# Infectious Diseases in Pregnancy screening: checks and audits to improve quality and reduce risks

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| **Identify the eligible population;** have systems to**:**   * record all pregnant women booking for antenatal care (including women who book late or present unbooked in labour) * record the screening offer, test or decline in the eligible population in every pregnancy * collect and submit data for IDPS standards and/or Key Performance Indicators (KPIs) | To make sure the eligible population who accepted the offer complete screening. Timing is crucial to facilitate timely entry into treatment and care  We have evidence from screening safety incidents of:   * women who are not offered screening, including women presenting unbooked in labour or with no laboratory evidence of screening results * unnecessary delays between presenting for maternity care and screening and between screening and entry into care | Maintain an accurate record of the  eligible population which includes screening tests and declines   * date of completion of the screening tests * processes in place for notification of declines to the screening team and follow up * processes in place for notification to screening team of unbooked women presenting on delivery suite with no reliable evidence of screening results * processes in place for women who do not attend and follow up actions * cross reference bookings with laboratory systems, to make sure any women not accounted for can be followed up * track all women through the system to a screening outcome   **It is advisable to engage IT teams from maternity and screening laboratories if systems are not already in place** | Weekly | Submit **quarterly** data on coverage KPIs (ID1, ID3 and ID4) to the NHS screening programmes |
| Trust response: this row for you to enter results or summarise whether you have these checks in place or not and if not to identify gaps and develop an action plan | | | | |

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| **Provide information, and offer and recommend screening;** have systems to:   * record that each woman is given the NHS screening programmes booklet “screening tests for you and your baby” (STFYAYB) * record that the verbal and written information about the 3 infections and the benefits of screening for the woman and her unborn baby has taken place * offer and recommend screening for each of the 3 infections | To support personalised informed choice.  Screening should not be offered as a suite of tests | Record the date that STFYAYB is given and discussed with the woman in the maternity notes/system  Make sure written information and the opportunity for discussion is provided in another language or an alternative format for those women who need it | Contemporaneously | **Annual** audit that STFYAYB was given and verbal discussion took place and the 3 infections are not offered as a suite of tests. This is evidenced by records in the maternity notes/system |
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| **Complete screening**  Take the sample and send to the laboratory with the required request form or completed electronic data fields; have systems to:   * identify sample as antenatal in the laboratory * record accept or decline for each infection | Earlier diagnosis leads to improves outcomes for mothers and babies  We have evidence from KPIs and screening safety incidents that screening is incomplete or delayed because:   * samples are taken but do not arrive in the laboratory * samples are not identified as antenatal in the laboratory * samples were tested where screening was declined * checks to follow up results are in place but these are not timely | Record declines or samples are taken and received in the laboratory and match against the eligible population | Weekly | Submit **quarterly** data for coverage KPIs (KPI ID1, ID3 and ID4) |
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| **Declined screening;** have systems to record screening declines for any of the 3 infections in order to:  facilitate a formal reoffer of screening by a member of the local multi-disciplinary team (MDT) before 20 weeks gestation or as soon as possible if booked after this gestation  make sure there is an outcome of the offer of screening | To make sure that the benefits of screening for the woman and her baby are communicated and understood | Have a process in place to ensure the receipt of the notification of a decline by the screening team  The healthcare professional responsible for offering screening should:   * record the decline in the maternity notes/system * notify the screening team immediately of any declines * if screening is declined for one or two conditions complete the details on the blood request form and send to the laboratory marked ‘decline’ for those infections   A member of the MDT should:   * make a formal reoffer of screening at a face to face appointment at or before 20 weeks gestation * inform the woman that she can have screening at any point during the pregnancy if she changes her mind or if she deems herself at risk * record this information in the maternity notes/system   If the woman declines the formal reoffer of screening, the local MDT will be responsible for further management in line with local clinical protocols  **The rationale of the reoffer is to facilitate an informed choice and not to coerce women to accept screening** | Contemporaneously when screening is declined | Review and monitor rates of declines as detailed in the **annual** standards data report and investigate any inequalities that may exist and any significant changes  **Annual** audit of the formal reoffer of screening by 20 weeks gestation for women who decline screening at booking |
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| **Laboratory analyses sample and report results as per national guidelines**; have systems in place to comply with the programme laboratory handbook | To make sure there is a timely and consistent approach to the management of screening samples, including analysis and reporting of results  We have evidence from screening safety incidents of:   * laboratories reporting screening results **before** confirmatory tests have taken place * no system in place to follow up samples with incorrect or incomplete request forms * no system in place to follow up requests for repeat samples * mismanagement of inconclusive results * inappropriate reporting of results on an IT system and not directly to screening team * manual decapping of samples resulting in cross contamination of samples | Have mechanisms in place to:   * participate in UK national external quality assessment service schemes for laboratories (all that apply) * monitor repeat tests for inconclusive results and samples not fit for purpose (between screening team and laboratory) * a communication process in place between lab and screening team for direct notification and recording of receipt of result | As per quality assurance scheme requirements  Weekly | Submit **annual** data on standard 4: Test turnaround time (HIV, hepatitis B and syphilis)  **Annual** audit of repeat requests for samples not ‘fit for analysis’ |
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| **Women who miscarry or terminate the pregnancy after screening has taken place**; have systems to make sure women receive results of all screening tests | Women are entitled to their test results.  To ensure timely discussion of options and onward referral for women with screen positive infections  We have evidence from screening incidents that women accept screening tests but:   * screening is not completed * women are not informed of their results | Have a system in place to identify women who miscarry or end their pregnancy after the screening test is completed  Screen positive results: the laboratory should notify the screening team to facilitate appropriate onward referral into specialist services.  Screen negative results: send a letter to the woman (template available on GOV.UK  Close the maternity care episode | Weekly | Submit **quarterly** data for coverage KPIs (ID1, ID3 and ID4)  **Annual** audit of women who miscarry or terminate the pregnancy receiving results (negative and positive). |
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| **Known positive women**; have processes to:   * make sure women enter the treatment pathway as quickly as possible * repeat tests and alert laboratory of known positive infection on request form as per local protocol * notify known positive infection to the screening team with a face-to-face appointment with the screening team within 10 working days of the known status being reported to the screening team * screening for other conditions offered and take a blood test if accepted * offer screening for syphilis in every pregnancy irrespective of previous results | To ensure timely discussion of options and onward referral for women with known infections  All women require triage in every pregnancy to make sure they have information on current infection status and management and treatment options  The appointment also facilitates health promotion and information on their care including neonatal care and vaccination schedules  We have evidence from screening safety incidents of women with known positive infections who were not seen appropriately within specialist services | The healthcare professional responsible for offering screening should:   * record the disclosure of known positive status in the maternity notes/system * notify the screening team immediately of any known positives * have a process in place to ensure the receipt of the notification by the screening team * if infection status is known for one or two infections complete the details on the blood request form and send to the laboratory marked ‘decline’   A member of the screening team should:   * make a timely appointment with the woman * record information in the maternity notes/system | Contemporaneously at the time of booking or transfer of care | Submit **annual** data for IDPS standard 5  Submit **quarterly** data for KPI ID2  **Annual** audit of standard 5 to establish why some women with known infections are not seen within 10 working days of disclosure |
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| **Screen negative result;** have systems to make sure:   * the laboratory records the result on the IT system * results are documented in the maternity records * results are communicated to women at the next antenatal contact | Women are entitled to their test results  We have evidence from screening incidents that women accept screening tests but:   * screening is not completed * women are not informed of their results | Check that all women who want the test are tested; record results and match against the eligible population | Weekly | **Annual** audit that results are given to women and recorded in the maternity notes/system |
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| **Confirmed screen positive result;** have systems to make sure:   * the laboratory records the confirmed result on the IT system * the laboratory contacts the screening team directly to inform them of the result * women should be invited for specialist assessment within 10 working days of the positive result being available to the maternity service * results are documented in the maternity records * women who are hepatitis B positive (new and high infectivity) should be seen by a specialist within 6 weeks of the positive result being reported to the maternity service | To ensure timely discussion of options and onward referral for women with a screen positive result.  We have evidence from screening safety incidents of:   * inappropriate reporting and management of results * delay in discussion and referral of screen positive women * delayed diagnosis and/or treatment | Have a communication process in place between laboratory and the screening team for direct notification and recording of receipt of result  Check that all women with a positive result are offered a face to face discussion within 10 working days of result of the results by the screening team and document attendance or decline and reason for decline  Complete a neonatal alert to identify babies who will need neonatal assessment and treatment | Weekly | Submit **annual** data for IDPS standard 5  Submit **quarterly** data for KPI ID2  **Annual** audit of standard 5 to establish why some women with screen positive results (including known infections- see above) are not seen within 10 working days of availability of the positive result |
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| **Follow up of babies born to screen positive/known positive women**; have systems to make sure the baby’s care is managed in line with national guidance.   * HIV – paediatric assessment in line with BHIVA and CHIVA guidelines * Hepatitis B – administration of vaccination (+/- HBIG) within 24 hours of birth and transfer of information to CHIS and GP to schedule further vaccinations/serology in line with Green Book guidance * Syphilis – paediatric assessment and treatment in line with BASHH guidelines | To make sure babies born to mothers with an infection receive appropriate care  We have evidence from screening safety incidents of:   * babies not given appropriate neonatal assessment and treatment or subsequent entry into paediatric care * delays in or failure to administer Hepatitis B vaccinations (+/- HBIG) * non-compliance with the neonatal immunisation schedule | Neonatal alert and birth plan completed by the multi-disciplinary team (MDT) antenatally.  Follow up by screening team for all neonatal outcomes. | Weekly | Tracking process by screening team for all babies due to deliver  Report neonatal outcomes to IDPS outcomes systems (ICH).  Submit data for IDPS standard 7 **annually** |
| **BHIVA** – British HIV Association, **CHIVA**- Children’s HIV Association, **HBIG**- hepatitis B immunoglobulin, **CHIS**- Child Health Information Service  **BASSH** –British Association for Sexual Health and HIV, **ICH-** Institute of Child Health | | | | |
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