

Document Title:	GUIDELINES FOR PERFORMING THE 18 WEEKS AND 0 DAYS TO 20 WEEKS AND 6 DAYS GESTATION FETAL ANOMALY SCAN		
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Author/Contact: (Asset Administrator)	Emily Sawtell, Sonographer		
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Consulted With:	Post/ Approval Committee/ Group:	Date:
	MEHT Sonographers	23 rd August 2019
Andrea Francis	Radiology Governance/Clinical Lead	23 rd August 2019
Emma Neate	Antenatal Screening Coordinator	28 th July 2019

Related Trust Policies (to be read in conjunction with)	04071 Standard infection prevention 09015 Placenta praevia protocol 08054 Antenatally diagnosed renal pelvis protocol 06035 Referral to Tertiary unit for suspected fetal abnormality. 10009 – Support for Parents in Maternity With Actual or Suspected Poor Outcome. 10120 Dignity in Care Policy
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1.0	Tina Sheriff		26/08/2010
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4.0	Emily Sawtell	Full review	5th September 2019

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1.0 Purpose

- 1.1 To ensure that staff are familiar with the procedures to follow for the 18 weeks and 0 days to 20 weeks and 6 days gestation anomaly scan.

2.0 Background

- 2.1 Ensure access to a uniform screening programme which conforms to an agreed level of quality.
- 2.2 Provide appropriate information for women so that they are able to make an informed choice.
- 2.3 Offer choices to women about their screening options and pregnancy management.
- 2.4 Identify serious fetal abnormalities, either incompatible with life or associated with morbidity, allowing women to make reproductive choices.
- 2.5 Identify certain abnormalities that may benefit from antenatal intervention.
- 2.6 Identify certain abnormalities that require early intervention following delivery.
- 2.7 The objective of the fetal anomaly scan is to screen for the following abnormalities:
 - Anencephaly;
 - Open spina bifida;
 - Cleft lip;
 - Diaphragmatic hernia;
 - Gastroschisis;
 - Exomphalos;
 - Serious cardiac abnormalities, to include the following four defects:
 - Atrial ventricular septal defect;
 - Transposition of the greater arteries;
 - Hypoplastic left heart;
 - Tetralogy of Fallot;
 - Bilateral renal agenesis;
 - Lethal skeletal dysplasia;

- Edwards' syndrome (Trisomy 18);
- Patau's syndrome (Trisomy 13);
- It is possible that other conditions may be detected at this ultrasound scan;
- There is no requirement to recall the woman if the fetal sex is not identified due to poor visualisation or difficult fetal position.

3.0 Scope

- 3.1 This document encompasses all patients who consent to and attend for 18 weeks and 0 days to 20 weeks and 6 days gestation anomaly screening.

4.0 Equality Impact Assessment

- 4.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.
(Refer to Appendix C)
- 4.2 The ultrasound department should be proactive and flexible in meeting the needs of each pregnant woman, particularly those who are vulnerable and 'hard to reach'.

5.0 Standards

- 5.1 Detailed ultrasound scans should be performed providing methodical examination of the fetus.
- 5.2 All pregnant women should be offered the 18 weeks and 0 days to 20 weeks and 6 days gestation fetal anomaly scan. The appointment time should be 30mins for a singleton and at least 45 minutes for twins.
- 5.3 The scan should be performed between 18 weeks and 0 days to 20 weeks and 6 days gestation.
- 5.4 An explanation of the scan should be given to the patient before the examination i.e. the purpose of the scan and its limitations.
- 5.5 All women should be informed of an inconclusive or abnormal scan finding before they leave the ultrasound examination room.
- 5.6 If a repeat scan is needed, tick the reason box on CRIS and mention the in the report i.e. difficult fetal lie or increased BMI. Current guidelines from the National Screening Committee (NSC) state that the second examination should be performed before 23 completed weeks of pregnancy.
- 5.7 To carry out the scan in accordance with the Trust's 'Dignity in Care Policy'; register number 10120.

- 5.8 One accompanying adult will be invited into the scan room during the anatomical checks. Children will not be admitted into the scan room until all of the checks have been completed. Any other people accompanying the patient, including children will be allowed to view the scan once the sonographer is satisfied the scan is complete.
- 5.9 Fetal sexing is offered by MEHT (at this scan only), but there is no requirement to determine fetal gender within the NHS FASP in England; it is not part of the 18 weeks and 0 days to 20 weeks and 6 days gestation NHS FASP ultrasound scan base menu. There is no programme requirement to recall the woman if the fetal sex is not identified due to poor visualisation or difficult fetal position. Fetal sexing is the opinion of the Sonographer only and will only be given verbally to the patient at the time of the scan. This will not be written down and is never guaranteed to be 100% accurate.
- 5.10 The use of mobile phones or other recording equipment is strictly prohibited during this scan due to the medical nature of the work being undertaken by the sonographer.

6.0 Fetal Anatomy to be Included

- 6.1 The NHS Fetal Anomaly Screening Programme (FASP) 18 weeks and 0 days to 20 weeks and 6 days gestation fetal anomaly scan national standards and guidance for England recommend the following anatomy is looked at:

Table 1:

Area	Structure	View
Head and Neck:	Skull	Shape
	Neck: Skin fold NF (Nuchal Fold)	Subjective- measure NF if looks increased.
	Brain: - Cavum septum pellucidum - Ventricular atrium -Cerebellum	
Face:	Lips	Coronal view
Chest:	Heart: - Four-chamber view - Outflow Tracts (Including 3VT)	Refer to fetal cardiac protocol
	Lungs	
Abdomen:	Stomach: - stomach and short intra hepatic section of umbilical vein	Transverse, Sagittal
	Abdominal wall	Transverse
	Bowel	
	Renal Pelvis	Transverse, measure if looks increased

	Bladder	Sagittal and transverse
Spine:	Vertebrae	Sagittal, coronal and transverse (image sagittal)
	Skin covering	Sagittal and transverse
Limbs:	Femur	Length (one only)
	Hands: metacarpals left and right	Visible (not counted)
	Feet: Metatarsals left and right	Visible (not counted)
Uterine Cavity	Amniotic fluid	Subjective volume
	Placenta	Visible and position noted.

7.0 Fetal Cardiac Protocol:

Table 2:

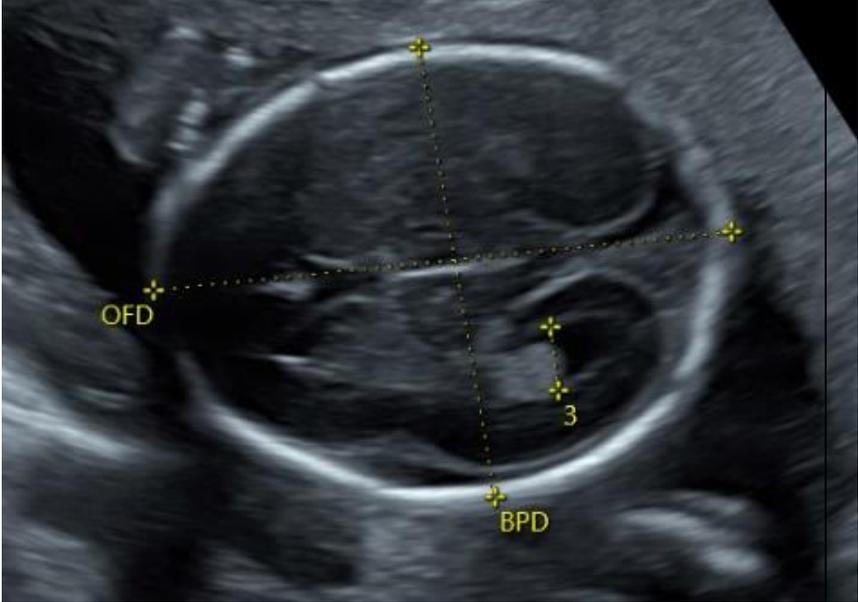
View	Size	Position	Structure	Function
Situs/Laterality Determine left and right side of the fetus from position in utero, include annotation to represent fetal lie, i.e, head above or below, fetal left or right.		Stomach and heart on the left, viewed in split screen.	Ensure descending aorta seen on anatomical left and IVC to the right of aorta	
Four chamber: Transverse section of the thorax including a complete rib and crux of the heart	Normal cardiac size occupies 1/3 of area of the thorax. X2 atria of equal size X2 ventricles of equal size X2 atrioventricular valves of equal size.	-Mostly in the left chest. -Apex points towards the left, approximately 45 degrees.	-Left and right sides of the heart are symmetrical. -Moderator band at right ventricle apex. -Crux -Differential offsetting of valves. -Ventricular septum intact -Foramen ovale flap in left atrium.	-Rhythm -Two ventricles contract equally. -Mitral and tricuspid valves open freely.
Aorta/Left ventricular outflow tract:		Aorta arises from the left ventricle and sweeps out towards the right shoulder	The anterior wall of the aorta is continuous with the ventricular septum.	Aortic valve opens freely.
Pulmonary/right	The diameter of	Main	The main	Pulmonary valve

<p>ventricular outflow tract</p> <p>OR</p> <p>Three vessel view: This view shows the outflow tract of the right ventricle including the pulmonary artery, the aorta and the superior vena cava.</p> <p>AND 3VT (three vessel trachea view) Shows the relationship of the pulmonary artery and the aorta in relation to the trachea.</p>	<p>the pulmonary artery is slightly greater than that of the aorta which is slightly greater than that of the superior vena cava.</p> <p>The pulmonary artery and aorta should be of equal diameter and be seen joining each other. The merging together of aortic and ductal arches into the descending aorta.</p>	<p>pulmonary artery arises from the right ventricle and is directed backwards towards the spine. -The pulmonary artery lies to the left with the superior vena cava to the right and aorta in the middle. -Pulmonary artery continues as the arterial duct.</p> <p>Both the pulmonary artery and aorta should be positioned to the anatomical left of the trachea.</p>	<p>pulmonary artery bifurcates.</p>	<p>opens freely.</p>
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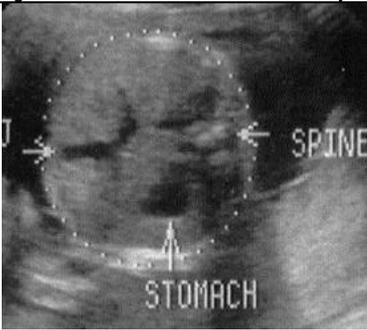
8.0 Images to be Recorded

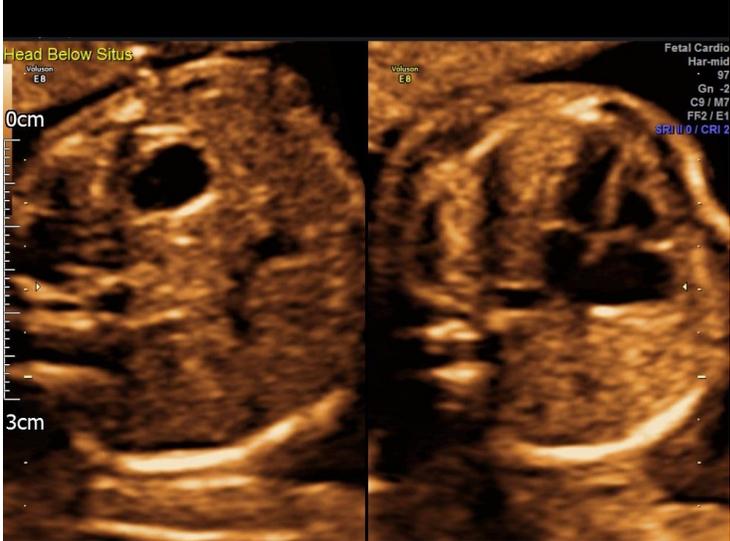
- 8.1 The following images should be captured stored and archived on PACS as a record of the examination. All images should be magnified appropriately and the fetal echo setting should be used to assess the fetal heart.

Table 3:

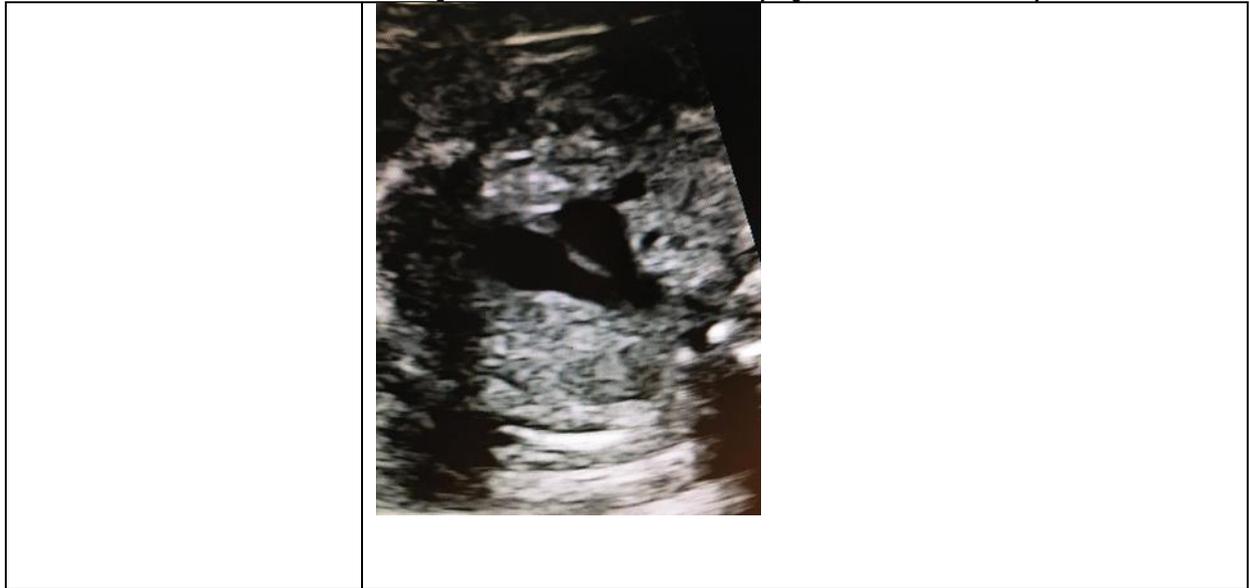
<p>Head Circumference (HC) and ventricular atrium</p>	<p>Obtained according to the FASP (Fetal Anomaly Screening Programme) recommended section and should include:</p> <ul style="list-style-type: none">• Midline echo• The cavum septum pellucidum• The posterior horn of the lateral ventricle• Choroid plexus <p>Measures the circumference of the outer edge of the fetal skull. Measures the posterior horn of the lateral ventricle.</p> 
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<p>Transcerebellar diameter (TCD) and nuchal fold</p>	 <p>The NF only needs to be measured if it appears subjectively increased.</p>
<p>Lips and nasal tip</p>	
<p>Abdominal Circumference (AC)</p>	<p>Transverse section of the fetal abdomen including:</p> <ul style="list-style-type: none">• Stomach• Inner third of intra-hepatic vein• Single rib• Rounded aorta

	
<p>Stomach/Diaphragm</p>	<p>Longitudinal section of the fetal chest and abdomen including the position of the diaphragm in relation to the fetal heart and stomach</p> 
<p>Femur Length (FL)</p>	<p>Longitudinal section of the femur bone measured in a straight line from end to end.</p> 

<p>Longitudinal spine</p>	<p>To include the skin covering.</p> 
<p>Situs/laterality</p>	<p>Split the screen and demonstrate the stomach in relation to the heart, labelling the image 'Situs' and head above/ head below/ fetal left/ fetal right. Demonstrate the descending aorta to the left of the spine as well as stomach on the left.</p> 
<p>Four chamber heart view</p>	<p>To demonstrate structure outlined in the fetal cardiac protocol.</p>

		
<p>Aorta/left ventricle outflow tract</p>		
<p>Pulmonary /right ventricular outflow tract</p> <p>OR</p> <p>3 vessel view</p> <p>3 vessel trachea view (3VT)</p>		



Placental Site



Un-zoomed ultrasound image showing the relationship of the leading edge of the placenta to the internal os of the cervix. Split the screen if required. Low placentas should be followed up according to the placenta praevia protocol.

In cases of increased BMI measure the depth of the skin to the posterior wall of the uterus.

Capture, store and archive additional images to PACS.

<p>Images demonstrating suboptimal views</p> <p>When an abnormality is suspected or found</p>	
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9.0 Other Factors to Consider:

9.1 Liquor volume

This should be assessed subjectively with measurement of deepest pool taken if an abnormal volume is suspected (normal range between 2cm and 8cm).

9.2 Normal variants

In line with the 2015 FASP Guidelines women who have been found to be 'low risk' through either first or second trimester Down's syndrome screening should not be referred for further assessment of a chromosomal abnormality even if normal variants, such as the examples listed below (whether single or multiple) are seen at the 18 weeks and 0 days to 20 weeks and 6 days gestation fetal anomaly screening scan. The term 'soft marker' should not be used.

- Choroid plexus cyst(s);
- Dilated cisterna magna;
- Echogenic foci in the heart;
- Two vessel cord.

9.2.1 The following appearances are to be reported and the patient referred to the screening midwife:

- Nuchal fold greater than 6mm;
- Ventriculomegaly (atrium greater than 10mm);
- Echogenic bowel (with density equivalent to bone);
- Renal pelvis dilatation, AP measurement greater than 7mm (follow renal pelvis protocol);
- Measurements below the 5th centile.

10.0 Pathway of Care when an Abnormality is Suspected or if Advice is Required

10.1 Breaking bad news or discussing the possibility of an abnormality should be handled carefully and sensitively by sonographers. Many patients may be ill equipped to receive bad news and may experience feeling of grief, anger, despair or guilt. The sonographer should give an explanation of the ultrasound findings, taking into account the needs of the patient and taking time to answer any questions the patient may have.

- 10.2 Depending on the ultrasound findings the patient should be referred to the Antenatal Newborn Screening Coordinator at Broomfield Hospital on 01245 513433. The screening coordinator is available Monday to Friday 09.00 - 17.00 hours. If the screening coordinator is busy she will return the call as soon as possible.
- 10.3 In the event of the identification of an abnormality by ultrasound, advice and support to the patient / couple will be provided throughout the pregnancy by the maternity department via the Antenatal Newborn Screening Co-ordinator and Obstetric Consultant, as outlined 'Support for parents in maternity with actual or suspected poor outcome'; register number 10009.
- 10.4 If at St. Peter's Hospital and the sonographer cannot contact the Antenatal Newborn Screening Co-ordinator, the sonographer must assess the severity and urgency of the problem. If considered urgent, contact should be made through the Broomfield ultrasound department on extension 3065 or Broomfield Antenatal Clinic on extension 3289. A message for the Antenatal Newborn Screening Co-ordinator can be left in less urgent cases, either by secure email or telephone answering service. As and when possible a contact telephone number for the woman should be passed on to the Antenatal Newborn Screening Co-ordinator to maintain contact if necessary between sites. The woman should also be given the contact details of the Antenatal Newborn Screening Co-ordinator with directions and instructions of where to report to if an appointment is made.
- 10.5 Following the breaking of 'Bad News', the quiet room is available for the patient and anyone accompanying her to use for as long as is needed at Broomfield Hospital. At St Peters Hospital a bereavement office may be available for use and should be arranged at the time with the receptionist at main reception. Availability of this office will depend on demand from other areas of the hospital.
- 10.6 All women should be informed of an abnormal scan finding before leaving the examination room. Information leaflets for renal pelvis dilatation and talipes are available on the shared 'S' drive and stored behind Reception. The Antenatal Newborn Screening Co-ordinator has access to FASP leaflets.
- 10.7 In the event of a diagnosis of renal pelvis dilatation, follow the protocol (ref. 08054) and only refer to the Antenatal Newborn Screening Co-ordinator if the abnormality meets the criteria outlined in the protocol.

11.0 Dichorionic Twins

Dichorionic twins require further growth scans. Following the 18 weeks and 0 days to 20 weeks and 6 days gestation fetal anomaly screening scan, growth scans should be booked for 24, 28, 32 and 36 weeks gestation. A double slot is required for each scan.

12.0 Staff and Training

- 12.1 As a minimum requirement, the procedures should be carried out by suitably qualified sonographers and/or obstetric staff, possessing the Diploma in Medical Ultrasound (DMU), a Postgraduate Diploma in Medical Ultrasound (PG Dip) or equivalent CASE accredited qualification. Under new regulations of the FASP guidelines it is a requirement to undertake the online FASP cardiac training resource.
(<http://cpd.screening.nhs.uk/fetal-cardiac-module>)
- 12.2 Ultrasound students may carry out ultrasound scans under the supervision of a qualified Sonographer.
- 12.3 In keeping with HPC requirements, sonographers should have a commitment to CPD. Counselling courses by ARC (Antenatal results and choices) are preferred by FASP.

13.0 Infection Prevention

- 13.1 All staff should follow Trust guidelines on infection control by ensuring that they effectively 'decontaminate their hands' before and after each procedure. All staff should pay attention to the ultrasound specific protocols relating to the cleaning of ultrasound equipment which can be found in appendix 2.

14.0 Audit and Monitoring

- 14.1 Compliance with guidelines is to be monitored by the multi-disciplinary screening group which oversees the clinical management. The Trust should supply an annual screening service report to key health professionals within and outside of the Trust screening programme.
- 14.2 On an annual basis this trust should provide the screen positive rate and detection rates for the 11 conditions listed:
 - Anencephaly;
 - Open spina bifida;
 - Cleft lip;
 - Diaphragmatic hernia;
 - Gastroschisis;
 - Exomphalos;
 - Serious cardiac abnormalities;
 - Atrial ventricular septal defect;
 - Transposition of the greater arteries;
 - Hypoplastic left heart;

- Tetralogy of Fallot;

- Bilateral renal agenesis;
- Lethal skeletal dysplasia;
- Edwards' syndrome (Trisomy 18);
- Patau's syndrome (Trisomy 13).

- 14.3 The 12 images described in Table 3 should be captured stored and archived on PACS as a record of the examination. Additional images should be stored as appropriate when an abnormality is found or suspected.
- 14.4 There should also be a permanent electronic record of all the imaging studies. Ultrasound scan reports and images should be on an auditable electronic hospital reporting system.
- 14.5 When an abnormality is found or suspected, details should be entered in the fetal anomaly books in each ultrasound room. For St. Peter's Hospital, the details are to be entered into any of the books upon returning to base.
- 14.6 The following comment should be typed in the comments section: **Fetal heart pulsations seen.**
- 14.7 Although fetal structures within our guidelines have been identified, ultrasound alone cannot exclude all chromosomal or genetic abnormalities. For patients who are above average weight the image quality is reduced due to increased body tissue depth. This can be done using the short cut USOBST.

15.0 Communication

- 15.1 Approved guidelines are published monthly in the Trust's staff newsletter that is sent via email to all staff.
- 15.2 The latest revised guidelines can be accessed via the intranet and clinical guideline folders in each ultrasound room.
- 15.3 The guideline will be published on the Trust website.

16.0 References

NHS Fetal Anomaly Screening Programme: 18 weeks and 0 days to 20 weeks and 6 days gestation fetal anomaly screening scan National Standards and Guidance for England and the NHS Fetal Anomaly Screening Programme (NHS FASP)
Published June 2015. Accessed:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/456654/FASP_programme_handbook_August_2015.pdf

Appendix A



11 physical conditions (the 20-week scan)

Purpose of screening

This is a screening test that takes place between 18 weeks and 20 weeks 6 days of pregnancy and is commonly called the 20-week scan. It is also sometimes referred to as the mid-pregnancy scan. The scan only looks for 11 different conditions in the baby and cannot find everything that might be wrong.

To check for the 11 conditions, the scan looks in detail at the baby's:

- bones
- heart
- brain
- spinal cord
- face
- kidneys
- abdomen

Screening is your choice. You do not have to have the scan. Some people want to find out if their baby has one of the 11 conditions and some do not. If you choose not to have the scan you can still have all other parts of your routine antenatal care.

The scan

Most scans are carried out by specially trained staff called sonographers. Having the scan does not hurt, but the sonographer may need to apply slight pressure to get the best views of the baby. This might be uncomfortable. A black and white picture of the baby will then be seen on the ultrasound screen. During the examination, sonographers need to keep the screen in a position that gives them a good view of the baby. The screen may be directly facing them or at an angle.

1. You will be asked to lie on a couch.
2. You will then be asked to raise your top to your chest and lower your skirt or trousers to your hips.
3. Tissue paper will be tucked around your clothing to protect it from the ultrasound gel, which will then be put on your tummy.



4. The sonographer will pass a hand-held probe over your skin to examine the baby's body. The gel makes sure there is good contact between the probe and your skin.

The appointment usually takes around 30 minutes.

You may like someone to come with you to the scan appointment. Most hospitals do not allow children to attend scans as childcare is not usually available. Please ask your hospital about this before your appointment.

Safety of the test

There are no known risks to the baby or the mother from having an ultrasound scan, but it is important that you consider carefully whether or not to have the 20-week scan.

You may be offered further tests

Sometimes it is difficult to get good views of the baby. This does not mean there is anything to worry about. If this happens, you will be offered one further scan by 23 weeks of pregnancy. Very occasionally this second scan cannot be completed, for example because:

- the baby is lying in an awkward position
- you are above average weight

In this case you will not be offered another screening scan, but you will be offered an all-over physical examination for your baby after birth.

What the results of this ultrasound scan mean

Most scans show that the baby seems to be developing as expected, and none of the 11 conditions are found.

If one of the conditions is found or suspected, the sonographer may ask for a second opinion from another member of staff. You might be offered another test to find out for certain if the baby has one of the conditions.

If you are offered further tests, you will be given more

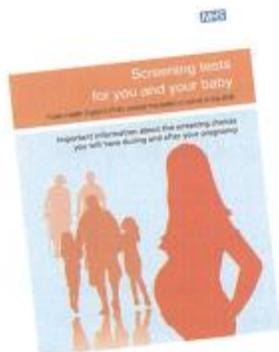
information about them so that you can decide whether or not you want to have them. You will be able to discuss this with your midwife or consultant. If necessary, you will be referred to a specialist, possibly in another hospital.

Scans cannot find all conditions. There is always a chance that a baby may be born with a health issue that scans could not have identified.

- The ultrasound scan showed that your baby appears to be developing as expected
- The sonographer was not able to complete your scan and you are being offered another appointment
The sonographer will try to complete the scan at one more appointment but this is not always possible.
- The ultrasound scan showed that your baby is not developing as expected. We have referred you to a specialist for further discussions

Find out how Public Health England and the NHS use and protect your screening information at

www.gov.uk/phe/screening-data



More information

You can get more information from:

- the 'Screening tests for you and your baby' leaflet
- your midwife or hospital doctor
- Antenatal Results and Choices, a registered charity, which gives non-directive support and information to expectant parents making choices on screening in pregnancy. Helpline: 0845 077 2290 or 0207 713 7486 from a mobile phone or www.arc-uk.org

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Appendix B

Infection control procedure for the decontamination of ultrasound transducers used for intracavity and non-intracavity procedures.

Equipment

- The equipment must be thoroughly cleaned prior to use and decontaminated after use.
- The operator’s hands must be washed or decontaminated with alcohol gel hand rub both before and after the scan.

Procedure – Intracavity ultrasound

- Examination gloves must be worn when carrying out the procedure.
- Apply a small amount of gel in the teat of the condom.
- Cover the intracavity transducer with a new intact ultrasound probe cover. Use a non-spermicidal condom for infertility patients. Use a latex-free condom for patients with a latex allergy.
- Undertake the procedure.

Procedure – Non-Intracavity ultrasound

- Apply a small amount of gel to the surface of the transducer.
- Undertake procedure.

Decontamination of equipment after each procedure

<u>Intracavity transducers</u>	<u>Non-intracavity transducers</u>
1. Remove excess gel with a paper tissue	1. Remove excess gel with a paper tissue.
2. Clean and decontaminate the intracavity transducer and cable with a <u>Clinell</u> wipe, by: (i) Covering the surface and sides of the transducer with the Clinell wipe (ii) Rotate and progress the wipe along the length of the cable. (iii) This step should be repeated with a fresh wipe until the transducer and cable are visibly clean.	2. Clean all surfaces of the transducer with a Clinell wipe.
3. Next decontaminate the transducer using Tristel Duo by: (i) Depress the pump once to dispense one 0.8ml aliquot of Duo Foam onto the surface. (ii) Use a paper towel and spread evenly. (iii) Ensure all areas of the surface come into contact with foam. (iv) Leave to dry, allow 30 seconds before contact.	3. Dry the transducer with a paper tissue.
4. Dispose of gloves.	4. The non-intracavity transducer is now ready for the next patient.

Appendix C: Preliminary Equality Analysis

This assessment relates to: Guidelines for performing the 18 weeks and 0 days to 20 weeks and 6 days gestation fetal anomaly screening scan/10095

A change in a service to patients		A change to an existing policy	X	A change to the way staff work	
A new policy		Something else (please give details)			
Questions			Answers		
1. What are you proposing to change?			Full Review		
2. Why are you making this change? (What will the change achieve?)			3 year review – update of current National guidelines		
3. Who benefits from this change and how?			Patients and clinicians		
4. Is anyone likely to suffer any negative impact as a result of this change? If no, please record reasons here and sign and date this assessment. If yes, please complete a full EIA.			No		
5. a) Will you be undertaking any consultation as part of this change? b) If so, with whom?			Refer to pages 1 and 2		

Preliminary analysis completed by:

Name	Emily Sawtell	Job Title	Sonographer	Date	August 2019
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