Mid Essex Hospital Services NHS
NHS Trust

NUTRITION IN LABOUR AND ANTACID PROPHYLAXIS FOR THE PREGNANT PATIENT AT TERM	CLINICAL GUIDELINES Register no: 04253 Status: Public

Developed in response to:	Intrapartum NICE Guidelines, CNST Requirement RCOG guideline
Contributes to CQC outcome	9, 12

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Version Number	6.0
Issuing Directorate	Obstetrics and Gynaecology
Ratified By	DRAG Chairmans Action
Ratified On	29th October 2017
Trusts Executive Sign Off Date	November 2017
Implementation Date	7th November 2017
Next Review Date	October 2020
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Policy to be followed by (target staff)	**Midwives, Obstetricians, Paediatricians**
Distribution Method	Intranet & Website. Notified on Staff Focus
Related Trust Policies (to be read in conjunction with)	04071 Standard Infection Prevention 04072 Hand Hygiene 09079 Guideline for the Management of Normal Labour and Prolonged Labour in Low Risk Patients 07069 Antacid Prophylaxis and Feeding Policy for Elective Caeasarean Sections

Document Review History:

Review No	Reviewed by	Active Date
1.0	Dr G Philpott	October 2002
2.0	Dr G Philpott	October 2005
3.0	Dr G Philpott	April 2008
3.1	Sarah Moon-Front sheet, equality and diversity; audit and monitoring update	June 2010
4.0	Sam Brayshaw	April 2011
5.0	Sam Brayshaw, Consultant Anaesthetist	April 2014
6.0	Sam Brayshaw, Consultant Anaesthetist	7 Nov 2017

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1.0 Purpose

1.1 Patients in labour may need to have their baby delivered as a matter of urgency due to either maternal or fetal compromise.

1.2 In certain circumstances this may necessitate a general anaesthetic.

1.3 There is an increased risk of reflux of gastric contents in a term pregnant patient and this is exacerbated by relaxation of the gastro-oesophageal sphincter when a general anaesthetic is administered.

1.4 This guideline is designed to classify patients into low and high-risk labour groups, which 11006 Pre-Eclampsia & Hypertension on DAU 3.0.pdfcorrelates with the increased risk of requiring a general anaesthetic in the high-risk labour group.

1.5 The feeding and antacid policy is designed to minimise the risk of reflux and to reduce the potential for aspiration of gastric contents into the lungs.

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 Definition of Low and High Risk Labour

3.1 There may be a debate over the definition of low and high-risk labour; this document is merely aimed at providing guidelines on risk stratification. The final decision is left to the individual midwife/ obstetrician

3.2 Low Risk Includes:

- Spontaneous labour, no known obstetric problems
- Induction of labour (no previous adverse obstetric history) including syntocinon augmentation
- Prolonged rupture of membranes (if no deviations from normal)
- Opiods or epidural analgesia

3.3 High Risk Includes:

- Multiple pregnancy
- Maternal medical problems
- Vaginal birth after caesarean section (VBAC)/ trial of Labour for previous section
- Combined risk factors i.e. epidural and syntocinon augmentation

4.0 Definition of Active Labour

4.1 Active labour is defined as the onset of strong, regular, painful contractions associated with progressive cervical dilatation (> 4cm) and descent of the presenting part.

5.0 Feeding and Antacid Guidance

5.1 Early and active labour - **low risk**:

- Normal diet in early labour
- A light diet is recommended for established labour
- Antacid prophylaxis is not required

5.2 Early and active labour - **high risk**:

- A light diet is recommended in early labour
- Once labour is established, 150mg ranitidine orally every 6 hours with oral intake restricted to water, fruit squash or isotonic non-carbonated drinks

5.3 Normal diet constitutes any foodstuffs

5.4 Light diet is classified as tea, coffee, toast, fruit, yoghurt, cereals, biscuits and low fat snack foods

5.5 Drinking in labour - carbonated drinks and fruit juices are found to delay gastric emptying. Cold iced water or drinks that are isotonic (<30Kcal/100ml) for example lucozade sport are best for established labour. In addition, clear squash should be encouraged, emphasizing that the squash must be diluted.

5.6 Emergency or urgent anaesthesia for caesarean section; at decision to operate, the medical practitioner is to give:

- Metoclopramide, 10mg intravenously
- Ranitidine, 50mg intravenously (diluted in 10mls normal saline 0.9% and given slowly)
- Immediately prior to induction of general anaesthesia: sodium citrate 0.3M, 30mls by mouth

6.0 Staffing and Training

6.1 All midwifery and obstetric staff must attend a yearly statutory training to ensure that

their knowledge and skills are up-to-date in order to complete their portfolio for appraisal.

7.0 Professional Midwifery Advocates

7.1 Professional Midwifery Advocates provide a mechanism of support and guidance to women and midwives. Professional Midwifery Advocates are experienced practising midwives who have undertaken further education in order to supervise midwifery services and to advise and support midwives and women in their care choices.

8.0 Audit and Monitoring

8.1 Completed adult resuscitation checklists will be collected and archived on a monthly basis to assess overall compliance each month.

8.2 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.

8.3 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.

8.4 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.

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

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

9.0 Communication

9.1 A quarterly 'maternity newsletter' is issued to all staff to highlight key changes in clinical practice to include a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly. Midwives that
are on maternity leave or 'bank' staff have letters sent to their home address to update them on current clinical changes.

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

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

9.4 Regular memos are posted on the guideline and audit 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.

10.0 Guideline Management

10.1 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.

10.2 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.

10.3 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.

10.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for future training needs will be met using methods such as 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

11.0 References

Yentis, S M (2007) Analgesia, Anaesthesia and pregnancy: A practical guide. WB Cambridge University Press.