Document Title:	**MANAGEMENT OF NEONATES BORN TO HUMAN IMMUNO-DEFICIENCY VIRUS (HIV) POSITIVE MOTHERS**		
Document Reference/Register no:	07056	**Version Number:**	5.0
Document type: (Policy/ Guideline/ SOP)	Guideline	**To be followed by:** (Target Staff)	Obstetricians, Midwives & Paediatricians
Ratification Issue Date: (Date document is uploaded onto the intranet)	30th October 2018	**Review Date:**	29th October 2021
Developed in response to:	National Guidance/Recommendations (i.e. NICE; RCOG)		
Contributes to HSC Act 2008 (Regulated Activities) Regulations 2014(Part 3); and CQC Regulations 2009 (Part 4) **CQC Fundamental Standards of Quality and Safety:**			11, 12
Issuing Division/Directorate:	Women's and Children's		
Author/Contact: (Asset Administrator)	Emma Neate, Antenatal and Newborn Screening Coordinator		
Hospital Sites: (tick appropriate box/es to indicate status of policy review i.e. joint/ independent)	✓ MEHT □ BTUH □ SUH		
Consultation:	(Refer to page 2)		
Approval Group / Committee(s):	n/a	**Date:**	n/a
Professionally Approved by: (Asset Owner)	Miss Rao, Lead Consultant for Obstetrics and Gynaecology Dr Hassan, Consultant Paediatrician	**Date:**	27th September 2018 24th October 2018
Ratification Group(s):	DRAG Chairman' Action	**Date:**	24th October 2018
Executive and Clinical Directors (Communication of minutes from Document Ratification Group	**Date:** November 2018	**Distribution Method:**	Trust Intranet/ Internet

Consulted With:	Post/ Approval Committee/ Group:	Date:
Alison Cuthbertson	Clinical Director for Women's and Children's Division	27th September 2018
Anita Rao	Consultant for Obstetrics and Gynaecology	
Miss Dutta	Consultant for Obstetrics and Gynaecology	
Dr Agrawal	Consultant Paediatrician	
Alison Cuthbertson	Head of Midwifery for Women's and Children's	
Amanda Dixon	Lead Midwife Acute In-patient Services	
Chris Berner	Lead Midwife Clinical Governance	
Joyce Macintosh	Lead Nurse for Neonatal	
Jude Horscraft	Practice Development Midwife	
Emma Neate	Antenatal and Newborn Screening Midwife	
Sheena Smith	Senior Midwife Postnatal Ward	

Related Trust Policies (to be read in conjunction with)	(Refer to the main body of the text) 07056 Management of Neonates Born to HIV positive Mother 04071 Standard Infection Prevention 04072 Hand Hygiene 06036 Guideline for Maternity Record Keeping including Documentation in Handheld Records 06031 Receiving and Acting on Test Results in Maternity by both Hospital and Community 04272 Maternity Care 04225 Examination of the Newborn 07065 Administration of Antenatal Steroids

Document Review History:			
Version No:	**Authored/Reviewer:**	**Summary of amendments:**	**Issue Date:**
1.0	Sarah Moon		October 2007
2.1		Front sheet and audit section updated	March 2009
2.2		Equality and diversity; audit and monitoring update	January 2010
3.0	Nicky Leslie		February 2012
3.1	Nicky Leslie	Clarification to point 7.4, 8.0 and 11.0	June 2012
4.0	Nicky Leslie		3rd July 2015
5.0	Emma Neate	Full review	30th October 2018

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1.0 Purpose

1.1 If a patient known to have HIV is pregnant or has received a positive HIV screening result during pregnancy a number of important issues need to be discussed including interventions to minimise the risk of transmission of HIV to her baby and maximize the long term health prospects for herself and her child.

1.2 This guideline is designed to assist the multidisciplinary team (MDT) in the care of a neonate born to a mother who is HIV positive and is not intended to be used for care of a patient with HIV. There may be other areas of concern (i.e. social) that the lead midwife should also address.

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 Staff involved in Neonate's Plan of Care

3.1 The following staff members need to be involved as soon as the diagnosis of HIV is known.

- Screening midwife based at Broomfield antenatal clinic
- Consultant Obstetrician and consultant's team
- Consultant Paediatrician and consultant's team
- Microbiologist/ Microbiology laboratory
- Lead Midwife
- Community midwife/ lead midwife for antenatal and postnatal care
- Patient's G.P
- Health visitor

3.2 All pregnant women are offered a screening at their booking for infectious diseases to include:

- Human immunodeficiency virus (HIV)
- Syphilis
- Hepatitis B

3.3 Informed consent must be obtained prior to the specimen being taken

3.4 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
For women who do not have English as a first 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 When the midwife completes the woman's booking and discusses the various blood tests; bloods **must** be taken at booking or within 5 days for the booking (where not possible at booking). The booking midwife should review the blood results within 10 days of the sample being taken and for them to follow up with women for samples to be taken or repeated where required.

3.6 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.

3.7 All women with a positive result require a second confirmatory blood sample and will be contacted by the Screening Team and urgently referred to an appropriate specialist (Sexual Health Department).

3.8 **Offer of bloods to 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.

3.9 **Declined Screening**
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.

3.9.1 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.

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

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

3.10 **Positive Antenatal Screening Results**

3.10.1 High risk blood results are referred to the Antenatal and Screening Team by virology team in the laboratory; this is communicated via telephone and email to screening generic email address (Refer to Appendix E).

3.10.2 A second blood sample is required to confirm a positive HIV. Confirmation testing is carried out at the Sexually Transmitted Bacterial Reference Laboratory.

3.10.3 Results should be available after 5 working days, as extra time is required transporting specimens and receiving results.

3.10.4 The Antenatal Screening Team will contact the patient. A referral to the Consultant in the Genitourinary medicine (GUM) will be booked, along with an appointment in Antenatal clinic with the Obstetric Consultant Lead for Infectious Diseases, after the GUM appointment.

3.10.5 All HIV positive patients presenting in the Genitourinary Medicine Clinic will be assessed for the following:

- Management of maternal treatment requirements
- Screening for HIV, Hepatitis B and C
  (Refer to HIV ‘Management of Human Immunodeficiency Virus (HIV) in pregnancy’; register number 08056)
- Follow up bloods, to check the efficiency of the treatment will be arranged by the Genitourinary Medicine Clinic.

3.10.6 All neonates born to HIV positive mothers, whether they are infected or not, should be reported to the Royal College of Paediatric and Child Health HIV Surveillance Unit. They will monitor the child over the next few years.
(Refer to Appendix D)

3.10.7 Should the patient be based at a Midwife-led Unit, then the midwifery manager of that unit should also be made aware.

3.10.8 A referral to the Lead midwife for vulnerable women may be considered if applicable.

4.0 Communication Among Staff

4.1 The following documentation must be completed:

- Retroviral Infection Care Plan (to remain in patient's clinical notes folder)
- A neonatal alert form should be completed and sent to the named Paediatric Consultant located in the paediatric office, for a plan of care post delivery.
(Refer to the 'Guideline for calling paediatric staff and for obtaining paediatric referral'; register number 09113)

4.2 When the named Paediatric Consultant has completed the neonatal alert form with a care plan, a copy will be retained in the neonatal folder. A further copy will be sent to the Antenatal Screening Office; who will then provide a subsequent copy for the Labour Ward folder. The Antenatal Screening Team will provide a copy which should be filed in the patient's lilac folder. (Refer to Appendix C)

4.3 Neonatal prescription chart with the appropriate drugs required following delivery, will be ordered by the Sexual Health Consultant and sent to the screening team, the will arrange for the medication to be on Labour Ward prior to delivery.

5.0 Reducing Mother to Child Transfusion (MTCT) of HIV
(Refer to Appendix A)

5.1 It is strongly advised that the paediatric team check the website of the British HIV Association (BHIVA) for the latest research on neonatal drug regimes before signing any prescription chart. Drug doses change regularly and therefore this guideline is correct at time of approval. Website address is: www.bhiva.org.

5.2 **Antenatal Medication:**

- Effective (≥3 drug) combination therapy and short-term anti-retroviral therapy (START) is now most commonly prescribed
- If HAART (highly active anti retroviral therapy) was commenced prior to conception then it is usually continued throughout the pregnancy
- Dual NRTI therapy is not recommended for use in pregnancy

5.3 **Intrapartum – Delivery**

5.3.1 A summary of the advice regarding the type of delivery recommended is as follows:

i. **For women with a plasma viral load of < 50 HIV RNA copies/mL at 36 weeks**, no genital infection and in the absence of obstetric contraindications, a planned vaginal

delivery is recommended. Traditionally amniotomy, fetal scalp electrodes and blood sampling, instrumental delivery and episiotomy have been avoided in HIV infection because of theoretical transmission risks. Data from the pre-HAART era have been reviewed. These show little or no risk for many of these procedures for these women.

ii. **For women with a plasma viral load of 50–399 HIV RNA copies/mL at 36 weeks,** PLCS should be considered, taking into account the actual viral load, the trajectory of the viral load, length of time on treatment, adherence issues, obstetric factors and the woman's views.

iii. **Where the viral load is ≥ 400 HIV RNA copies/mL at 36 weeks,** Planned LCS is recommended at 38 weeks gestation (before rupture of membranes and onset of labour) with a zidovudine infusion, starting four hours before beginning the caesarean section and continuing until the umbilical cord has been clamped.

5.3.2 A maternal sample (7mls using an EDTA/ purple top bottle) for plasma viral load should be taken at delivery and sent with the baby's blood

5.3.3 If pre-term delivery is threatened then give corticosteroids
(Refer to the guideline entitled 'Administration of antenatal steroids'; register number 07065)

5.4 **Immediate care of neonate**

- The cord should be clamped as early as possible after delivery and the baby should be bathed immediately after the birth
- Drug therapy to be commenced within 4hrs of birth
- **Paediatric team to be informed of delivery to** administer first dose of prescribed medication. **On-call Paediatric Consultant to be informed of delivery**
- Always BLEED the NEONATE, NEVER TAKE blood from the CORD for the following blood tests, which are to be taken at delivery by the attending paediatrician
  - HIV PCR,
  - FBC, U+E's and LFTs.

5.5 On the blood forms the indication for the tests are 'retroviral disease - indeterminate status'. send this off with mother's blood sample.

5.6 Feeding **-** breastfeeding to be avoided, formula feeding babies born to HIV positive mothers is the national recommendation and should the mother breastfeed it may be a child protection concern; safeguarding team to be informed. HIV virus is found to be higher in colostrum than in breast milk.

6.0 Care of Low Risk Neonates

6.1 Zidovudine monotherapy is recommended for the neonate if maternal viral load is < 50 HIV RNA copies/mL at 36 weeks' gestation or thereafter prior to delivery (or mother delivered by PLCS whilst on Zidovudine (AZT) monotherapy).
Check www.bhiva.org website to ensure doses have not altered.

6.2 Monotherapy:
Zidovudine (AZT), start within 4 hours of birth after blood test

- >34 weeks – term: 4mg/kg/dose TWICE a day ORALLY for the first 4 weeks of life

- Premature infants (30-34 weeks) - 2 mg/kg/dose, twice a day for 1st two weeks, then 2mg/kg/dose three times a day for next 2 weeks
- <30 weeks – 2mg/kg/dose TWICE a day for 4 weeks.

6.3 If not tolerating oral medication of if infant is sick:
Zidovudine (AZT), start within 4 hours of birth – see also 7.3

- Term babies: 1.5mg/kg /dose IV FOUR times a day given as an infusion over 30 minutes
- Preterm babies: 1.5mg/kg /dose IV TWICE a day over 30 minutes

6.4 **Neonatal Period**

- First HIV PCR (paediatric EDTA bottle- Full) – not cord blood
  (Only likely to be positive in the minority of infants infected in utero)
- Check infant's FBC, U+E, LFT
- Take mothers blood for HIV viral load testing at the same time (7mls EDTA purple top)
- Monotherapy, AZT, started for 4 weeks
- Follow up **at** 6 weeks of age and **no** later in the clinic of the Consultant on-Call
- TTA given for 4 weeks
- RCPCH surveillance unit notified.

6.5 Should a neonate's blood result come back as HIV positive at any stage please refer them to St. Mary's Hospital, Paddington London.

Age 4 weeks – First review appointment at the clinic

- Check result of First HIV PCR; if negative
- Arrange second HIV PCR test (paediatric EDTA bottle- Full) and FBC, U's & E's, and LFT's at age 6 weeks i.e. as soon as possible. (i.e. This test is 2 weeks after Rx stopped. This is to prevent missing any infant in whom monotherapy may have delayed the appearance of the virus and to check for side effects of treatment e.g. hepatitis)
- Consultant to Contact parents with results – remember to chase results. (In non-breast fed infants >90% of babies with HIV should be positive by this time)
- Arrange follow up 3rd HIV PCR blood test (paediatric EDTA bottle- Full) at 3 months (in non-breast fed infants >95% of babies with HIV should be positive by this time)
- Arrange clinic follow up 2 weeks after this blood test i.e. 3 months

Age 3 months – second review appointment at the clinic

- Check result of third HIV PCR; if negative
- Refer for BCG immunization for eligible babies
- Arrange final HIV antibody test (paediatric EDTA bottle- Full) at age 18 months (i.e. takes up to 18months until maternal antibodies acquired in utero to disappear)
- Follow up at 18 and a half months.

Age 18 months – Fourth and final review appointment at the clinic

- Check result of HIV antibody test; if negative discharge patient

Additional testing maybe carried out at any time if there has additional risks such as breastfeeding

7.0 Care of High Risk Neonates

7.1 High risk and/ or emergency situations –you know the mother is positive and she is not on antiretroviral therapy (ART), there is no estimation of maternal viral load or there is a high maternal viral load despite treatment, there has been prolonged rupture of membranes or there has been premature rupture of membranes before starting ART or within four weeks of starting ART, poor maternal compliance with treatment or no treatment at all.

7.1.2 Neonate to be born by caesarean section, formula feed and treated with triple therapy for four weeks.

7.2 **Triple therapy**

AZT as above PLUS:
Nevirapine (NVP) (orally only)

- 2mg/kg once a day for the 1st week and then
- 4mg/kg once a day for the 2nd week (use NVP 4mg/kg OD for 2 weeks if the mother has received > 3days NVP).
- STOP NVP after two weeks, in view of long half-life.

Lamivudine (3TC) (orally only)

- 2mg/kg/dose TWICE a day orally
- Start within 12 hours of birth
- For 4 weeks

7.3 If sick term infant or premature infant unable to tolerate oral medication – give IV AZT (only IV drug). If mother has been loaded with nevirapine at least 2 hours before delivery it has a long half life and will remain in the newborn circulation for 7 days. Convert to oral medications when tolerated in next 48-72 hours.

7.4 **Neonatal Period**

- First HIV PCR (paediatric EDTA bottle- Full) – not cord blood
  (Only likely to be positive in the minority of infants infected in utero)
- Check infant's FBC, U & E's, LFT's
- Mothers blood for HIV testing at the same time (7mls EDTA purple top)
- Arrange extra second HIV PCR test at 2 weeks
- Follow up at age 4 weeks
- TTA given for 4 weeks
- RCPCH surveillance unit notified

7.4.1 Should a neonate's blood result come back as HIV positive at any stage please refer them to St. Mary's Hospital, Paddington London.

7.4.2 **Age 4 weeks - First review appointment at the clinic**

- Check result of First (birth) and Second (2weeks old) HIV PCR (paediatric EDTA bottle- Full); if negative
- STOP triple therapy

- Start PCP prophylaxis with co-trimoxazole, 120mg, once a day, 3 times a week (on Mon, Wed, Fri).
- Arrange third HIV PCR test at 6 weeks
- FBC, U and E, LFT at age 6 weeks (this test is 2 weeks after Rx stopped. This is to prevent missing any infant in whom monotherapy may have delayed the appearance of the virus and to check for side effects of treatment e.g. hepatitis)
- Follow up at 8 weeks of age.

7.4.3 **Age 8 weeks - Second review appointment at the clinic**

- Check result of third HIV PCR and FBC, U & E's, LFT's; if negative
- Arrange fourth HIV PCR test at age 3 months (paediatric EDTA bottle- Full)
- Follow up at age 3 and a half months (i.e. to allow 2 weeks for results to be back)

7.4.4 **Age 3.5 months – Third review appointment at the clinic**

- Check result of Fourth HIV PCR; if negative
- STOP PCP prophylaxis
- Arrange final HIV antibody test at age 18 months (i.e. takes up to 18 months until maternal antibodies acquired in utero to disappear)
- Follow up at 18 and a half months

7.4.5 **Age 18.5 months – Fourth and final review appointment at the clinic**

- Check result of HIV antibody test; if negative discharge patient

8.0 Follow up Care

8.1 Follow up of the infant: (arranged by neonatal team BEFORE discharge following birth).

8.2 Medication prescribed and TTA for 4 weeks.
(Refer to Appendix B)

8.3 The birth is reported to the RCPCH HIV surveillance Unit.

8.4 Follow up depends on the risk of vertical transmission:

- The low risk infant should have a clinic appointment with consultant of the day of birth in 6 weeks and a repeat HIV PCR test that week.
- The high risk infant should have a HIV PCR test (paediatric EDTA bottle- Full) at 2 weeks arranged and a clinic appointment at 4 weeks.

9.0 Immunisation

9.1 Infants of HIV infected mothers should not be given live vaccines until they are known not to be infected. They should not receive BCG at birth. It can be given when the infant has 3 negative HIV PCR tests. They should receive the normal schedule at 2, 3 and 4 months, as the current Polio vaccine is not live.

10.0 Mothers who Refuse any or all Methods of Reducing MTCT

10.1 From time to time there are mothers who for reasons which may be personal, religious or cultural do not wish to take up interventions to reduce transmission. This decision rests finally with the mother. There may be language issues or communication difficulties so it is

important that interpreters are available to allow the woman the opportunity to discuss her care with her practitioner. It is important that women feel supported whatever their decision. (Refer to the policy entitled 'Interpreting and translating policy'; register number 09127)

10.2 An HIV positive mother who breastfeeds her baby may be a child protection issue and it is important to seek advice from Named Midwife Safeguarding. HIV positive mothers are 10-20% more likely to infect their babies if they breastfeed. In the event of refusal to accept treatment for the baby, the Paediatric Consultant for the child and the Named Consultant Paediatrician Safeguarding, must lead on a multi agency approach in order to safeguard the best interests of the child. This may require referral to Children's Social Services

11.0 Staffing and Training

11.1 All midwifery and obstetric staff must attend yearly mandatory training which includes HIV training.

11.2 All paediatric and neonatal staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal.

12.0 Infection Prevention

HIV is a blood-borne virus and all staff should follow the Trust's guideline on infection prevention, using Aseptic Non-Touch Technique (ANNT) when taking bloods and wearing the appropriate uniform, i.e. non-sterile gloves.

13.0 Useful Contact Details

13.1 **Family HIV Service**

6th Floor
QEQM Wing
St Mary's Hospital
South Wharf Road
London
W2 1NY
Telephone: 020 7886 6666
Fax: 020 7886 6341
E-mail: familyclinic@st-marys.nhs.uk

This centre is available to families infected or affected by HIV, starting from the antenatal period.

13.2 **St. Mary's Hospital, Paddington, London**

A paediatrician is available 24/7 via the hospital switchboard, 020 7886 6666, ask for either the consultant on-call or the registrar for Infectious Diseases/ Paediatric Intensive Care.

Paediatric Infectious Disease Consultant
Pager H2395
020 7886 1013

Paediatric Infectious Disease Consultant
Pager H3058
020 7886 6304
Neonatal SpR

Neonatal Unit
Bleep 1812
20 86 1103

13.3 **Mid-Essex Hospital Services**

Consultant in HIV
The Crompton Clinic
01245 515911

Consultant in Respiratory Medicine
Secretary: (01245) 51 4146

Antenatal and Newborn Screening Team
(01245) 513433

13.4 British Paediatric Surveillance of HIV in Children, Epidemiology and Biostatistics, Institute of Child Health, London.
Telephone Number: 020 7829 8686
Fax Number: 020 7905 2381

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14.0 Audit and Monitoring

14.1 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.

14.2 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.

14.3 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.

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

14.5 Key findings and learning points will be disseminated to relevant staff.

15.0 Guideline Management

15.1 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.

15.2 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.

15.3 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.

15.4 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.

16.0 Communication

16.1 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.

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

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

16.4 Regular memos are posted on the 'Risk Management' 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.

17.0 References

Children`s HIV Association (2017) CHIVA Standards of Care for Infants, Children and Young People with HIV, (including infants born to mothers with HIV)

BHIVA (2014) Guidelines for the management of HIV infection in pregnant women. HIV Medicine (2014), 15 (Suppl. 4), 1–77.

BHIVA (2013) Guidelines for the treatment of HIV-1-positive adults with antiretroviral therapy. HIV Medicine (2014), 15 (Suppl. 1), 1–85.

National Aids Manual (2007) Risk of mother-to-child transfusion www. Aidsmap. com Risk of mother-to-child transmission of HIV.htm (accessed 18th June 2007)

With thanks to North Middlesex Hospital antenatal and neonatal guidelines

With thanks to St Mary's Hospital guidelines antenatal and neonatal guidelines

Glossary of Terms

HIV	Human Immunodeficiency Virus
START	Short term anti-rectroviral therapy
HAART	Highly active anti-rectroviral therapy
MCT	Mother to Child Transfusion
BHIVA	British HIV Association
NRTI	Nucleoside reverse transcriptase inhibitor (antiviral drug)
ARM	Artificial rupture of membranes
FBC	Full blood count
EDTA	ethylene-diamine-tetra-acetic acid (prevent blood samples from clotting before tests are run)
TTA's	Tablets to take away
U&E's	Urea and electrolytes
RCPCH	Royal College of Paediatric and Child Health HIV Surveillance Unit
PCR	Polymerase chain reaction
GUM	Genito-urinary medicine
LFT's	Liver function tests

NHS
Mid Essex Hospital Services
NHS Trust

Management of Human Immunodeficiency Virus (HIV) Positive Women in Pregnancy

First Name	**Surname**	
NHS No	**Hospital No**	**DOB**
EDD	**Date of Diagnosis**	

Antenatal Newborn Screening Co-ordinator

Contacted / seen by Antenatal Newborn Screening Team — No ☐ Yes ☐

Second confirmatory blood sample required — No ☐ Yes ☐

Date Taken _____

Previous Diagnosis — No ☐ Yes ☐

Referral to GUM / Gastroenterologist — No ☐ Yes ☐

Consultant(s) name and contact details:

_____

Date _____

Print Name _____ Signature _____

Antenatal Care Plan

Antenatal Clinic Appointment 16-18 weeks gestation — No ☐ Yes ☐

Neonatal Unit Alert form completed and sent — No ☐ Yes ☐

Anesthetic Appointment booked — No ☐ Yes ☐

Medication ordered from pharmacy — No ☐ Yes ☐

Date Taken _____

Medication received on Labour Ward — No ☐ Yes ☐

Date Taken _____

Date _____

Print Name _____ Signature _____

Antenatal Discussion of the Benefits and Risks

Antiretroviral Therapy — No ☐ Yes ☐

Vertical Transmission — No ☐ Yes ☐

Avoidance of Breast Feeding — No ☐ Yes ☐

Mode of Delivery — No ☐ Yes ☐

Date _____

Print Name _____ Signature _____

Management Plan for Delivery

Elective Caesarean Section — No ☐ Yes ☐

Vaginal Delivery — No ☐ Yes ☐

Comments

Date _____

Print Name _____ Signature _____

NHS
Mid Essex Hospital Services
NHS Trust

Neonatal Alert Form

First Name	**Surname**	
NHS No	**Hospital No**	**Referral Date**
EDD	**Gestation**	**Consultant**

Background history & problem summary

Delivery Plans

Broomfield Hospital ☐ Not Decided ☐

Other Hospital _____

Neonatal Alert Form Criteria

Please use the neonatal alert form for the following conditions:

- Multiple pregnancy (higher order > 2 fetus)
- Hepatitis B positive mother
- HIV positive mother
- Previous baby with GBBS sepsis / meningitis
- Significant structural abnormalities diagnosedon ultrasound scan
- All cases that require referral to specialist units for treatment or advice
- Mothers with high antibody titres e.g. Anti-D, C and Kell
- Severe oligohydramnios / IUGR
- Abnormal dopplers
- Genetic / hereditary conditions in the immediate family that may affect the fetus
- Social e.g. drug abuse, alcohol abuse in this pregnancy
- Any other condition that will require paediatric input at birth

Postnatal Plan *(paediatric)*

Designation _____ Date _____

Print Name _____ Signature _____

Royal College of Obstetricians & Gynaecologists

NATIONAL STUDY OF HIV IN PREGNANCY

Quarterly Notification Card

This card is for reporting cases first seen between April and June 2007, including pregnancies in previously diagnosed women.

If there are no HIV positive pregnancies to report please tick the box marked None.

Q72

Please note below the hospital number(s) or other identification for cases notified, and **keep this section of the card** for easy reference when you receive a clinical form.

Hospital No:

Surname:

First Name:

In case of enquiries, please contact

Janet Masters or Claire Townsend tel: 020 7829 8686

RECEIVING HIV BLOOD RESULTS **Appendix E**

Negative Results