, epilepsy or if the woman has BMI>30 o Vitamin D supplement (10 micrograms daily) o Benefits of pertussis and influenza vaccines ✓ Carry out booking risk assessments using NIMATS Screening questions and reference to risk assessment tools (appendix 1, 2 & 3) and in MHHR relating to diabetes and VTE which should be carried out by midwife and referred to obstetrician if appropriate ✓ Urinalysis - MSSU to detect asymptomatic bacteriuria ✓ Discuss booking screening bloods to be taken and why, reserve screening blood tests with consent ✓ Discuss choices for antenatal care, midwife led, consultant led, consultant shared or group based care and education, who the lead professional will be and ensure contact details are written in MHHR ✓ Continue discussion regarding place of birth to include homebirth, MLU, hospital. If interested in MLU give user leaflet for GAIN guidelines for admission to an MLU ✓ Notification of booking to GP (Appendix 4) ✓ Generate customised growth chart ✓ Offer appointment for fetal anomaly scan, arrange appointment at 20weeks informing the woman about consent prior to scan and discuss appointment schedule ✓ Continue discussions regarding building relationships with baby and infant wellbeing ✓ Complete routine enquiry and UNOCINI if required ✓ Document findings and discussions in MHHR	

SIGNATURE _____**DATE**_____

WEEK16: REVIEW VISIT FOR ALL WOMEN

Referral By	Assessment By	OPPORTUNITIES TO DISCUSS AND ASSESS THE FOLLOWING WITH THE WOMAN THIS APPOINTMENT IS TO:	Tick when complete or note when not
Midwife or Obstetrician	Lead Professional	✓ Continue to build relationships between the woman and her midwife ✓ Review booking blood results and reassess woman's obstetric and medical history using risk assessment tool provided ✓ Clinical Examination - measure blood pressure and test urine for proteinuria (NICE CG62) ✓ If requested by woman – listen to fetal heart ✓ Continue using risk assessment tool (appendix 1, 2 or 3), if outside normal parameters refer in writing to Consultant Obstetrician for assessment (appendix 5) (if this is an urgent referral this needs to be communicated verbally by phone directly to the consultant) ✓ Give early pregnancy advice in conjunction with pregnancy book including: o Smoking – including Carbon Monoxide monitoring o Healthy eating/ foods to avoid, regular gentle exercises o Alcohol, drugs, prescribed and non-prescribed o Folic Acid completed at 12 weeks (unless history of neural tube defect, diabetes, epilepsy or if the woman has BMI>30 o Vitamin D supplement (10 micrograms daily) o Benefits of pertussis and influenza vaccines ✓ Discuss any issues with previous birth experiences and direct woman towards completing a birth plan ✓ Follow- up on initial discussion about place of birth to include Home, Midwife-Led Unit or Hospital, if choosing to Midwife Led refer to GAIN Guidelines for Admission to MLU ✓ Continue discussions regarding building relationships with baby and infant wellbeing (refer to antenatal and postnatal mental health NICE guideline CG45 if necessary) ✓ If seen by midwife only -notification of on-going pregnancy to GP (appendix 4) ✓ Document discussions and findings in MHHR	

SIGNATURE _____**DATE**_____

WEEK 20:- ULTRASONIC FETAL ANOMALY SCAN FOR WOMEN (who chose this option)

Referral by	Assessment By	WHY SEE ACTION (WHAT'S DONE) This appointment is to:	Completed By Date and Sign
By midwife for USS	Obstetric Ultra-Sonographer	✓ Conduct a detailed structural scan ✓ Anomaly scan ✓ Risk assessment:- if outside normal parameters refer in writing to Consultant Obstetrician for reassessment (if this is an urgent referral communicate verbally by phone directly with the consultant) ✓ Document discussions and findings in MHHR	

WEEK 25:- REVIEW FOR PRIMIGRAVIDA MOTHERS ONLY

Referral by	Assessment By	OPPORTUNITIES TO DISCUSS AND ASSESS THE FOLLOWING WITH THE WOMAN THIS APPOINTMENT IS TO:	Tick when complete or note when not
Midwife or Obstetrician	Lead Professional	✓ Continue to build relationships between the woman and her lead professional ✓ Full Clinical examination ✓ Begin to explain measuring Symphysis-Fundal Height (SFH) (Plot when seen from 26 weeks onwards) ✓ Continue to reassess risk factors using NIMATs and risk assessment tool (appendix 1, 2 or3) and if outside normal parameters refer in writing to Consultant Obstetrician for assessment (appendix 5) (if this is an urgent referral this needs to be communicated verbally by phone directly to the consultant) ✓ Follow- up on initial discussion about place of birth to include Home, Midwife-Led Unit or Hospital, if choosing to Midwife Led refer to GAIN Guidelines for Admission to MLU, discuss birth plan ✓ Give public health advice in conjunction with pregnancy book including: o Smoking – including Carbon Monoxide monitoring o Healthy eating, regular gentle exercises o Alcohol, drugs, prescribed and non-prescribed o Vitamin D supplement (10 micrograms daily) o Benefits of pertussis and influenza vaccines ✓ Continue discussions regarding building relationships with baby and infant wellbeing (refer to antenatal and postnatal mental health NICE guideline CG45 if necessary) ✓ Provide Mat B1 form if required ✓ Prepare woman for next appointment and document discussions and findings in MHHR	

SIGNATURE _____**DATE**_____

WEEK28:- REVIEW FOR ALL WOMEN

Referral by	Assessment By	OPPORTUNITIES TO DISCUSS AND ASSESS THE FOLLOWING WITH THE WOMAN THIS APPOINTMENT IS TO:	Tick when complete or note when not
Midwife or Obstetrician	Lead professional	✓ Continue to build relationships between the woman and her midwife ✓ Full clinical examination, including customised growth chart by measuring Symphysis-Fundal Height (SFH) plot findings on chart ✓ Reassess risk factors using NIMATs and risk assessment tool (appendix 1, 2 or 3) and if outside normal parameters refer in writing to Consultant Obstetrician for assessment (appendix 5) (if this is an urgent referral this needs to be communicated verbally by phone directly to the consultant) ✓ Follow- up on initial discussion about place of birth to include Home, Midwife-Led Unit or Hospital, if choosing to Midwife Led refer to GAIN Guidelines for Admission to MLU, encourage her to complete a birth plan ✓ Reserve screening bloods (Hb and Antibodies) with consent ✓ offer anti‑D prophylaxis to rhesus‑negative women(NICE CG62), ✓ Give public health advice in conjunction with pregnancy book including: o Smoking – including Carbon Monoxide monitoring o Healthy eating/ foods to avoid, regular gentle exercises o Alcohol, drugs, prescribed and non-prescribed o Vitamin D supplement (10 micrograms daily) o Benefits of pertussis and influenza vaccines ✓ Continue discussions regarding building relationships with baby and infant wellbeing (refer to antenatal and postnatal mental health NICE guideline CG45 if necessary) ✓ Benefits of breastfeeding , importance of management of Skin to Skin contact and Rooming in ✓ Issue Mat B1 form if required ✓ Arrange parenting education ✓ Prepare woman for next appointment and document discussions and findings in MHHR	

SIGNATURE _____**DATE**_____

BETWEEN WEEKS 30/31:- ALL WOMEN TO INCLUDE ADMINISTRATION OF ANTI D FOR RHESUS NEGATIVE WOMEN

Referral by	Assessment By	OPPORTUNITIES TO DISCUSS AND ASSESS THE FOLLOWING WITH THE WOMAN THIS APPOINTMENT IS TO:	Tick when complete or note when not
Midwife or Obstetrician	Lead Professional	✓ Continue to build relationships between the woman and her midwife ✓ offer anti‑D prophylaxis to rhesus‑negative women(NICE CG62), ✓ Full clinical examination, including customised growth chart by measuring Symphysis-Fundal Height (SFH) and plot findings on chart ✓ Continue to assess risk factors using NIMATs and risk assessment tool (appendix 1, 2 or 3) and if outside normal parameters refer in writing to Consultant Obstetrician for assessment (appendix 5) (if this is an urgent referral this needs to be communicated verbally by phone directly to the consultant) ✓ Follow- up on initial discussion about place of birth to include Home, Midwife-Led Unit or Hospital, if choosing to Midwife Led refer to GAIN Guidelines for Admission to MLU, encourage her to complete a birth plan ✓ Give public health advice in conjunction with pregnancy book including: o Smoking – including Carbon Monoxide monitoring – if available o Healthy eating, regular gentle exercises o Alcohol, drugs, prescribed and non-prescribed o Vitamin D supplement (10 micrograms daily) o Benefits of pertussis and influenza vaccines ✓ Benefits of breastfeeding (refer to BFI[1]) and the importance of management of Skin to Skin contact and Rooming in ✓ Arrange Parenting Education if not already arranged ✓ Continue discussions regarding building relationships with baby and infant wellbeing (refer to antenatal and postnatal mental health NICE guideline CG45 if necessary) ✓ Issue Mat B1 form if required ✓ Prepare woman what to expect at next visit ✓ Document discussions and findings in MHHR	

SIGNATURE _____**DATE**_____

[1] BFI Baby Friendly Initiative Guidelines

WEEK 34:-REVIEW VISIT FOR ALL WOMEN

Referral By	Assessment By	OPPORTUNITIES TO DISCUSS AND ASSESS THE FOLLOWING WITH THE WOMAN THIS APPOINTMENT IS TO:	Tick when complete or note when not
Midwife or Obstetrician	Lead professional	✓ Continue to build relationships between the woman and her lead professional ✓ Full clinical examination measure, including customised growth chart by measuring Symphysis-Fundal Height (SFH) and plot findings on chart ✓ Continue to assess risk factors using NIMATs and risk assessment tool (appendix 1, 2 or 3) and if outside normal parameters refer in writing to Consultant Obstetrician for assessment (appendix 5) (if this is an urgent referral this needs to be communicated verbally by phone directly to the consultant) ✓ Review blood results ✓ Follow- up on initial discussion about place of birth to include Home, Midwife-Led Unit or Hospital, if choosing to Midwife Led refer to GAIN Guidelines for Admission to MLU, encourage her to complete a birth plan ✓ Give public health advice in conjunction with pregnancy book including: o Smoking – including Carbon Monoxide monitoring o Healthy eating, regular gentle exercises o Alcohol, drugs, prescribed and non-prescribed o Vitamin D supplement (10 micrograms daily) o Benefits of pertussis and influenza vaccines ✓ Continue discussions regarding building relationships with baby and infant wellbeing (refer to antenatal and postnatal mental health NICE guideline CG45 if necessary) ✓ Benefits of breastfeeding and the importance of management of Skin to Skin contact and Rooming in ✓ Arrange parenting education if not already arranged ✓ Issue Mat B1 form if required ✓ Prepare woman for next appointment and document discussions and findings in MHHR	

SIGNATURE _____**DATE**_____

WEEK 36:-REVIEW VISIT FOR ALL WOMEN

Referral By	Assessment By	OPPORTUNITIES TO DISCUSS AND ASSESS THE FOLLOWING WITH THE WOMAN THIS APPOINTMENT IS TO:	Tick when complete or note when not
Midwife or Obstetrician	Lead professional	✓ Continue to build relationships between the woman and her lead professional ✓ Full clinical examination, including customised growth chart by measuring Symphysis-Fundal Height (SFH) and plot findings on chart ✓ Continue to assess risk factors using NIMATs and risk assessment tool (appendix 1,2 or 3) and if outside normal parameters refer in writing to Consultant Obstetrician for assessment (appendix 5) (if this is an urgent referral this needs to be communicated verbally by phone directly to the consultant) ✓ Follow- up on initial discussion about place of birth to include Home, Midwife-Led Unit or Hospital, if choosing to Midwife Led refer to GAIN Guidelines for Admission to MLU, encourage her to complete a birth plan ✓ Give public health advice in conjunction with pregnancy book including: o Smoking – including Carbon Monoxide monitoring o Healthy eating, regular gentle exercises o Alcohol, drugs, prescribed and non-prescribed o Vitamin D supplement (10 micrograms daily) o Benefits of pertussis and influenza vaccines ✓ Continue discussions regarding building relationships with baby and infant wellbeing (refer to antenatal and postnatal mental health NICE guideline CG45 if necessary) ✓ Discuss benefits of breastfeeding and the importance of management of Skin to Skin contact and Rooming in ✓ Refer to information in on labour and recognition of labour ✓ Refer to information on care of new born/ Vitamin k and new born screening ✓ Prepare woman for next appointment and document discussions and findings in MHHR	

SIGNATURE _____**DATE**_____

WEEK 38:-REVIEW VISIT FOR ALL WOMEN

Referral by	Assessment By	OPPORTUNITIES TO DISCUSS AND ASSESS THE FOLLOWING WITH THE WOMAN THIS APPOINTMENT IS TO:	Tick when complete or note when not
Midwife or Obstetrician	Lead Professional	✓ Continue to build relationships between the woman and her midwife ✓ Full clinical examination, including customised growth chart by measuring Symphysis-Fundal Height (SFH) and plot findings on chart ✓ Continue to assess risk factors using NIMATs and risk assessment tool (Appendix 1,2 or3), if outside normal parameters refer in writing to Consultant Obstetrician for assessment (appendix 5) - (if this is an urgent referral this needs to be communicated verbally by phone directly to the consultant) ✓ Follow- up on initial discussion about place of birth to include Home, Midwife-Led Unit or Hospital, if choosing to Midwife Led refer to GAIN Guidelines for Admission to MLU. ✓ Begin discussions regarding preparation for labour and coping with contractions in labour ✓ Encourage completion of birth plan. ✓ Give public health advice in conjunction with pregnancy book including: o Smoking – including Carbon Monoxide monitoring o Healthy eating, regular gentle exercises o Alcohol, drugs, prescribed and non-prescribed o Vitamin D supplement (10 micrograms daily) o Benefits of pertussis and influenza vaccines ✓ Continue discussions regarding building relationships with baby and infant wellbeing (refer to antenatal and postnatal mental health NICE guideline CG45 if necessary) ✓ Issue Mat B1 form if required ✓ Arrange parenting education ✓ Discuss benefits of breastfeeding and the importance of management of Skin to Skin contact and Rooming in ✓ Prepare woman for next appointment and discuss the option of being offer ‘sweep of membranes’ at 40 or 41 weeks if appropriate, document all discussions and findings in MHHR	

SIGNATURE _____**DATE**_____

WEEK 40:-REVIEW VISIT FOR ALL WOMEN

Referral By	Assessment By	OPPORTUNITIES TO DISCUSS AND ASSESS THE FOLLOWING WITH THE WOMAN THIS APPOINTMENT IS TO:	Tick when complete or note when not
Midwife or Obstetrician	Lead professional	✓ Continue to build relationships between the woman and her midwife ✓ Full clinical examination, including customised growth chart by measuring Symphysis-Fundal Height (SFH) and plot findings on chart ✓ Continue to assess risk factors using NIMATs and risk assessment tool (appendix 1,2 or 3)and if outside normal parameters refer in writing to Consultant Obstetrician for assessment (appendix 5) (if this is an urgent referral this needs to be communicated verbally by phone directly to the consultant) ✓ Follow- up on initial discussion about place of birth to include Home, Midwife-Led Unit or Hospital, if choosing to Midwife Led refer to GAIN Guidelines for Admission to MLU. ✓ Discuss preparation for labour and coping with contractions in labour ✓ Encourage completion of birth plan. ✓ Give public health advice in conjunction with pregnancy book including: o Smoking – including Carbon Monoxide monitoring o Healthy eating, regular gentle exercises o Alcohol, drugs, prescribed and non-prescribed o Vitamin D supplement (10 micrograms daily) o Benefits of pertussis and influenza vaccines ✓ Continue discussions regarding building relationships with baby and infant wellbeing (refer to antenatal and postnatal mental health NICE guideline CG45 if necessary) ✓ Discuss benefits of breastfeeding and the importance of management of Skin to Skin contact and Rooming in ✓ Discuss and offer ‘sweep of membranes’ at 40 weeks, if appropriate ✓ Discuss induction of labour and arrange for T+10 if appropriate ✓ Prepare woman for next appointment and discuss the option of being offered a ‘sweep of membranes’ at 41 weeks if appropriate, document discussions and findings in MHHR	

SIGNATURE _____**DATE**_____

WEEK 41:-REVIEW VISIT FOR ALL WOMEN

Referral By	Assessment By	OPPORTUNITIES TO DISCUSS AND ASSESS THE FOLLOWING WITH THE WOMAN THIS APPOINTMENT IS TO:	Tick when complete or note when not
Midwife or Obstetrician	Lead professional	✓ Continue to build relationships between the woman and her midwife ✓ Full clinical examination, including customised growth chart by measuring Symphysis-Fundal Height (SFH) and plot findings on chart ✓ Continue to assess risk factors using NIMATs and risk assessment tool (Appendix 1,2 or3) and if outside normal parameters refer in writing to Consultant Obstetrician for assessment (appendix 5) (if this is an urgent referral this needs to be communicated verbally by phone directly to the consultant) ✓ Follow- up on initial discussion about place of birth to include Home, Midwife-Led Unit or Hospital, if choosing to Midwife Led refer to GAIN Guidelines for Admission to MLU. ✓ Discuss preparation for labour and coping with contractions in labour ✓ Encourage completion of birth plan. ✓ Discuss Induction of labour and give date for same ✓ Give public health advice in conjunction with pregnancy book including: o Smoking – including Carbon Monoxide monitoring o Healthy eating, regular gentle exercises o Alcohol, drugs, prescribed and non-prescribed o Vitamin D supplement (10 micrograms daily) o Benefits of pertussis and influenza vaccines ✓ Continue discussions regarding building relationships with baby and infant wellbeing (refer to antenatal and postnatal mental health NICE guideline CG45 if necessary) ✓ Discuss benefits of breastfeeding and the importance of management of Skin to Skin contact and Rooming in ✓ Discuss and offer ‘sweep of membranes’ ✓ Arrange and book for induction of labour at Term+10 ✓ Document discussions and findings in MHHR	

SIGNATURE _____**DATE**_____

RISK ASSESSMENT TOOLS

The risk assessment tools (appendices 1, 2 &3) have been developed by incorporating the current criteria from all 5 HSC Trusts within NI, for women to either be admitted into midwife led care or transferred to consultant led care. Women who have any of the risks on table 1 or 2 will not immediately enter this care pathway but will instead be referred to consultant led maternity care where they will receive specialised care as required. For some women with these risk factors once they have been seen by an obstetrician they may be referred back to this pathway if agreed by the obstetrician (appendix 5). Alternately they may follow this pathway for most of the pregnancy and require only occasional appointments with the specialist team e.g. previous caesarean section.

The purpose of the risk assessment at booking is to determine at that stage which women are at present undergoing a straightforward pregnancy and can receive their care in their local community largely from their midwife and on occasion their General Practitioner. While the work carried out through GAIN into the development of the guideline for “Admission to MLU’s in NI” has been considered in the development of this risk assessment there will be some variances between the two in as they are for different parts of the woman’s journey.

It should be stressed that all women will also receive all the care stipulated within this care pathway, particularly around parenting education and relationship building both between them and the professionals providing their care but more importantly building the relationship between them and their baby.

At present most of the information required to make an appropriate risk assessment at booking is asked within NIMATs and therefore given time NIMATs could produce a risk profile for women following their booking visit.

Risk assessment needs to be continuous and occur with every contact in the antenatal period and table 3 shows those risks that if identified during pregnancy the woman should be referred for senior medical advice. If deemed appropriate she may then be referred back into this pathway.

NB Women with some of the risk factors in table 2 a “birth choices” clinic referral may be the most appropriate option.

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National Institute for Health and Care Excellence (NICE, 2008) *Antenatal care for uncomplicated pregnancies NICE guidelines [CG62] Published date: March 2008*

Royal College of Obstetricians and Gynaecologists (RCOG, 2012) *Bacteria Sepsis in Pregnancy*: Green Top Guidance. London

Royal College of Obstetricians and Gynaecologists (RCOG 2012) *Information for you: Your baby's movements in pregnancy.* London

The Kings Fund (2010) *The role of GPs in maternity care – what does the future hold?* London

APPENDIX 1

Table 1: Previous Medical History

A woman who has any of the risks on table 1 or 2 will also be either referred for a consultant appointment or a discussion with a consultant will take place and she will be offered additional specialised care if required. If deemed appropriate, the woman will then be referred back to this pathway Also use in conjunction with the GAIN Admission to and transfer from Midwife-Led Care Guidelines.

Alcohol dependency
Previous anaesthetic problems
Autoimmune diseases
BMI>30 or <18
Cardiovascular disease including hypertension
Endocrine disorder or insulin dependent diabetes or H/O gestational Diabetes
Family history of genetic disorders
Female Genital Mutilation
Haematological disorder
Higher risk of developing complications e.g. over 40 or smoker
HIV or Hep C infection
Infertility treatment this pregnancy
Latex allergy
Liver disease
Major abdominal surgery
Malignant disease
Multiple pregnancy
Neurological disorder e.g. epilepsy
Psychiatric disorder – Severe/Moderate/Mild
Renal disease
Severe asthma or other respiratory disease
Skeletal problems e.g. scoliosis, rheumatoid arthritis
Use of recreational drugs
>2 LLETZ procedures
Uterine surgery
Infections e.g. Group B Streptococcus
Thrombo embolic disorders
Gastro intestinal disorders

Source: Adapted for regional use from BHSCT/NHSCT/SHSCT/SEHSCT/WHSCT

APPENDIX 2

Table 2: Previous Obstetric History

A woman who has any of the risks on table 1 or 2 will also be referred for a consultant appointment where she will be offered additional specialised care if required. If deemed appropriate, the woman will then be referred back to this pathway. Also use in conjunction with the GAIN Admission to and transfer from Midwife-Led Care Guidelines

Antenatal or postnatal Haemorrhage
Baby with congenital abnormality
Baby weighing <2500 or >4500
Baby less than 5th centile
Baby greater than 95th centile
Grand multiparity>4
Mid trimester loss
Preterm birth/ cervical suture
Puerperal psychosis
Recurrent miscarriage >2
Retained placenta on 2 occasions
Rhesus isoimmunisation
Severe pre eclampsia, HELLP or eclampsia
Significant perineal trauma i.e 3rd or 4th degree tears
Stillbirth or neonatal death
Previous caesarean section
Previous shoulder dystocia
Previous difficult instrumental delivery
Previous uterine rupture
Previous baby with Group B Streptococcus
Previous placental abruption

Source: Adapted for regional use from BHSCT/NHSCT/SHSCT/SEHSCT/WHSCT

Table 3: Risks developing during this pregnancy

Risk assessment needs to be continuous at every visit in the antenatal period and table 3 shows those risks that if identified during pregnancy the woman should be referred for Consultant Obstetric advice. If deemed appropriate she may then be referred back into this pathway. Also use in conjunction with the GAIN Admission to and transfer from Midwife-Led Care Guidelines

Anaemia <9g/dl
Antepartum haemorrhage requiring admission
Fetal abnormality
Fetal macrosomia
Abnormal glucose tolerance
Hypertension, diastolic>90, systolic >140
IUGR
Intrauterine death
Low lying placenta
Malpresentation after 36 weeks
Maternal infection
Medical complication (not definitive)
Multiple pregnancy
Oligohydramnios
Polyhydramnios
Post maturity >41 weeks
Preterm rupture of membranes
Primary genital herpes
Proteinuria (+) on more than 1 occasion
Reduced fetal movements (after 2 admissions)
Threatened premature labour
Epigastric pain
Sepsis
Development of rhesus antibodies
Placental abruption

Source: Adapted for regional use from BHSCT/NHSCT/SHSCT/SEHSCT/WHSCT

Letter of Notification/Ongoing Pregnancy to General Practitioner

To Dr_____
Practice_____

Addressograph Label

History
Age_____
Parity_____
Gestation_____Wks Temp_____Pulse_____
Blood Pressure (BP)_____/_____
HB_____(if known)

This lady is registered with your practice
(Complete as necessary)

- **Her pregnancy has been confirmed on Date_____**
- **A 'booking appointment' has been arranged for _____Date**
- **This lady has been assessed as having a straightforward pregnancy and has been booked for:**
    1. **Midwife Led Unit at _____**
    2. **Obstetric Unit at _____**
- **This lady has been assessed as high risk and has been booked for:**
    3. **Consultant Led Care at_____**

Low and High Risk Assessment of current situation

_____
_____
_____
_____
_____
_____

Confirmation of her on-going pregnancy will be communicated to you again at _____wks

If for any reason there is a change in the management of her care you will be notified_____Sign Midwife

Final Core Pathway for Antenatal Care - Community Ma

HART Referral and / or Transfer Report

Between Midwifery Led Care and
Obstetric Led Care
Regarding On-going Management

AFFIX ADDRESSOGRAPH

LABEL HERE

H	**History** Antenatal ☐ Intrapartum ☐ Postnatal ☐ Parity _____ Gestation (if applicable) _____ A/N / Intrapartum / P/N History (as applicable) _____ _____
A	**Assessment of Current Situation** Temp____ Pulse ____ Blood Pressure (BP) ____/____ OEWS score _____ FH_____ (as applicable) Assessment of current situation and reason for referral/transfer _____ _____
R If Obstetric Emergency proceed directly to **T**ransfer	**Referral** Referred to Dr _____ (name) on _____ (date) at _____ (time) Reviewed by Dr _____ Date _____ Time _____ Suitable to remain Midwifery Led Care Yes ☐ No ☐ (if **no** please complete transfer section below) Arrangements for next review (if applicable) Date _____ Time _____ Department _____
T	**Transfer** Is transfer agreed Yes ☐ No ☐ Obstetric Consultant informed of transfer Yes ☐ No ☐ Date _____ Time _____ Consultant Dr _____ (name) **agrees / disagrees** to assume on-going responsibility for the care of this woman **Plan for on-going management should be documented in Maternity Hand Held Record** Arrangements for next review (if applicable) Date _____ Time _____ Department _____

Midwife Name (Printed) _____ Signature _____ Date _____ Time _____

Doctor Name (Printed) _____ Signature _____ Date _____ Time _____

Source: Adapted for regional use from SHSCT/BHSCT