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Antenatal Care Pathways

- Green Boxes – Primary Care Responsibility
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**No1 COMMUNITY AND SECONDARY CARE PATHWAY FOR BLEEDING IN PREGNANCY - 14/07/2022 V5**

**History/Risk Factors to consider:**
- Onset and estimation of bleeding
- Previous episodes
- Preceding trauma
- Location
- Duration
- Continuous pain, consider abruption
- Abruption in previous pregnancy
- Intermittent pain, consider labour/miscarriage
- SROM consider vasa praevia
- Fatal Movements
- Smear history, PCB, and discharge
- Placenta Praevia (painless bleeding consider placental site)
- PET
- Consider social concerns – (depression/ Domestic Abuse)

If Rhesus D Negative and recurrent APH for Anti-D every 6 weeks

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**Take full history and risk assessment (including amount of blood loss)**

**IF BLEEDING WITH PAIN-FOR URGENT HOSPITAL REVIEW**
- If bleeding without pain, follow pathway below

**BEFORE 13 weeks**
- Refer to EPAU Pathway

**13-19+6 week**
- Refer to EPAU/ DAU dependant on local guidance

- Spotting /Minimal loss on wiping/post coital bleed
- Pink / brown discharge
- Advise to monitor/ give safety netting advice- to call back if increased/ continued loss
- Check Rhesus factor (of mother and baby) to determine if Kleihauer indicated

- Minimal< 50mls now ceased

- Assess fetal wellbeing
- Check Rhesus factor to determine if Kleihauer indicated

- Urgent Medical Review for individualised plan of care

**AFTER 19+6 weeks**
- DAU

- Major 50-1000mls
- Urgent hospital referral

- Massive ≥ 1000mls
- Urgent referral direct to delivery suite or ED if below 20 weeks according to local guidance

**RECURRENT APH in second and third trimester**
- Consider cause
- Accumulative total
- Serial growth Scans
- If Rhesus D Negative and recurrent APH for Anti-D every 6 weeks
- Plan for potential birth (including neonatal/ haematology support

**Reference:**

This guidance does not replace the need for application of clinical judgement by clinicians to each individual presentation and specifics of the situation. Pathways current at time of Publication.
If abnormal movements follow pathway 6
** Red flag symptoms: abdo pain, jaundice, vomiting, fever, deteriorating LFTs or abnormal clotting – day unit review within 6 hours to consider alternative diagnoses including HELLP/AFLP and further investigations
Investigations may include viral screen (Hep A, B and C, EBV, CMV), Liver USS, liver autoimmune screen

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** Diagnosis levels**

(Bile Acids- micromol/l)

- **Mild** ≥19-39
- **Moderate** ≥40-99
- **Severe** ≥100

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**No2 COMMUNITY AND SECONDARY CARE PATHWAY FOR INTRAHEPATIC CHOLESTASIS OF PREGNANCY (ICP)**

- 15.09.2022 V4

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**Itching in pregnancy**
- Perform full antenatal assessment
- Ensure normal fetal movements *
- No red flag symptoms **
- Examine skin to exclude other conditions

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**Labour plan**
- Recommend continuous CTG monitoring if severe cholestasis (mild/ moderate on individualised basis)
- FBC and coagulation screen on admission
- IM vitamin K for baby recommended

---

**Postnatal Plan**
- Repeat LFTs and bile acids ≥14 days after birth by CMW/ GP and ensure normalising (≥4 weeks)
- If remain abnormal, GP review to consider alternative causes
- Progesterone only contraception until LFT’s normal
- Advise increased incidence of ICP in future pregnancies (when compared to general population)

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**Take Bloods for LFTs and Bile Acids**
Offer symptomatic treatment (topical emollients and/ or antihistamine – obtainable OTC)

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**Bile Acids <19**
- Refer for obstetric review (day unit or consultant ANC)

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**Bile acids ≥19**
- Explain diagnosis of Intrahepatic Cholestasis of pregnancy (see diagnosis levels)
- Explain no treatments have any benefit on perinatal outcomes (which are nearly always good)
- Advise symptomatic treatment as above
- Consider offer of Urso deoxycholic acid 250mgs BD/ TDS with advice re evidence
- Offer consultant follow up in 1-2 weeks
- Advise to report any pale stools, dark urine, yellow skin, or eyes or reduced fetal movements by telephoning Antenatal triage.
- Reassure those additional fetal scans or CTG not indicated for ICP alone
- Confirm follow up arrangements (usually testing will be at routine community appointments with consultant ANC around 36 weeks to plan birth)

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**If bile acids ≥19-39 repeat bloods weekly from 38 weeks and offer IOL by 40 weeks**

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**If bile acids ≥40-99 then repeat bloods weekly from 35 weeks and offer induction of labour at 38 to 39 weeks**

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**If bile acids ≥ 100, repeat LFTs and bile acids at 32 and 36 weeks by community midwife at usual appointment ? not at all**
If remain ≥ 100 discuss risks and benefits of planned birth at 36-37 weeks gestation in view of increased risk of stillbirth

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This guidance does not replace the need for application of clinical judgment by clinicians to each individual presentation and specifics of the situation. Pathways current at time of Publication.
Community and Secondary Care for Symptomatic Urinary Infection (UTI) in Pregnancy

14.07.2022 V4

Symptoms of UTI e.g., Burning / pain frequency, urgency during micturition

Signs and symptoms of pyelonephritis +/- sepsis e.g., loin pain, pyrexia, uterine tightening, and tachypnoea – Screen for sepsis as per local guidance

Community Midwife or GP to send MSU and start empirical antibiotics (if symptoms moderate and dipstick positive for nitrates. Refer to South Central antimicrobial network guidance (reference below) to guide treatment options

Positive Urine culture with a known urinary pathogen i.e., E. coli, Enterococcus, GBS ($10^5$/ml) - see GBS pathway 19

Recurrent UTI

- Repeat MSU each trimester
- Consider urology review if recurrent pain with UTI


This guidance does not replace the need for application of clinical judgment by clinicians to each individual presentation and specifics of the situation. Pathways current at time of Publication.
Hisotry to consider:
- Bleeding
- Gestation
- Nature of accident
- Continuous pain, consider abortion
- Fetal Movements
- Anxiety levels

Abdomen not involved

If history NAD - offer safety netting advice
If requires review - auscultate FH

FH heard
Continue with routine antenatal care
Viable pregnancy

FH NOT heard

Stable

Consider mechanisms for all:
• Faint e.g., Anaemia
• Fit e.g., hypertension, epilepsy
• Domestic Abuse
• Fall from height

Haemodynamically unstable/ Major Trauma
Non obstetric injury

Go to ED
Involve Obstetric team in ED

NO FH PRESENT AT ANY ATTENDANCE
Confirm by USS
Continue IUD pathway

Abdomen involved
Ascertain if direct trauma i.e., seat belt involved

Urgent referral to maternity

For urgent obstetric review if bleeding/pain or uterine activity
Take full history & Risk Assessment
Consider cannulation and take bloods for:
FBC, Kleihauer and Group & Save
Perform full antenatal assessment
Auscultate FH ≤26/40 or CTG ≥26/40
If FH absent arrange USS for viability
Consider steroids
If Rh negative arrange and give anti D as per guidelines
Arrange USS if appropriate
Plan and agreed follow up documented in maternity and hospital notes
If transferring elsewhere, ensure handover of details

This guidance does not replace the need for application of clinical judgment by clinicians to each individual presentation and specifics of the situation.
Pathways current at time of Publication
References - no relevant references so based on clinical consensus
**No5 COMMUNITY AND SECONDARY CARE PATHWAY FOR DIARRHOEA AND VOMITING IN PREGNANCY**
(including hyperemesis) - 14.07.2022 V4

- **Ongoing history with compromise**
  - Advise fluids
  - Refer to GP

- **GP to refer for hospital review if any fetal concerns and consider Isolation on admission (as per local infection prevention policy) following discussion with obstetric team**
  - Advise PO fluids as tolerated

- **If clinically stable and no concerns offer antiemetic**
  - Antiemetics safe for community use:
    - 1st line Promethazine
    - 2nd line Cyclizine
    - 3rd line Metoclopramide

- **If known outbreak of infection- follow PHE advice**

**Hospital Review**

- Assess whether systematically unwell / dehydrated, send stool sample
- Abdominal exam: tenderness / uterine irritability
- Fetal wellbeing: Auscultate <26 weeks, CTG > 26 weeks
- Admit only if moderate or severely dehydrated (for IV fluids VBG for monitoring of potassium and monitoring of fluid balance) or mild dehydration but unable manage at home
- Anti-emetics (order may change as per Trust guidance)
  - 1st line Promethazine
  - 2nd line Cyclizine
  - 3rd line Metoclopramide

References NHS choices [Diarrhoea and vomiting - NHS (www.nhs.uk)]
This guidance does not replace the need for application of clinical judgment by clinicians to each individual presentation and specifics of the situation. Pathways current at time of Publication.
**INITIAL PHONE CALL: MOTHER REPORTS CONCERNS REGARDING REDUCED FETAL MOVEMENTS**
**TAKE FULL HISTORY AND RISK ASSESS. ASCERTAIN USUAL FETAL MOVEMENTS PATTERN**

24-26 WEEKS 1st EPISODE
Midwife to review and auscultate using handheld Doppler
If FM never felt by 24 weeks, refer to obstetric team and organise departmental scan
This can be done in MDAU if no community capacity

≥ 26 WEEKS or RECURRENT EPISODES 24-26 weeks
See in DAU for review
Perform full antenatal assessment (including review of risk factors) with careful assessment of fundal height. Follow SGA pathway if any concerns
Commence CTG as soon as possible (if ≥ 26 weeks) *
Obstetric review if 24-26 weeks and recurrent episodes

1ST EPISODE
Or previous episode > 21 days ago

CTG NORMAL *
FETAL MOVEMENTS detected/present

FTG NORMAL *
REDUCED OR NO FETAL MOVEMENTS PRESENT/DETECTED

CTG ABNORMAL *
or ABNORMAL MATERNAL OBSERVATIONS

CTG and SCAN NORMAL *
FETAL MOVEMENTS FELT detected/present
If >39 weeks for senior obstetric review following scan **

2ND EPISODE or recurrent within 21 days-
Arrange USS (if no scan within previous 14 days)
If scan in last 14 days obstetric review following CTG

CTG NORMAL *
BUT SCAN ABNORMAL

CTG NORMAL *
REDUCED OR NO FETAL MOVEMENTS PRESENT/DETECTED

A CTG should always be reviewed in context of the full antenatal assessment alongside computerised analysis

**DISCHARGE HOME**
Return to routine antenatal care
Ensure woman has information - Kicks Count, Wessex healthier together

Arrange USS and request obstetric review if abnormal. Ensure woman has information - Kicks Count, Wessex healthier together

Urgent obstetric review and management plan accordingly

**DISCHARGE HOME**
Return to routine antenatal care
Ensure and document woman has information such as Kicks Count, Wessex healthier together

Arrange same day obstetric review

Consider these risk factors when completing assessment:
- Risk Factors include -
  - Multiple consultations for reduced FMs
  - Hypertension
  - Known IUGR
  - Diabetes
  - Smoking/ Elevated CO Reading
  - Social concerns - inc Domestic Abuse
  - Mental Health concerns
  - Poor obstetric history
  - Congenital Malformations
  - Low PAPP A
  - Age <16 and >40
  - BMI >35

NO FH PRESENT AT ANY ATTENDANCE
Confirm by USS
Continue IUD pathway


This guidance does not replace the need for application of clinical judgment by clinicians to each individual presentation and specifics of the situation.
No7 COMMUNITY AND SECONDARY CARE PATHWAY FOR SUSPECTED SROM AT TERM (No labour) - 14.07.2022

V5

**PRACTICE points**

Digital vaginal examination should be avoided unless mother is contracting and in labour.

If discharge prior to IOL

Provide written information and advice women to record temperature every four hours during waking hours and report immediately if a temperature >37.4°C or a change in colour or smell of vaginal loss.

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**Suspected SROM at Term**

- **Immediate day unit assessment**
  - Antenatal assessment
  - CTG if indicated

- **Telephone risk assessment**
  - Take Full Maternal History*

  - GBS, meconium, vaginal bleeding, constant pain, reduced movements, feeling unwell or any language, communication barriers

- **Good history of SROM and liquor definitely seen**
  
  - Advise patient to lie supine for 20 minutes then speculum/Amniotic tear detector by midwife

  - If history unclear - ask to put a pad on and call back if SROM remains evident

  - If blood-stained liquor include questioning on:
    - Placental location, show, pain, uterine tone between contractions.
    - Consider: abruption, uterine rupture, placenta praevia, vasa praevia. Obstetric review if concerns

  - If on questioning no other risk factors identified, then blood-stained liquor SROM assessment can take place in the chosen place of birth within 12-24 hours as above.

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**SROM confirmed?**

- **YES**
  
  - Refer to IOL guidance (this may be offer of expectant or immediate management)

  - Refer to GBS/meconium guidance if appropriate

- **NO**
  
  - Refer to IOL guidance (this may be offer of expectant or immediate management)

  - Refer to GBS/meconium guidance if appropriate

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**Obstetric led care/ VBAC with no concerns**

- Day unit review within 12-24 hours (Timings may be altered based on maternal preference on induction and ability to attend)

- For both auscultate fetal heart with sonic aid or perform CTG

**Midwifery led care with no concerns**

- Birth centre (or home) assessment within 24 hours (auscultate fetal heart with sonic aid as part of assessment)

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*Full maternal history to include:
- Fetal movements
- Gestation
- Pregnancy history

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This guidance does not replace the need for application of clinical judgment by clinicians to each individual presentation and specifics of the situation.

Pathways current at time of Publication. NICE Inducing labour guidance NG 207 (2021) [https://www.nice.org.uk/guidance/ng207](https://www.nice.org.uk/guidance/ng207)
This guidance does not replace the need for application of clinical judgment by clinicians to each individual presentation and specifics of the situation. Pathways current at time of Publication. Lack of referenced evidence so based on clinical consensus.
NO 9 COMMUNITY CARE PATHWAY FOR ASYMPTOMATIC BACTERICURIAS IN PREGNANCY - 14.07.2022 V5

Positive urine culture, Confirmed with repeat culture

Repeat culture positive

Treat with antibiotics for 7 days according to antibiotic susceptibility pattern

Arrange a repeat MSU as a “test of cure” 7 days after completing antibiotic course
As per pathway 3

Repeat culture negative

Return to routine

MSU Sent if nitrites positive on dipstick
Or MSU sent at booking (Booking MSU only required if requiring preterm birth referral as per trust Preterm birth policy)

Nb. GBS >10^5 organisms per ml treat with antibiotics during pregnancy
Any GBS detected during pregnancy recommend antibiotics in labour and refer to GBS pathway 19

This guidance does not replace the need for application of clinical judgment by clinicians to each individual presentation and specifics of the situation.
Pathways current at time of Publication. NICE antenatal care ng 201 (2021) NICE Schedule of antenatal Appointments NG201 (2021) https://www.nice.org.uk/guidance/ng201
NEW HYPERTENSION WITHOUT PROTEIN

Systolic ≥ 140 ≤ 159
Diastolic ≥ 90 but ≤ 100 on 2 occasions (15 minutes apart) and asymptomatic

Take bloods.
(FBC, U & E’s, LFT’s- urates if trust policy)

Arrange assessment within 24 hours in day unit

NEW HYPERTENSION WITH PROTEIN

Systolic ≥ 160
OR
Diastolic ≥ 100
OR
Diastolic ≥ 90 ≤ 100 with symptoms
Take bloods.
(FBC, U & E’s, LFT’s- urates if trust policy)

Refer to Day unit for assessment within 4 hours

Urgent hospital referral if symptomatic

Send MSU

Send MSU

Systolic ≥ 140 OR
Diastolic ≥ 90 and proteinuria ≥ 1 + on urine dipstick on clean catch of urine
Take bloods and urine PCR
(FBC, U & E’s, LFT’s- urates if trust policy)

Follow pathway 3 if symptomatic of UTI

Follow pathway 9 if asymptomatic of UTI but positive urine culture

NEW PROTEINURIA WITHOUT HYPERTENSION

Symptoms WITHOUT RAISED BP OR PROTEINURIA

Same day DAU assessment for differential diagnosis

If Persistent proteinuria, repeat MSU in 1 week. Take PET bloods, Urine PCR, Refer to ANC

Principles of taking Blood Pressure

Diagnose hypertension if average systolic BP ≥ 140 and/or diastolic BP ≥ 90 on 2 occasions 4 or more hours apart

Full A/N assessment using correct cuff
If arm > 33cms, use large cuff
Use right arm
Take BP at the beginning and end of appointment
Take at level of heart
Take in sitting position
Take BP reading when sounds disappear
Check Urine, using a clean pot and midstream catch

If hypertensive repeat at end of consultation- at least 15 minutes after initial BP

Significant Signs / Symptoms:
• Epigastric Pain
• Vomiting
• Headache
• Visual Disturbances
• Reduced fetal movements or change in pattern of movements
• Small for gestation age infant

Ref NG 201 Antenatal Care (2021). For advice on medication see Diagnosis and management of hypertension- a summary of NICE guidance (2019) BMJ- available at https://www.bmj.com/content/366/bmj.l5119/infographic
No11 COMMUNITY CARE PATHWAY FOR ITCHING OR RASH IN PREGNANCY - 14.07.2022 V5

REFER TO GP
History taken by GP
Consider exposure to viral infection
Gestational pemphigoid (autoimmune disease of pregnancy- associated with blisters and second/third trimester
PEP (polymorphic eruption of pregnancy)- not an autoimmune disease- typically occurs in stretch marks on abdomen
Obstetric cholestasis (follow obstetric cholestasis pathway No 2)
Itching without a rash, consider OC and follow pathway no 2

Rash associated with viral infection
Consider review of booking bloods:
Contact with chickenpox or shingles- reliable history of either or two doses of varicella vaccine- if no test for VSV IgG)
Contact with non-vesicular rash (parvovirus B19, rubella or measles)- if parvovirus test for IgG and IgM,
CMV and Epstein Barr Virus may also present as a rash so should be considered as differential diagnosis

Rubella- (if not vaccinated (x2), or x 1 with at least 1 rubella antibody positive test ≤10 IU/ml or rubella antibody tests x 2 (at least one ≤ 10 IU/ml) then test for Rubella IgG and IgM
Measles- known to be immune or 2 vaccines containing measles- reassure, if not and confirmed case or confirmed likely case with exposure within 6 days test for measles IgG.
Secondary Syphilis - Update from screening – specific advice 2019 has been issued regarding rising incidence of syphilis nationally but notably in Hampshire & IOW. **Retesting of women should be considered alongside screening for Hepatitis and HIV and reaffirm rubella status.** ‘Common symptoms of secondary syphillis include a rash which may involve the palms and soles, lymphadenopathy, and constitutional symptoms’
Consider any current public health outbreaks (e.g., monkeypox) and follow national guidance on history taking, clinical care/treatment

Treatment:
If requires Antihistamine, consider chlorphenamine/ cetirizine
STEROID CREAM

If test results are positive
Refer for Obstetric Review

References
Health Protection Agency (2019) Guidance on Viral Rash in Pregnancy
This guidance does not replace the need for application of clinical judgment by clinicians to each individual presentation and specifics of the situation. Pathways current at time of Publication.
**History of Flu**
- Influenza presenting with fever, coryza, generalised symptoms, (headache, malaise, myalgia, arthralgia) and sometimes gastrointestinal symptoms, but without any features of complicated influenza.

**Complicated Flu or Swine (H1N1) Flu, Avian (H5N1), or SARS-CoV 2**
- Influenza requiring hospital admission and/or symptoms and signs of lower respiratory tract infection (hypoxaemia, dyspnoea, lung infiltrate, central nervous system involvement and/or a significant exacerbation of an underlying medical condition.

Check for recent vaccination

**Management**
- Community Care unless complications of flu are present
- Reassure most flus including Swine Flu are mild & self-limiting within a week / they do not infect the fetus
- Advise paracetamol and **avoid NSAIDs (e.g., Ibuprofen)**
- Advise rest / fluids / codeine & antihistamine containing preparations including cough syrups / advise to eat little & frequently
- Antiviral: Relenza inhaler (not suitable for asthmatics or COPD),
- Antivirals have been recommended for pregnant women due to the adverse clinical outcomes that have been observed from influenza infection in this group. Oseltamivir remains the first line option for the vast majority of pregnant women with influenza, including during seasons that are dominated by influenza A(H1N1). Oseltamivir (Tamiflu) orally remains the first line of treatment
- Prevention/limiting spread: Advise women to prevent/limit spread
  - Seasonal flu vaccine (also protects against swine flu) vaccine is recommended for all pregnant women at any stage of pregnancy. It is safe and usually offered by GP and Maternity from October each year. It is also advisable to vaccinate any children aged 2-10 years in the household & aged 2-18 years with a long-term health conditions & the elderly. Ensure flu information leaflet available.
  - Signpost to NHS advice:
- Follow most recent RCOG guidance on Treatment of SARS-CoV-2 in pregnancy [Coronavirus (COVID-19), pregnancy and women’s health (rcog.org.uk)]

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**References**
Public Health England (2021) PHE guidance on use of antiviral agents for the treatment and prophylaxis of seasonal influenza (version 11)
This guidance does not replace the need for application of clinical judgment by clinicians to each individual presentation and specifics of the situation. Pathways current at time of Publication.
Consider the following when taking history

- **Type** - Watery, no smell normal
  - Thick white (cottage cheese like), no smell, itching - Thrush (Candidiasis)
  - White or grey with fishy smell - Bacterial Vaginosis
  - Green, yellow / frothy discharge - Trichomoniasis (STI) / GBS (non STI)
- Associated with pain on urination
- Presence or absence of abdominal pain - consider preterm labour, PPROM (refer to obstetrics)
- Discharge with urinary symptoms (Chlamydia, Gonorrhoea, STIs)
- Bleeding (usually contact following sex): Chlamydia, Cervical Ectropion, Polyp, rarely Cervical Cancer (ask for smear history, any treatment to cervix)
- Painful red blisters / sores around Genitals – Herpes
- Consider LVS or HVS if doing a speculum

**Normal**
Refer to routine antenatal care

**Infection Confirmed**
GP to treat infection and follow up (Bacterial Vaginosis- metronidazole Thrush- Clotrimazole Trichomonas- metronidazole)

**Suspected SROM**
Usually, a gush or a trickle of fluid that cannot be controlled
May see fluid draining at introitus
On speculum will see either fluid draining from cervix or pooling in vagina

Advise to attend GUM if Chlamydia, Trichomonas, Gonorrhoea or Genital Herpes proven or suspected, to exclude other STI & for contact tracing

Follow suspected SROM (pathway 7) PPROM (pathway 16)

References:
https://www.nice.org.uk/guidance/ng207
Further resources: British Association for Sexual Health and HIV includes section on pregnancy- www.bashhguidelines.org
This guidance does not replace the need for application of clinical judgment by clinicians to each individual presentation and specifics of the situation. Pathways current at time of Publication.
Diagnose hypertension if average systolic BP ≥ 140 and/or diastolic BP ≥ 90 on 2 occasions 15mins apart

Hypertension 140/90 - 159/109
Severe Hypertension- ≥ 160/110

Full A/N assessment using correct cuff. If arm >33cms, use large cuff.

Take right arm
Take BP at the beginning and end of appointment
Take at level of heart
Take BP reading when sounds disappear
Check Urine, using a clean pot, midstream catch

Significant symptoms:
- Epigastric pain
- Vomiting
- Headache
- Visual Disturbances
- Reduced fetal movements or change in pattern of movements
- Small for gestation based on SFH

**ADMIT if**
- Sustained SBP ≥ 160mmHg ≥110mmHg
- Concerning haematological or biochemical investigations
- Suspected fetal compromise
- Signs of impending eclampsia/ severe PET/ pulmonary oedema
- Any other clinical signs that cause concern

**REFERENCES**
- Hypertension in pregnancy NICE NG 133
- For advice on medication see Diagnosis and management of hypertension- a summary of NICE guidance (2019) BMJ available at https://www.bmj.com/content/366/bmj.l5119/infographic
No16 SECONDARY CARE PATHWAY FOR SUSPECTED/ CONFIRMED PRE-TERM PRE-LABOUR SPONTANEOUS RUPTURE OF MEMBRANES (PPROM) - 14.07.2022 V5

First call with suspected SROM - enquire re colour of liquor, fetal movements, uterine activity, maternal wellbeing, if no concerns raised - advise to put on pad and call back if remains suspected SROM. On second triage call (or concerns raised re liquor colour, fetal/ maternal wellbeing) invite in for review in day assessment unit.

Perform a full antenatal assessment and maternal observations
- Review previous history of GBS/ infectious diseases
- CTG ≥26 weeks only required when PPROM confirmed or if otherwise clinically indicated

Good history of SROM and liquor seen
- Auscultate FH/CTG to be performed ≥26 weeks

Inform on call obstetric team
- Vaginal Swab
- Take bloods for FBC & CRP
- Consider USS

If GBS +ve follow pathway 19
- If infectious diseases follow local guideline
- Erythromycin should be prescribed for 10 days
- Consider use of QUIPP app
- Aim for full course of steroids +/-MgSO4 if likely to birth within 7 days - (gestation dependant)
- Consider admission to antenatal ward as per local policy
- If admitted inform NNU
- Antibiotics to be given in established labour

No liquor seen
- Reassure and advise to return if further PV loss

Unconfirmed but good history of SROM
- Seek senior review
- Consider repeat speculum/amniotic leak detector

Liquor seen
- Unconfirmed but good history of SROM
- Lie supine for 20 minutes prior to speculum/amniotic leak detector

No evidence of SROM:
- Reassure, advise to return if further PV loss

Discharge
- Review investigation results prior to discharge
- Seen by Consultant team whilst inpatient to arrange plan of care is in place and documented
- Arrange a minimum of weekly review for maternal and fetal wellbeing (either in community or hospital as per local policy)
- Request fetal monitoring if concerned about movements
- Arrange ANC and scan as per individual need
- Patient to check her own temperature a minimum of twice a day at home
- Provide contact numbers and patient information leaflet RCOG/Local or App
- Patient to contact Maternity service if feels unwell, temp ≥37.4°C, liquor colour changes or reduced fetal movements

This guidance does not replace the need for application of clinical judgment by clinicians to each individual presentation and specifics of the situation. Pathways current at time of Publication.
At EVERY Antenatal contact: Offer CO monitoring BEFORE you ask if the women or anyone in the household smokes

Results below 4ppm
Normal CO level
Ask if they smoke

Non smoker
- CO testing at every ante natal contact
- Ask if anyone in the household smokes
- Record smoking status and CO levels in Notes
- Kicks count
- Information given

Results 4ppm and above Raised CO level
Ask if they smoke.

Smoker
- CO testing at every ante natal contact
- Ask if anyone in the household smokes
- Record smoking status and CO levels in Notes
- Even though low reading still refers to smoking cessation services.
- Offer referral for partner if appropriate.
- Give leaflet or signpost to information in Badgernet library on smoking in pregnancy.
- Reiterate risks of smoking to mother and fetus
- Kicks count information given.
- Ensure they are on the correct scan pathway

Non-Smoker
- CO testing at every ante natal contact / record CO reading
- Ask if anyone in the household smokes.
- Record smoking status and CO levels on Badgernet.
- Consider causes for raised CO if non smoker
- Passive smoking- refer household smokers to smoke cessation service with consent.
- Check environmental factors including faulty boilers, cookers, gas fires, wood burners, car exhaust- see advice below
- Lactose intolerance can also cause raised CO- question if bowel related symptoms such as bloating after eating (within 30 minutes), excessive flatus or explosive bowel movements- refer to GP if any symptoms
- Kicks Count Information given.
- See advice box below for readings of more than 10ppm

Results of more than 10 ppm
Ask if any of the following symptoms
- Ask about following symptoms: Headache, nausea/vomiting, drowsiness, dizziness, dyspnoea, or chest pain, reduced fetal movements

Yes
Advise ED/ DAU admission as per trust guidance and follow NICE guidance on the Management of CO poisoning

CO monitoring levels decreasing
Continue to monitor CO levels at every ante natal contact. If the woman is now a non-smoker, ensure this is recorded in maternity records.

No
Give Gas emergency line (0800 111 999) for gas safety advice
Advise they stop using all appliances that might be causing the leak. Open doors and windows to ventilate the property. Advise to obtain CO detector in the home

CO monitoring levels same or increasing
- Check they have accessed Smoking support service
- Re refer
- Consider other sources for CO such as environmental factors, passive smoking, lactose intolerance.

This guidance does not replace the need for application of clinical judgment by clinicians to each individual presentation and specifics of the situation.
No 19 MANAGEMENT OF GBS IN PREGNANCY - 14/07/2022 V6 (See WICN pathway 2)

Past or current GBS Identified

Previous pregnancy, prolonged rupture of membranes, preterm labour - follow WICN pathway no 2

If SROM: management as per preterm/pre labour rupture of membranes guidelines.

Current Pregnancy

GBS in urine

Positive Urine culture with a known urinary pathogen i.e., GBS (10^5 / ml)

Primary care to prescribe antibiotics (as per sensitivity), arranging MSU for seven days after completion of antibiotic (as per pathway number 3)

GBS on HVS

Inform women that immediate treatment is not required but they will be offered IAP in labour

Follow pathway number 7 (suspected SROM) or pathway 14 (vaginal discharge in pregnancy) if appropriate

Information for women:

Confirmation they have received information leaflet during pregnancy - if have not received should provide either GBSS/RCOG or local leaflet to give women information on both early onset and late onset neonatal infection and management of GBS

Advise them to notify labour line when either in labour or SROM so IAP can be commenced as per WICN pathway no 2


This guidance does not replace the need for application of clinical judgment by clinicians to each individual presentation and specifics of the situation.

Pathways current at time of Publication
### Appendix: Background information

#### Background

In 2018 the Wessex Maternity Clinical Network was asked to coordinate a review of the existing Wessex Ante Natal Care Pathways, to update where necessary in line with the latest clinical guidelines, to provide governance and sign off and produce an agreed standardised set of pathways and ensure dissemination to the appropriate individual trust boards.

From October 2020, due to a change in the Clinical Networks geographical areas, administration for the Ante Natal Care Pathways Review Group will be provided by Wessex Patient Safety Collaborative. Pathways will therefore be aligned to the Maternity & Neonatal Safety Improvement Programme (where appropriate) and co-designed by all Wessex Providers. The aim is to ensure the pathways support delivery of safe care across the whole of the Wessex region.

#### Aims and objectives of the group

<table>
<thead>
<tr>
<th>Aim</th>
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<tr>
<td>An updated, agreed and signed off set of Wessex Ante Natal Care Pathways</td>
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<table>
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<tr>
<th>Objectives</th>
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<td>To review existing pathways and update where necessary</td>
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<td>Agree the sign off process for the pathways</td>
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<td>Agree how the signed off pathways will be disseminated</td>
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<td>Highlight issues and challenges and discuss solutions</td>
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<tr>
<td>Make recommendations of how to take this work forward</td>
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#### Membership of the Group

- All trusts provided clinical representation to form part of the review group

**Trust Representatives are:**

- **University Hospital Southampton NHS Foundation Trust**
  - Sarah Walker (Consultant Obstetrician), Lisa Smith (Consultant Midwife)

- **Hampshire Hospitals NHS Foundation Trust**
  - Dotun Ilori/ Kirsty Revell (Consultant Obstetricians) Katherine Barrio (Quality Assurance Matron)

- **Isle of Wight NHS Trust**
  - Emma Reynolds (Consultant Midwife) Anu Dhanpal (Consultant Obstetrician)
Portsmouth Hospitals NHS Trust
Alison Scannell (Matron), Gill Allen (Community Matron), Gergana Nikolova (Deputy DOM)

Dorset County Hospital NHS Foundation Trust
Jane Hall (Matron Antenatal and Intrapartum) Suguna Balasundram (Consultant Obstetrician)

University Hospitals Dorset NHS Foundation Trust
Sam Dell –(Midwife) Latha Vinayakarao (Consultant Lead) Lisa Relton (Consultant Midwife)

Salisbury NHS Foundation Trust
Stuart Verdin (Consultant Obstetrician) Hannah Rickard (Consultant Obstetrician), Liz Kimber (Community Matron)

General Practice
Dr Holly Foster GP (Westbourne Medical Centre) Clinical Director Poole Central PCN

Wessex Patient Safety Collaborative

Sign off process, dissemination, and implementation
- The pathways have been developed and changes agreed where necessary and signed off by the group.
- Each Trust representative will be responsible for presenting the final updated pathways to their own clinical governance boards for information and dissemination
- The final updated pathways will be re issued to the LMS boards (for notation in partnership meeting minutes) and to all trusts in PDF format
- The review group will meet every six months to review relevant pathways that require review and agree any changes.
- Implementation of the pathways can, where appropriate, will be supported in the MatNeoSIP Patient Safety Network using quality improvement methodology.
- The next meeting will be held in October 2022-

- The multidisciplinary group that developed this guidance have made considerable efforts to ensure the information upon which these guidelines are based is accurate and up to date. Revision may be deemed appropriate if and when new data or national/ international guidance becomes available. These guidelines do not replace the need for application of clinical judgment by clinicians to each individual presentation and specifics of the situation.

Administration and Support
Administrative support will initially be provided by Wessex Patient Safety Collaborative
- To include minute taking, action tracking and the distribution of papers.
- Updating the pathways, document control and governance
- The copy of the pathways will be held and stored by Wessex Patient Safety Collaborative on their central drive.

| Pathways version control       | All pathways will be dated and subject to version control to ensure that changes and amendments can be tracked, and documents are current
|                               | Process steps in each pathway are colour coded:
|                               | **Green Boxes - Primary Care Responsibility**
|                               | **Orange Boxes – Secondary Care Responsibility** |