ANTENATAL RISK ASSESSMENT AND ONGOING ANTENATAL CARE

This guideline supersedes the guidelines for Antenatal Risk Assessment published 23rd August 2010.

<table>
<thead>
<tr>
<th>Name of Author of Original Document</th>
<th>Carol Lee</th>
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<tbody>
<tr>
<td>Date written</td>
<td>June 2010</td>
</tr>
<tr>
<td>Previously Published</td>
<td>23rd August 2010</td>
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</tbody>
</table>
| Revised 2011                        | Carol Lee  
Debby McKnight  
Alison Schofield  
Margaret Robinson |
| Approved by (Committee/Group)       | Maternity and Gynaecology Clinical Governance Group  
August 2011 |
| MR Eki Emovon                       |           |
| Clinical Governance Lead            |           |
| Sharon Smithson                     |           |
| Acting Head of Midwifery            |           |
| Date issued/implemented             | 12th August 2011 |
| Review date                         | June 2014 |
| Target audience:                    | All Maternity Service staff |

Warning: always ensure that you are using the most up-to-date policy or procedure document. If you are unsure you can check on the Trust intranet under the heading Division and Directorates ➔ Family Health ➔ Maternity ➔ Antenatal
This guideline supersedes the guidelines for Antenatal Risk Assessment published 23rd August 2010.

<table>
<thead>
<tr>
<th>Version date</th>
<th>Brief Summary of changes</th>
<th>Author/reviewer</th>
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</thead>
<tbody>
<tr>
<td>August 2011</td>
<td>• Section 3 - Actions required to ensure migrant women have had a full physical examination before pregnancy has been clarified.</td>
<td>Carol Lee, Alison Schofield, Margaret Robinson, Debby McKnight</td>
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<tr>
<td></td>
<td>• The father’s details should be requested and entered onto page 2 of the handheld records. Actions where not disclosed and where there are concerns are detailed.</td>
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<tr>
<td></td>
<td>• The Maternity service will adhere to, on DRI site the Doncaster Safeguarding Children’s Board Policy, BDGH the Nottinghamshire Safeguarding Children’s procedures and carry out the Common Assessment Framework where appropriate to ensure that the needs of the family are met in the most appropriate way.</td>
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<td></td>
<td>• Section 4 Planned place of birth will be documented on page 1 of the handheld pregnancy notes. Discussion of place of birth will be documented in the preferences for birth section (page 21).</td>
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<tr>
<td></td>
<td>• <strong>Section 5 added concerning ongoing antenatal care.</strong> For these women the 2nd and third trimester risk assessments may need to be undertaken in the hospital setting.</td>
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<tr>
<td></td>
<td>• Section 5.1 self discharge added including actions required where safeguarding concerns</td>
<td></td>
</tr>
</tbody>
</table>
DONCASTER AND BASSETLAW HOSPITALS NHS FOUNDATION TRUST
WOMEN’S, GYNAECOLOGY AND GUM CSU

ANTENATAL RISK ASSESSMENT GUIDANCE AND ONGOING
ANTENATAL CARE

INDEX

1. Introduction 4
2. Purpose 4

3. Antenatal Risk Assessment 4
   3.1 Booking visit 4
   3.1.2 Documentation 4
   3.2 Assessment 5

4. Further Antenatal Risk Assessments 6
   4.1 Choice of place of birth.

5. Ongoing Antenatal care 7
   5.1 Self Discharge From Hospital 7

6. Referral Process From MLC To Consultant Led Care 7
   (Maternity Team Care)
   6.1 Women Receiving Midwifery Led Care And Requiring 8
      Induction of Labour.

7. Documentation of Change of Lead Health Care Professional 8

8. Monitoring Of Compliance 8

9. References and Bibliography 8

Appendix
Antenatal Appointment Guidance for Community Midwives
ANTENATAL RISK ASSESSMENT GUIDANCE AND ONGOING ANTENTAL CARE

1. INTRODUCTION

Antenatal risk assessments will initial occur at the booking visit, and be repeated in the 2nd and 3rd trimesters, in which ever care setting the woman is receiving care, to ensure the woman is receiving appropriate care and identify the need for referral where risks are identified.

All woman need to know the pathway their pregnancy is likely to follow and be given every opportunity to plan with the midwife or Maternity Team how and with what frequency they will access and receive care and be able to exercise choice in whom the lead health care professional will be for their pregnancy.

2. PURPOSE

This guideline discusses the process for antenatal risk assessment and referral processes for all women.

3. ANTENATAL RISK ASSESSMENT

3.1 Booking visit

At the booking visit the information ascertained from the woman, GP records and clinical indications will inform the risk assessment. Please also see the Guideline for the Booking Appointment MSG 173.

3.1.2 Documentation

The following documentation will be completed at booking and during the antenatal period:

- Maternity Hand Held records.
- Hospital records. Hospital booking record / electronic record information (incorporating Antenatal front sheet, Antenatal past history sheet and Antenatal current pregnancy sheet)
- Antenatal thromboprophylaxis checklist
- Booking visit risk assessment
- Referral for Maternity Services Form.
3.2 Assessment

- In the case of migrant women confirmation must be obtained from the GP records that a full physical examination has occurred prior to the pregnancy. This should be documented in the antenatal hand held record. Where there is no evidence that this has occurred, the woman should be referred for an early appointment with her GP for the taking of a full medical history and clinical assessment made of their overall health.

- The risk assessment takes in to account medical, obstetric social and, mental health factors. The antenatal booking risk assessment form will be completed.
  - Medical history including
    - Venous thrombosis - the Antenatal Thromboprophylaxis Risk Assessment Form should be completed. (Thromboprophylaxis guidelines MSG 20).
    - Body Mass Index (BMI) should be calculated on all women. (Guideline for the Care of Women with a Large BMI MSG 155).
    - Anaesthetic history
  - Previous pregnancy history
  - Pre-eclampsia and diabetes risk (Guideline for the Management of Hypertensive Disorders of Pregnancy and Management of Eclampsia MSG 14, Antenatal and Postnatal Care Of Women with Diabetes in Pregnancy MSG 159.
  - Social history, behaviors and lifestyle. Including smoking history.
    The father’s details should be requested and entered onto page 2 of the handheld records. Where not disclosed this should be documented. Any safeguarding concerns about the father of the baby or the woman’s current partner should be addressed by following the appropriate Local safeguarding Children Board Procedures and discussed with the midwives identified safeguarding supervisor. The attendance of her partner/others should be documented at antenatal appointments. issues.
  - Mental Health Issues (Mental Health Guidelines MSG 169).
  - Identification of women who would decline blood and blood product (Guideline for women declining blood products MSG 96.

- The risk assessment will identify women suitable for midwifery led care or requiring referral for Consultant Led Care. The factors requiring referral for opinion or Consultant Led Care are identified in appendix 2. On completion of the risk assessment the booking visit risk assessment tool will be completed identifying women suitable for Midwifery Led Care/ for referral for Maternity Team based care. The outcome of the risk assessment will also be documented in the hand held and hospital notes.

- All documentation will have the date and time of the assessment recorded.

- Where risks are identified an individual management plan will be made and documented.
• Where a referral for Maternity Team Care is required after 12 weeks gestation, the community midwife will contact the hospital Antenatal Lead Midwife on that day to arrange an urgent appointment at a consultant clinic.

• The Maternity service will adhere to, on DRI site the Doncaster Safeguarding Children’s Board Policy, BDGH the Nottinghamshire Safeguarding Children’s procedures and carry out the Common Assessment Framework where appropriate to ensure that the needs of the family are met in the most appropriate way.

• Communication with the Health Visitor and Children’s Centre commences following the first trimester ultrasound scan when the Midwife to health Visitor Referral Form is completed. Ongoing communication with the Health Visitor will occur advising her/him of any relevant events/concerns. It is good practice for the midwife to regularly meet with health visitors colleagues concerning the women on the Midwife’s case load. This should be documented in the midwife’s diary.

4. FURTHER ANTENATAL RISK ASSESSMENTS

Throughout ongoing antenatal care risk factors may be identified. These will result in appropriate referrals being made, along with the development of an individual management plan.

There will be a review of medical, obstetric, social and mental health factors in the 2nd and third trimesters. These will be documented in the risk assessment section of the hand held notes (page 11) and where available the hospital records. The mental health questions will also be repeated in the second and third trimesters and documented in the mental health section of the hand held records (page 3).

The management of women who fail to attend is discussed in the Guideline for Women Who Fail to Attend Antenatal Appointments MSG 104.

4.1 Choice of place of birth.

In the absence of clinical risk factors information on place of birth and the offer of home birth should be made at booking and again at 36 weeks to all women. A risk assessment will be undertaken and documented, this may also raise issues about the domestic setting and its’ suitability.

Planned place of birth will be documented on page 1 of the hand held pregnancy notes. Discussion of place of birth will be documented in the preferences for birth section (page 21).

Women with risk factors requesting a home birth will be cared for in accordance with the home Birth Guidelines MSG 68.
5. ONGOING ANTENATAL CARE
Women with high risk pregnancies who are receiving antenatal care mainly at hospital antenatal clinics will have a named midwife in the hospital as well as the community. The named hospital midwife will ensure there is ongoing communication with the community midwife concerning the care provided and any care requirements. Continuity of care will therefore be provided and the community midwife will be able to liaise with outside agencies and the Health Visitor as required.

For these women the 2nd and third trimester risk assessments may need to be undertaken in the hospital setting.

5.1 Self Discharge From Hospital
Where women who have been admitted to hospital wish to self discharge the Trust Policy for the Discharge of Patients from Hospital PAT/PA3 section 3.2 should be followed.

In addition the community midwife, Health and where previously involved Social Services should be informed. Where there are child protection issues/concerns the Safeguarding Adults and Children's Policies should be followed.

6. REFERRAL PROCESS FROM MLC TO CONSULTANT LED CARE (MATERNITY TEAM CARE).

Referral during the antenatal period, for obstetric opinion and management, will be by proforma/letter, detailing the area of concern, requesting a Consultant opinion. If required, transfer of care will be requested. The intention to transfer care must be stated if required. The G.P will be informed of any changes to booking arrangements.

If an urgent referral to ANC is required the ANC Lead Midwife will be informed, a letter to the Consultant will still be required. Women referred for obstetric opinion will be seen by the Consultant or ST3 and above.

If the woman is referred for an obstetric opinion, but is found suitable to remain under Midwifery Led Care, or is suitable to return after receiving an episode of care, this will be recorded in the woman’s hand held records. Women attending a ward, Antenatal Assessment Unit (ANAU)/ Pregnancy Assessment Centre (PAC) or CDS/Labour Ward and requiring obstetric referral/opinion will be seen by a member of the obstetric on call team. The doctor will assess whether a consultant opinion is required at that time and must be informed of the woman’s previous booking for MLC.

The Consultant on call will be informed at the time of the transfer out of hours if indicated by the woman’s clinical condition i.e. requiring caesarean section, eclampsia etc.
The transfer of women from MLC to Consultant Led Care will be highlighted to the Consultant and obstetric team during ward rounds.

6.1 Women Receiving Midwifery Led Care And Requiring Induction Of Labour (IOL).

- Women receiving MLC and requiring IOL for post maturity will have the date of induction arranged by the Community Midwife and will remain under MLC until admitted for the process to commence.

- Where women decline IOL for postmaturity Consultant referral will be made. If women booked for Midwifery led Care and reaching Term + 12 declines any obstetric input, a Supervisor of Midwives should be contacted for advice and support.

7. DOCUMENTATION OF CHANGE OF LEAD HEALTH CARE PROFESSIONAL

Any change of lead healthcare professional is to be documented by use of the approved stamp. The electronic record must also be amended.

8. MONITORING OF COMPLIANCE

Compliance with the guideline will be monitored via audit, with a frequency as identified within the approved Clinical Governance Monitoring Document

9. REFERENCES AND BIBLIOGRAPHY


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Screening Committee', DOH. www.nsc.nhs.uk

This is based on the guidance of NICE (March 2008).

**Women with the following conditions will require Consultant Led Care (MTC).**

**Pre-existing conditions**
- Cardiac disease, including hypertension
- Renal disease
- Endocrine disorder or Diabetes.
- Psychiatric disorder requiring medication.
- Haematological disorder, including thalassaemia, Sickle Cell Disease, thromboembolic disease, autoimmune diseases such as Antiphospholid Antibody Syndrome.
- Epilepsy requiring anticonvulsant drugs
- Malignant disease
- Severe asthma
- Maternal infections- Human Immune Virus (HIV), Hepatitis B (Hep, B) or Hepatitis C (Hep. C) infection, Herpes, Group B Streptococcus in pregnancy, Pelvic Inflammatory Diseases, Methycillin Resistant Streptococcus A (MRSA) etc.
- Autoimmune disorders
- Obesity (BMI 35 or more at first contact) or underweight (BMI less than 18 at first contact).
- Current/ recent drug misuse use such as Heroin, Cocaine (including crack cocaine) and Ecstasy
- Family history of genetic disorders e.g. Down’s Huntingdon’s Chorea, Cystic Fibrosis etc.
- Women who may be at a higher risk of complications i.e. women aged 40 years and older, women who smoke and fail to engage with smoking cessation services, 10 or more cigarettes a day and/or have a CO reading of 10 or above.
- Teenagers 16 years and below
- Pelvic or spinal abnormalities

**Previous obstetric and gynaecology history**
- Recurrent miscarriage until mid trimester (defined as 3 or more consecutive pregnancy losses) or a mid-trimester loss.
- Rhesus isoimmunisation or other significant blood group antibodies
- Uterine surgery including caesarean section, myomectomy or cone biopsy.
- Cone biopsy or Cervical Diathermy
- Antenatal or postpartum haemorrhage on 2 occasions.
- Severe pre-eclampsia, HELLP syndrome eclampsia
- Retained placenta on 2 occasions
- Puerperal psychosis
- Grand multiparty (more than 4 pregnancies)
• Previous stillbirth or neonatal death
• Severe pre-eclampsia, HELLP syndrome, eclampsia
• Previous stillbirth or neonatal death,
• Small for gestational age infant (less than fifth centile)
• Large for gestational infant (greater than the 95th centile)
• Baby weighing less than 2500gms or more than 4500gms
• Baby with congenital anomaly (structural or chromosomal)
• Previous pre-term birth
• Female circumcision
• Gestational diabetes
• 3\textsuperscript{rd}/4\textsuperscript{th} degree tear

**Current pregnancy conditions requiring MLC women to be referred**

Consultant Led Care or Consultant opinion

• Diagnosis of a fetal abnormality
• Multiple pregnancy.
• Women with antenatal vaginal bleeding will be referred for an obstetric opinion. If major causes are excluded once settled the woman will return to Midwifery Led Care.
• Development of a medical complication or any other condition e.g. anaemia (Less than 11gms at booking, less than 10.5 gms from 28 weeks onwards).
• Development of Pregnancy Induced Hypertension (see guidelines for the management of hypertensive disorders of pregnancy-MSG 14).
• Non-cephalic presentation after 36 weeks gestation.
• Suspected small or large for gestational age-seek a second opinion and advice from Senior Midwife ANC in the 1\textsuperscript{st} instance.
• ANAU attendance at which clinical risk factors were identified.
• Multiple pregnancy

Schedule of visits to be added-Debby did you do a revised copy I can have electronically.
# Antenatal Appointment Guidance for Community Midwives

<table>
<thead>
<tr>
<th>Contact In Children’s Centre or GP surgery.</th>
<th>Length of Appt.</th>
<th>Information given</th>
<th>Investigations carried out</th>
<th>Resources Given</th>
<th>Documentation</th>
<th>Actions taken</th>
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<tbody>
<tr>
<td><strong>First Contact</strong></td>
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<tr>
<td>As soon as possible</td>
<td>15-20 min</td>
<td>Healthy start</td>
<td></td>
<td>Booking pack (if telephone contact leave pack for collection at a convenient place). See content of booking pack supplied.</td>
<td></td>
<td>Arrange booking appt.</td>
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<tr>
<td>Can be telephone contact</td>
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<td>vitamins/ folic acid supplementation</td>
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<td></td>
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<td>Food hygiene</td>
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<td></td>
<td></td>
<td>Lifestyle (including smoking and substance misuse)</td>
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<td></td>
<td></td>
<td>Antenatal screening</td>
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<td>Substance Misuse identified (or self referred) - see Substance Misuse Pathway.</td>
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<tr>
<td><strong>Booking</strong></td>
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<tr>
<td>8 – 10 weeks</td>
<td>90 min</td>
<td>Ensure that woman has understood the information in green hand held notes and screening leaflet. Explain again the booking process, bloods and first trimester screening. Healthy start information given. Triage contact number given. Advise to keep hand held notes with her at all times.</td>
<td></td>
<td></td>
<td></td>
<td>Review GP records for medical &amp; social history. Explain outcome of Risk assessment and place on either MLC or Team care pathway. Ref to teenage pregnancy, smoking cessation if smokes or has smoked in the last 12 months, substance misuse services &amp; Monday clinic as appropriate. Document all referrals made and follow appropriate pathways. Refer for 1st trimester</td>
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</table>
breastfeeding, healthy lifestyle and explaining the benefits of attending parent education sessions at a later stage in pregnancy. Ensure the family origin questionnaire is completed. Question about mental health & domestic abuse.

<table>
<thead>
<tr>
<th>11-13 weeks</th>
<th>16 weeks</th>
<th>20-22 weeks</th>
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<tbody>
<tr>
<td>Ensure the family origin questionnaire is completed. Question about mental health &amp; domestic abuse.</td>
<td>Blood test results &amp; screening results. Discuss test results and explain implications of anaemia, Rh-ve blood group etc. Give information about the anomaly scan (see p 32-43 of the booklet 'screening tests for you and your baby'). Parent Ed &amp; Aquanatal Information. Dates and times of local drop in sessions for Mat B1 signing (from 20 weeks).</td>
<td>Anomaly Scan at hospital</td>
</tr>
<tr>
<td>15-20 minutes</td>
<td>BP, Urine, abdominal palpation. Take AFP/DRF blood if 1st Trimester screening not done.</td>
<td>Personalised growth charts to be placed in the green notes. P12 by records staff. Be a start leaflet to be given to young mothers by scan.</td>
</tr>
<tr>
<td>1st Trimester screening at hospital</td>
<td>Complete midwife to HV &amp; Children’s Centre communication form. Complete scan &amp; blood results, p 7 &amp; 8 Green notes. Document the booking blood results.</td>
<td>Review all social risk information and carry out a CAF if required.</td>
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<tr>
<td>Nulliparous women only</td>
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</table>

| 28 weeks | 30 minutes | Health Promotion and Parent Education to be discussed. Smoking status to be confirmed. Referred to stop smoking services if continuing to smoke. Start Birth Plan and discuss option of home birth for low risk women. Give Information about Fetal Movements. | BP, Urine, Abdominal palpation & measurement of fundal height & FH. Weigh. Blood samples to be taken for Antibody Test and to check for anaemia. Breastfeeding to be discussed and ‘a mother’s guide to breastfeeding’ given. ‘How I feed my baby without showing my boobs’ leaflet (Be A Star)*. Invited to Breastfeeding Support groups. Discuss peer support service. Advice concerning Vitamin K for baby will be discussed. Midwives distribute parent education leaflet (includes Breastfeeding workshop dates). | Complete 2nd Risk assessment p11 and review management plan. Document discussions in green antenatal notes. Complete breastfeeding information p. 19 and start birth plan p21. Complete p 15 antenatal visit information. Plot fundal height on customised growth chart. Results of anomaly scan p9. Mat B1 completed (for those not seen at 25 weeks). Question about mental health & domestic abuse. Start Birth Plan. | Review Risk assessment and ensure she is on the appropriate pathway. Make referral for team based care if required. Give Anti-D prophylaxis to those women who are RH neg. after taking blood samples, Give parent education leaflet to those who have not already received it. |

| 31 Weeks | 15-20 minutes | BP, Urine, Abdominal palpation & measurement of fundal height. | Complete p 15 antenatal visit information. Plot fundal height on customised growth chart. Results of blood tests documented p 7 & document action taken. | Arrange for Iron therapy and/or referral to team care if required. |
| Nulliparous women only | | | | |

| 34 Weeks | 20-30 minutes | Health Promotion and Parent Education to be discussed. Offer the option of home birth for those women who are low | BP, Urine, Abdominal palpation & measurement of fundal height. | Complete p 15 antenatal visit information. Plot fundal height on customised growth chart. Results of blood tests documented p 7 & | Arrange for Iron therapy and/or referral to team care if required. If planning a home birth, ensure that she is |
36 Weeks

<table>
<thead>
<tr>
<th>15-20 minutes</th>
<th>care of new baby, newborn screening tests (see p 44-69 of the booklet 'screening tests for you and your baby'), postnatal care and emotions following childbirth. Smoking status to be confirmed Re- refer to stop smoking services Advise on availability of NRT products and refer as necessary’</th>
</tr>
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<tbody>
<tr>
<td>BP, Urine, Abdominal palpation &amp; measurement of fundal height. Weight. Repeat FBC.</td>
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38 Weeks

<table>
<thead>
<tr>
<th>15-20 minutes</th>
<th>Signs of labour will be discussed and when and how to contact a midwife Discuss options for care if baby is overdue (term + 12 days) and an induction will be arranged at 40 + 12 to 40 +14 weeks Discuss options of having a membrane sweep at 41 weeks</th>
</tr>
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<tbody>
<tr>
<td>BP, Urine, Abdominal palpation &amp; measurement of fundal height.</td>
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</tr>
<tr>
<td>Complete p 15 antenatal visit information. Plot fundal height on customised growth chart. Results of blood tests documented p 7 &amp; document action taken.</td>
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</table>

Review Risk assessment and ensure she is on the appropriate pathway. Make referral for team based care if required.
<table>
<thead>
<tr>
<th><strong>40 weeks (Nulliparous women only)</strong></th>
<th>15-20 minutes</th>
<th>Discuss options of having a membrane sweep at 41 weeks</th>
<th>BP, Urine, Abdominal palpation &amp; measurement of fundal height.</th>
<th>Complete p 15 antenatal visit information. Plot fundal height on customised growth chart. Results of blood tests documented p 7 &amp; document action taken.</th>
</tr>
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<tbody>
<tr>
<td><strong>41 Weeks (For women who have not given birth by 41 weeks)</strong></td>
<td>15-20 minutes</td>
<td>BP, Urine, Abdominal palpation &amp; measurement of fundal height. Membrane sweep.</td>
<td>Complete p 15 antenatal visit information. Plot fundal height on customised growth chart. Results of blood tests documented p 7 &amp; document action taken.</td>
<td>Offer a membrane sweep Arrange IOL for T+ 12-14 with CDS.</td>
</tr>
</tbody>
</table>