Mid Essex Hospital Services NHS Trust

RECEIVING AND ACTING ON TEST RESULTS IN MATERNITY BY BOTH HOSPITAL AND COMMUNITY	CLINICAL GUIDELINES Register No: 06031 Status: Public

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Consulted With:	Post/Committee/Group:	Date:
Anita Rao/ Alison Cuthbertson	Clinical Director for Women's and Children's	April 2018
Vidya Thakur	Consultant for Obstetrics and Gynaecology	
Alison Cuthbertson	Associate Director of Midwifery/Nursing	
Paula Hollis	Lead Midwife Acute Inpatient Services	
Chris Berner	Lead Midwife Clinical Governance	
Ros Bullen-Bell	Lead Midwife Community Services	
Sarah Iskander	Antenatal Clinic Midwife	
Sarah Moon	Specialist Midwife Guidelines and Audit	
Deborah Lepley	Warner Library	

Professionally Approved By:		
Miss Rao	Lead Consultant for Obstetrics and Gynaecology	April 2018

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1.0	Julie Bishop	January 2006
2.0	Kathleen Bird	December 2009
2.2	Cross reference Downs Syndrome and administration of prophylactic anti D for rhesus negative women. Clarification to 3.2, 16.4	February 2010
3.0	Nicky Leslie	February 2012
3.1	Nicky Leslie - Clarification to point 12.0	February 2013
4.0	Nicky Leslie, Antenatal Newborn Screening Co-ordinator	March 2015
4.1	Nicky Leslie - Clarification to remove information regarding rubella	20 March 2017
4.2	Sarah Moon - Clarification to point 13.0	16 June 2017
5.0	Emma Neate – Full review	16th July 2018

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1.0 Purpose

1.1 The purpose of this guideline is to provide staff with the appropriate procedure when working in the hospital or community environment when receiving blood results, mid-stream specimen urine results and high vaginal swab results.

1.2 The professional has a responsibility to the patient to ensure any abnormal results are acted upon and appropriate treatment provided.

1.3 To ensure that the patient receives the results in a timely manner.

2.0 Equality and Diversity

2.1 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

3.0 Review Process

3.1 All blood tests should be offered and undertaken by 10 weeks of pregnancy or as soon as possible as advised by the NHS Antenatal and Newborn Screening Programmes. (Refer to 'Guideline for Maternity Care' Number 04272)

3.2 Screening should be offered to all women regardless of the results of screening in previous pregnancies:

- Blood group screening
- Full blood count
- Haemoglobinopathy screening
- HIV screening
- Hepatitis B screening
- Syphilis screening

In order for women to make informed choice, the following should be discussed:

- The route of transmission of infectious diseases,
- Genetic passing on of Haemoglobinopathy status,
- Benefits to mother and baby of identifying and managing results,
- How women will receive results – both negative and positive.

3.3 All pregnant women should be provided with written information 'Screening tests for you and your baby' prior to their booking appointment. This is available in English and 12 other languages, via www.gov.uk/government/publications/screening-tests-for-you-and-your-baby-description-in-brief.

3.4 For women who do not have English as a language, they must be offered interpreting services to help them make an informed choice about screening. It is not acceptable to use friends or family to translate.

3.5 The midwife should clearly document whether the screening has been accepted or declined and whether a blood sample has been obtained in the handheld notes.

3.6 The midwife completing the booking and offering blood tests MUST ensure the bloods are taken at booking or within 5 days of the booking (where not possible at booking).

3.7 It is the booking midwife's responsibility to review bloods within 10 days of the sample being taken and to follow up women when samples are not taken or a repeat is required.

3.8 All patients should be seen at 16 -18 weeks gestation and the screening results reviewed and documented in the patient's healthcare records. If the patient attends at 16-18 weeks and the screening results are not available electronically or paper copy (Downs screening results), the midwife present at that time should follow up the missing results and if necessary obtain further blood samples. This should be documented by the midwife in the patient's healthcare records. The midwife should arrange a follow up appointment to review the missing results and ensure that all the results have been duly documented in the patient's healthcare records.

3.9 The midwife should ensure that any abnormal results are actioned and documented in the patient's healthcare records and the management process that follows as detailed in the relevant sections below. Not very clear

3.10 At every visit the test results should be reviewed to ensure that they are all in the notes. This is the responsibility of every clinician seeing the patient. Any missing results must be chased up and if not available, the test needs to be repeated.

4.0 Declined Screening for Infectious Diseases and Haemoglobinopathy Screening

4.1 Where women decline screening tests the midwife who offered the initial screening should inform them they will be contacted by the Screening Team to discuss their choices.

Women should be contacted by the Screening team as soon as possible and ideally before 20 weeks to discuss their decision to decline screening and ensure that they are fully aware of the benefits of screening for infectious diseases for them and their baby.

Reoffer the screening test and arrange testing and follow up of results.

The onus of the reoffer is to facilitate an informed choice and not to coerce women to accept screening.

5.0 Unbooked / Late bookers

Women who book after 24 weeks of pregnancy should have blood samples marked as urgent. Test results should be available after 24 hours of receipt of sample at laboratory.

6.0 Women Presenting in Labour without an Antenatal Screening Blood Result

6.1 Women presenting in labour, who have not attended previously for antenatal care at the Trust are recommended to be offered testing for HIV, Hep B, and Syphilis on first contact. The sample should be marked as urgent. Results should be available within 24hrs.

7.0 Full Blood Count (FBC)

7.1 Pregnant patients should be offered screening for anaemia. Screening should take place early in pregnancy (at the booking appointment) and at 28 weeks when other blood screening tests are performed. This allows enough time for treatment if anaemia is detected.

7.2 A haemoglobin (Hb) of 110 g/l and above at booking is classed as normal in pregnancy and does not need any further action. The midwife present at the 16-18 week antenatal visit should document all blood test results in the patient's healthcare records.

7.3 A haemoglobin of 110 g/l or below at booking is classed as a low Hb and iron therapy should be considered.

7.4 If the originator is the general practitioner (GP) the GP is responsible for documenting the test result and treating appropriately

7.5 If the test was originated by antenatal clinic (ANC), the midwife should telephone the patient and inform her of the need to commence oral iron therapy. The midwife should ensure that the abnormal results are actioned and then documented in the patient's healthcare records. The reporting of the results to the patient should not exceed 72 working hours.

7.6 If the midwife is unable to contact the patient by telephone, an explanatory letter should be sent to the patient with the instructions to collect TTA (to take away) packs of pregaday / ferrous sulphate from the antenatal clinic.

7.7 Oral pregaday and ferrous sulphate 200 mg are kept in the drug cupboard at Broomfield Antenatal Clinic, William Julian Courtauld Midwife-led Birthing Unit and St Peters (STP) Midwife-led Unit.

7.8 The patient may decide to contact her GP's surgery for a prescription.

7.9 The midwife should arrange a convenient time for the patient to collect her tablets.

7.10 The midwife should complete a drug chart prescribing the iron therapy.

7.11 The midwife should document the result and treatment in the patient's healthcare records.

8.0 28 Week Gestation Repeat FBC Blood Test

8.1 At 28 weeks gestation an Hb of 105g/l and above is classed as normal in pregnancy and does not need any further action. The report should be checked and documented in the patient's healthcare records.

8.2 A haemoglobin of 105g/l or below at 28 weeks is classed as a low Hb and iron therapy should be considered.

8.3 Follow the recommendations as in point 7.0?

9.0 Blood Group and Rhesus Status (Rh)

9.1 Patients should be offered testing for blood group and rhesus D status in early pregnancy.

9.2 The four main blood groups are group O, group A, group B and group AB, with a rhesus positive or rhesus negative status.

9.3 The patient should be informed of her blood group and rhesus status at her subsequent antenatal appointment i.e. at 16-18 weeks gestation.
(Refer to the 'Maternity Care' guideline; register number 04272)

9.4 At 16-18 week antenatal appointment the midwife should identify the patient's blood results electronically and document in the handheld records.

9.5 When the midwife has identified the patient as rhesus negative, the blood results are documented in the antenatal booking tests section of the patient's healthcare records and the midwife should stamp the intrapartum and partogram record with the rhesus negative status in the patient's healthcare record. A red rhesus negative stamp should be placed for documentation purposes in the Antenatal Care Records at the woman's anti-D clinic at 28 weeks gestation.

9.6 When a patient is confirmed as rhesus negative, the midwife should ensure that an appointment is offered for prophylactic Anti D and arrange a subsequent antenatal appointment for 28 weeks gestation. The appointment should be made for the antenatal clinic at either Broomfield Hospital, or the Midwife-led Units depending on where the patient is receiving her antenatal care.
(Refer to the guideline entitled 'Administration of anti D for Rh(D) negative patients in maternity; register number 06065)

10.0 Antibodies

10.1 Patients should be screened for atypical red-cell allo-antibodies in early pregnancy and again at 28 weeks, regardless of their rhesus D status.
(Refer to the 'Guideline for the administration of prophylactic anti D for rhesus negative women'; register number 06065 as 9.6)

10.2 If the patient's antibodies are negative, the midwife should document the blood results in the patient's health care records at the 16-18 week antenatal visit.

10.3 If the patient has antibodies detected, the midwife receiving the blood results should contact the patient by telephone to inform her of the result, answer any questions and ensure that further blood tests are undertaken at regular intervals to monitor their levels (or titres) (As advised by National Blood Service).

10.4 The patient's unborn baby may need closer monitoring for iso-immunisation.
Inform the screening team of results and make an appropriate plan of care dependent on which antibody, the levels in the blood and gestation.

If antibodies are found after 34 weeks and it is out of normal office hours; woman is to be reviewed / discussed with on call Obstetric team.

10.5 The anti-D antibody is the most likely to cause problems. It can cause rhesus disease in the baby. It can form if the maternal blood group is D negative and the baby's is D positive. The following levels of antibody are significant:

- Anti-D < 4.0 units/ml, low risk of fetus developing haemolytic disease of the newborn (HDN).
- 4 – 15 units/ml, moderate risk of fetus developing HDN
- above 15 units/ml, high risk of HDN

10.6 There are other antibodies that can arise and cause concern i.e. Anti-c ('little c')

- Anti-c <7.5 units/ml, low risk of fetus developing HDN
- 7.5-20 units/ml, moderate risk of fetus developing HDN
- >20 units/ml, high risk of fetus developing HDN

10.7 Anti-K (Kell) antibodies can cause haemolytic disease of the newborn. Anti-K is slightly different. The fetus may be affected regardless of titre. This antibody may cause anaemia by suppressing fetal erythropoiesis

10.8 For antibodies to other systems such as Kidd, Duffy and Ss, titres of >1 in 32 are significant and should still be monitored with the advised repeat blood tests.

10.9 Blood tests are repeated monthly until 28 weeks of pregnancy and then every 2 weeks until delivery, unless requested more frequently by the doctor. The midwife should ensure that the recommended action is documented on the printed blood report.

10.10 If antibody levels are rising, the midwife should ring the screening team and discuss the result and formulate a plan of care for her i.e. an antenatal consultant appointment. If the antibody levels rise dramatically, consider an urgent review on Day Assessment Unit (DAU). Patients may need to be referred to a Fetal Medicine Unit to monitor for signs of fetal anaemia.

10.11 The midwife should document all conversations and actions in the patient's healthcare records.

10.12 Further advice or information is available by contacting blood transfusion on extension 4140.

10.13 The midwife should complete a neonatal alert form when the antibodies are identified and forward to the consultant paediatrician.

11.0 Microbiology High Vaginal swabs (HVS) and Mid Stream Urine Specimens (MSU)

11.1 Patients should be offered routine screening for asymptomatic bacteriuria by midstream urine culture early in pregnancy. Identification and treatment of asymptomatic bacteriuria reduces the risk of pyelonephritis.

11.2 When a MSU or HVS is taken, the health professional should ask the patient to ring the originator of the test to discuss the result and see if any action is needed. The result will take 3 – 4 days to be analysed.

11.3 If the result shows an infection, the midwife/GP should ensure the patient is informed and that a convenient time is arranged for the patient to collect a prescription or medication.

11.4 The midwife should document the test results, all conversations and actions in the patient's healthcare records.

12.0 Group B Streptococcus (GBS)

12.1 Refer to the guideline for the 'Prevention of Early Onset Neonatal Group B Streptoccal Disease (EOGBS) in pregnancy and labour'. (Register number 04292)

13.0 Treponema Pallidum (Syphilis)

(Refer to the 'Management of Syphilis in Pregnancy'; register number 10083).

14.0 Hepatitis B (Hep B) and Human Immunodeficiency Virus (HIV)

(Refer to the 'Management of Human Immunodeficiency Virus (HIV) in pregnancy'; register number 08056, 'Hepatitis B in pregnancy and the postnatal period; register number 12004 and the 'Management of neonates born to Human Immunodeficiency Virus (HIV) positive mothers'; register number 07056).

15.0 Haemoglobinopathies

(Refer to the ' Haemoglobinopathies,
thrombocytopenia Von Villebrands disease and haemophilia carriers in pregnancy and labour'. Register number 08041)

16.0 Glucose Tolerance Test (GTT)

16.1 The health care professional should advise women having the glucose tolerance test that they should not smoke on the day of the test until after they have had both blood samples taken.

16.2 If results are normal sign and file results in the patient's health care records.

16.3 A result of **greater than or equal to 5.6 mmol/L at fasting** diagnoses gestational diabetes.

16.4 A result of **greater than or equal to 7.8 mmol/L at 2 hours** post glucose diagnoses gestational diabetes.

16.5 Refer all increased GTT results immediately to the diabetic centre on extension 6371/4388/4748 who will arrange a combined diabetic/antenatal clinic appointment on a Friday morning in the antenatal clinic at Broomfield.

16.6 The healthcare professional will discuss the result with the patient by telephone and document any action on the report. The printed report should then be signed and filed in the main healthcare records.
(Refer to the 'Diabetes in pregnancy'. Register number 04266)

17.0 Chlamydia Trachomatis

17.1 At the booking appointment, healthcare professionals should inform pregnant patients younger than 25 years about the high prevalence of chlamydia infection in their age group, and give details of their local National Chlamydia Screening Programme.

17.2 A self-testing kit is available from the midwife or antenatal clinic, encourage patients to undertake the test at the same time as the booking appointment.

17.3 A positive test result is sent directly to the Chlamydia screening team. The team will action the appropriate treatment.

18.0 Ultrasound Scanning

18.1 Ultrasound scans should be offered and arranged as follows

- Dating: 11weeks and 2 days – 14 weeks and 1 day gestation
- Structural anomalies: normally between 18 weeks 0 days and 20 weeks 6 days

18.2 A further scan will be offered by 23 weeks gestation if the sonographer was unable to complete the 20 weeks fetal anomaly scan. The incompletion of the 20 weeks fetal anomaly scan could be due to the fetus lying in a suboptimal position or due maternal obesity.

18.3 If the ultrasound scan at 23 weeks gestation remains uncompleted and normality cannot be confirmed; the woman will be seen by the Antenatal Screening Midwife who will inform the woman that no further scan will be offered and at this point normality cannot be confirmed for the structures that have not been clearly viewed. The Antenatal Screening midwife will complete a Neonatal Alert Form to alert staff that the fetal anomaly scan could be completed. This discussion should be documented in the Antenatal Care Record.

18.4 If anomalies are identified on scan, the ultrasonographer will immediately refer the patient to the screening midwife.
(Refer to "Antenatal screening for Downs, Edwards and Pataus Syndrome" Register Number 08058 and "Referral to tertiary unit for suspected fetal abnormality" Register number 06035)

18.5 If a low lying placenta or a placenta which extends across the internal cervical os is detected, the ultrasonographer should offer and arrange a repeat scan at 32 weeks gestation.

18.6 At the next antenatal appointment following the ultrasound scan, the healthcare professional should review the scan result; document any abnormal findings, and the plan of care.

19.0 Failsafe of Screening Results

19.1 Maternity Phlebotomist will review all women on the daily scan list for 1st trimester scans, review all the screening results and check for completion of screening – these results are checked by a Antenatal Clinic or Screening Midwife, if any results are missing; these bloods will be taken with consent after the scan.

19.2 The Failsafe Officer will carry out a failsafe check following the woman's 1st trimester scan to ensure all screening results are available and to highlight any that are abnormal to the screening midwives; this acts as a failsafe for abnormal results also. If any results are found to be missing, the following steps are followed:

- Screening team will send one letter to the woman regarding the need to have bloods taken (Appendix 1)

- Screening team will develop a missing bloods list – send to ANC, WJC, St Peter's, Chelmsford community team each month and for the teams to contact and arranging screening for the women within the following 2 weeks.

20.0 Staffing and Training

20.1 All midwifery and obstetric staff must attend yearly mandatory training which includes skills and drills training.

20.2 All midwifery and obstetric staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal.

21.0 Infection Prevention

21.1 All staff should follow Trust guidelines on infection prevention by ensuring that they effectively 'decontaminate their hands' before and after each procedure.

21.2 All staff should ensure that they follow Trust guidelines on infection control, using Aseptic Non-Touch Technique (ANTT) when carrying out procedures i.e. when obtaining blood samples.

22.0 Audit and Monitoring

22.1 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy (register number 08076), the Corporate Clinical Audit and Quality Improvement Project Plan and the Maternity annual audit work plan; to encompass national and local audit and clinical governance identifying key harm themes. The Women's and Children's Clinical Audit Group will identify a lead for the audit.

22.2 As a minimum the following specific requirements will be monitored:

- Designated lead for antenatal screening in the maternity service
- Antenatal screening tests, which follow the UK National Screening Committee guidance
- System for ensuring that appropriate tests are undertaken within appropriate timescales
- System for ensuring that appropriate tests are undertaken when patients book late
- Process for the review of the results
- Process for reporting all results to patients
- Process for reporting results to other relevant healthcare professionals
- Process for ensuring that women with screen positive test results are referred and managed within appropriate timescales
- Maternity service's expectations for staff training, as identified in the training needs analysis
- Process for audit, multidisciplinary review of results and subsequent monitoring of action plans

22.3 A review of a suitable sample will be audited from the health care records of patients who have delivered process for the review of the results to evidence the process for

ensuring that patients with screen positive test results are referred and managed within appropriate timescales.

22.4 A minimum compliance 75% is required for each requirement. Where concerns are identified more frequent audit will be undertaken.

22.5 The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

22.6 The audit report will be reported to the monthly Directorate Governance Meeting (DGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

22.7 Key findings and learning points from the audit will be submitted to the Patient Safety Group within the integrated learning report.

23.0 Guideline Management

23.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.

23.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.

23.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are now downloaded from the intranet and filed appropriately in the guideline folders. 'Spot checks' are performed on all clinical guidelines quarterly.

23.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for further training; possibly involving 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

24.0 Communication

24.1 A quarterly 'maternity newsletter' is issued and available to all staff including an update on the latest 'guidelines' information such as a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly.

24.2 Approved guidelines are published monthly in the Trust's Focus Magazine that is sent via email to all staff.

24.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.

24.4 Regular memos are posted on the guideline notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folders.

25.0 References

NHS Fetal Anomaly Screening Programme (2011) Screening for Down`s syndrome: UK NSC Policy recommendations 2011 – 2014 Model of Best Practice. Exeter: NHS Fetal Anomaly Screening Programme

Public Health England (2017) Screening tests for you and your baby. Important information about the screening choices you will have during and after your pregnancy. London: Public Health England.

Public Health England (2016) NHS Infectious Diseases in Pregnancy Screening Programme Standards2016 to 2017. London: Public Health England

National Institute for Health and Care Excellence (2008) Antenatal care for uncomplicated pregnancies. Clinical Guideline (CG 62) London: NICE

Appendix A

Letter to Indicate Repeat Blood Test is Required

Mid Essex Hospital Services NHS
NHS Trust

Broomfield Hospital
Antenatal Clinic
Level 4, Maternity 401
Court Road
Broomfield
Chelmsford
Essex
CM1 7ET
Tel: 01245 513433

Dear

Following a recent review of your screening blood results, we have identified that you are missing the following:-

- Sickle Cell and Thalassemia Screening (Haemoglobinopathy Screening)
- HIV Screening
- Hepatitis B Screening
- Syphilis Screening
- Blood Group
- Full Blood Count

Could you please arrange to see your midwife as soon as possible to arrange for these blood tests to be taken; early detection of any concerns regarding your results will aid appropriate care for both you and your baby.

If you do not wish to have these blood tests taken or you have any further questions, please contact the Screening Team on 01245 513433 and we will ensure to update your records accordingly.

Yours truly

Emma Neate
Antenatal & Newborn Screening Co-ordinator