**Haematology audit template**

|  |  |
| --- | --- |
| **Date of completion**  | (To be inserted when completed) |
| **Name of lead author/participants** | (To be inserted) |
| **Specialty** | Haematology |
| **Title** | **An audit of compliance with the British Society for Haematology guideline on the management of sickle cell disease in pregnancy** |
| **Background** | The British Society for Haematology (BSH) has published guidance on the management of pregnancy in women with sickle cell disease (SCD). This audit will review compliance with some of the recommendations made. |
| **Aim & objectives** | To review whether women with SCD are receiving appropriate care during the following phases of pregnancy: 1. preconception
2. antenatal
3. intrapartum
4. post-partum.
 |
| **Standards & criteria** | If the target (specified as 100% or 0% for each criterion) is not achieved, there should be documentation in the case notes that explains the variance.1. All pregnant woman with SCD should be offered partner screening and, if her partner is a carrier, early counselling, first-trimester diagnosis and a discussion of the options; target 100%.
2. Women with SCD who are attempting to conceive should not be taking hydroxycarbamide, unless the woman is considered to be at high risk of serious complications and blood transfusion is not feasible; target 0%.
3. Women with SCD who are attempting to conceive should not be taking ACE inhibitors; target 0%.
4. All women should receive antenatal care from a multidisciplinary team including an obstetrician and midwife with experience of high-risk antenatal care and a haematologist with links to a specialised haemoglobinopathy team; target 100%.
5. All women with SCD who are planning pregnancy should be offered folic acid 5 mg once daily (od) and this should be continued throughout pregnancy; target 100%.
6. Women with SCD should be considered for low-dose aspirin 75–150 mg od from 12 weeks of gestation; target 100%.
7. Women with SCD should be offered penicillin V 250 mg twice daily (bd) or an alternative throughout pregnancy; target 100%.
8. Women with SCD should be prescribed prophylactic low-molecular-weight heparin (LMWH) from 28 weeks gestation, or from presentation of pregnancy if there were additional risk factors; target 100%.
9. All women with SCD were prescribed prophylactic LMWH for six weeks after delivery; target 100%.
10. All women should receive post-partum contraceptive advice with this advice conveyed to the woman’s primary care team; target 100%.
 |
| **Method** | 1. **Sample selection**
* All women with SCD who are or have been pregnant in the preceding 12 months.
1. **Data to be collected on proforma (see below).**
 |
| **Results** | (To be completed by the author)The results of this audit show the following compliance with the standards.

|  |  |
| --- | --- |
| **Investigation** | **% compliance** |
| All pregnant woman with SCD were offered partner screening and, if her partner was a carrier, early counselling, first-trimester diagnosis and a discussion of the options  |  |
| No women were taking hydroxycarbamide while attempting to conceive unless at high risk of serious complications and blood transfusion was not feasible |  |
| No women were taking an ACE inhibitor while attempting to conceive |  |
| All women received antenatal care from a multidisciplinary team including an obstetrician and midwife with experience of high-risk antenatal care and a haematologist with links to a specialised haemoglobinopathy team |  |
| All women with SCD who were planning pregnancy were offered folic acid 5 mg od and this was continued throughout pregnancy |  |
| All women were considered for low-dose aspirin 75–150 mg od from 12 weeks of gestation  |  |
| All women were offered penicillin V 250 mg bd or an alternative throughout pregnancy |  |
| All women were offered prophylactic LMWH from 28 weeks gestation, or from presentation of pregnancy if there were additional risk factors |  |
| All women with SCD were prescribed prophylactic LMWH for six weeks after delivery |  |
| All women received post-partum contraceptive advice with this advice was conveyed to the woman’s primary care team |  |

 |
| **Conclusion** | (To be completed by the author) |
| **Recommendations for improvement** | Present the result with recommendations, actions, and responsibilities for action and a timescale for implementation. Assign a person(s) responsible to do the work within a time frame.**Some suggestions:*** highlight areas of practice that are different
* present findings.
 |
| **Action plan** | (To be completed by the author – see attached action plan proforma) |
| **Re-audit date** | (To be completed by the author) |
| **Reference** | Oteng-Ntim E, Pavord S, Howard R, RobinsonS, Oakley L, Mackillop L *et al*. Management of sickle cell disease in pregnancy. A British Society for Haematology Guideline. *Br J Haematol* 2021;194:980–995.<https://onlinelibrary.wiley.com/doi/10.1111/bjh.17671>  |

**Data collection proforma for pregnancy management in women with sickle cell disorders**

**Audit reviewing practice**

Patient name:

Hospital number:

Date of birth:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Standard** | **1****Yes**  | **2****No** | **3** If column 1 not ticked, was there documentation to explain the variance? **Yes/No** plus free-text comment | **4** Compliant with guideline if column 1 ticked or an appropriate explanation from column 3. **Yes/No**(Record if standard not applicable) |
| **1**  Were they offered partner screening and, if the partner was a carrier, were they offered early counselling, first-trimester diagnosis and a discussion of the options? |  |  |  |  |
| **2**  Was she taking hydroxycarbamide while attempting to conceive? *(A woman considered to be at high risk of serious complications for whom blood transfusion is not feasible is an exception for this standard)* |  |  |  |  |
| **3**  Was she taking an ACE inhibitor while attempting to conceive? |  |  |  |  |
| **4**  Was antenatal care provided by a multidisciplinary team including an obstetrician and midwife with experience of high-risk antenatal care and a haematologist with links to a specialised haemoglobinopathy team?  |  |  |  |  |
| **5**  Was she offered folic acid 5 mg daily while attempting to conceive and was this continued throughout pregnancy? |  |  |  |  |
| **6**  Was she offered aspirin 75–150 mg daily from 12 weeks gestation? |  |  |  |  |
| **7**  Was she offered penicillin V 250 mg bd or an alternative throughout the pregnancy? |  |  |  |  |
| **8**  Was she offered prophylactic LMWH from 28 weeks gestation, or from presentation of pregnancy if there were additional risk factors? |  |  |  |  |
| **9**  Was she prescribed prophylactic dose LMWH for six weeks post-delivery? |  |  |  |  |
| **10**  Was post-partum contraceptive advice given and conveyed to the woman’s primary care team? |  |  |  |  |

|  |
| --- |
| **Audit action plan**An audit of compliance with the British Society for Haematology guideline on the management of sickle cell disease in pregnancy |
| **Audit recommendation** | **Objective** | **Action** | **Time scale** | **Barriers and constraints** | **Outcome** | **Monitoring** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |