Mid Essex Hospital Services NHS
NHS Trust

ABDOMINAL PALPATION AND EXAMINATION IN PREGNANCY	**CLINICAL GUIDELINES** **Register No: 07043** **Status: Public**

Developed in response to:	Intrapartum NICE Guidelines RCOG guideline
Contributes to CQC Regulation	9, 12

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Related Trust Policies (to be read in conjunction with)	04071 Standard Infection Prevention 04072 Hand Hygiene 06036 Guideline for Maternity Record Keeping including Documentation in Handheld Records 09079 Management of Normal Labour and Prolonged Labour in Low risk Patients 04272 Maternity Care 15004 Assessment of Fetal Growth during the Antenatal Period

Document History Review:

Review No:	**Reviewed by:**	**Review Date:**
1.0	Hazel Smith	August 2007
2.0	Sarah Moon	September 2010
3.0	Sarah Moon	October 2013
4.0	Sarah Moon	5 October 2016

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1.0 Purpose

1.1 Abdominal examination and palpation is a screening procedure that should be performed at each antenatal appointment from 24 weeks to estimate fetal size and from 36 weeks gestation to assess fetal presentation.

1.2 It should be performed on admission to hospital, prior to an auscultation of a fetal heart, cardiotocograph (CTG), vaginal examination (VE), prior to any intervention i.e. external cephalic version (ECV) and daily if an antenatal inpatient.

1.3 Abdominal palpation can also be used as a means to assess, length, frequency and strength of uterine contractions and postnatally to gauge uterine involution.

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 Aims of Abdominal Palpation

3.1 The specific aims are to:

- Observe the signs of pregnancy
- Estimate gestation
- Assess fetal growth (symphysis- pubic height should not be measured until 24 weeks of gestation)
- Auscultate the fetal heart
- Locate fetal position, lie, engagement and presentation
- Detect any deviation from the normal.

4.0 Preparation

4.1 Preparation for abdominal examination and palpation include:

- Taking infection prevention precautions against cross-infection
- Ensuring the patient has a full understanding of the procedure
- The patient has given informed consent and this is documented in the patient's healthcare records
- Ensure privacy and comfort
- The patient has an empty bladder to reduce inaccurate measurements and discomfort
- Gather equipment, single tape measure, pinard/Dopplar

5.0 Position for the Procedure

5.1 To further reduce any inaccuracies the patient should adopt an almost recumbent/ dorsal position, with her knees slightly bent and arms by her side. Should the patient suffer from supine hypotensive syndrome, then a left lateral position should be adopted.

6.0 Inspection

6.1 Inspection of the abdomen is the first technique that should be employed by the examining practitioner. This should include size, shape, rashes, striae gravidarum, scars, bruises, fetal movements and contractions.

6.2 Abdominal size will give the practitioner an idea as to fetal size and if the pregnancy is singleton or not.

6.3 Abdominal shape (ovoid, round or others) gives an indication of fetal lie. If the uterus is longer than it is broad, it is most likely longitudinal. If the uterus is low and broad, the fetus is generally transverse. Should the fetus be in an occipitoposterior position then a saucer-like dip may be seen at the umbilicus. Multiparous patients may have a pendulous abdomen/ anterior obliquity of the uterus, due to lax abdominal muscle. This should not be seen in a primigravida, as it may indicate pelvic contraction.

6.4 Striae gravidarum from previous pregnancies appear silvery whereas striae gravidarum from the current pregnancy are pink. Pigmentation may also change longitudinally in the centre of the abdomen; this is a normal characteristic of pregnancy known as linea nigra.

6.5 Scars may indicate previous abdominal or obstetric surgery.

6.6 Fetal movements may be visible, although this is more common with primigravid patients with a snug ovoid uterine shape. Contractions too may be visible, and aid the practitioner in determining the frequency and strength of contractions.

6.7 Routine formal fetal movement counting should not be offered.

7.0 Auscultation of the Fetal Heart

7.1 Auscultation of the fetal heart may confirm that the fetus is alive but is unlikely to have any predictive value and routine listening is therefore not recommended. If the patient requests, auscultation of the fetal heart may provide reassurance. The maternal radial pulse should be assessed and documented in the health care records with every auscultation to confirm the difference in beat from maternal and fetal pulse.

8.0 Abdominal Palpation during the Antenatal and Labour Period

(Refer to Appendix A)

8.1 Fundal palpation should be performed first to assess if fetal growth is consistent with the gestational age. To gauge if fetal growth is in line with the stage of pregnancy, the distance between the symphysis pubis and fundus (SFH) should be taken in centimetres (cm) using a disposable tape measure. The tape measure should be placed longitudinally along the abdomen, with the start of the tape at the top of the symphysis pubis.

8.2 Start the measurement by first identifying the variable point, the fundus, and then measuring to the fixed point, the symphysis pubis, with the cm values hidden from the examiner. Symphysis-fundal height should be measured and recorded at each antenatal appointment in the patient's healthcare records from 24 weeks gestation.

8.3 The SFH should be plotted on the Customised Growth Chart and if any deviations from the norm then action should be taken as per guideline.
(Refer to the guideline entitled 'Assessment of fetal growth during the antenatal period' (15004)

8.4 If the patient's named obstetric consultant is not present in the Antenatal Clinic when the patient presents with her ultrasound scan for growth; then the patient should be reviewed by the obstetric registrar or consultant on call in the Day Assessment Unit.

8.5 SFH should only be used on singleton pregnancies.

8.6 Fundal palpation can also be employed to monitor uterine contractions, which can also be helpful to aid the patient on when to start using entonox or other pain relief.

8.7 Lateral palpation is used to determine fetal position/ lie (longitudinal, oblique or transverse). Lateral palpation should include both hands on either side of the uterus whilst the other hand progresses down the length of the uterus.

8.8 Pelvic palpation is used to determine fetal presentation, if the presenting part is engaged and the degree of flexion. The two handed technique (fingers are directed downwards and inwards) is generally preferred by patients compared to Pawlik's manoeuvre (practitioner 'grasps the lower pole of the uterus between her fingers and thumb' which should be spread wide enough apart to accommodate the presenting part).

8.9 Fetal presentation should be assessed by abdominal palpation at 36 weeks gestation or later when presentation is likely to influence the plans for the birth.

8.10 Suspected fetal malpresentations should be confirmed by an ultrasound assessment.

8.11 Abdominal palpation to include fundal height, lie, presentation, position and station/ engagement of the presenting part; and duration of contractions. The FHR (fetal heart rate) should be auscultated for 1 minute immediately after a contraction for at least 1 minute; the maternal pulse should be palpated to differentiate between the heart rates of the woman and the baby

8.12 In labour pelvic palpation can also help determine progress of descent of the presenting part. During established labour an abdominal palpation should be performed in the following circumstances:

- The midwife responsible for the patient; and subsequently on each shift change
- Review of a woman by the obstetric registrar/consultant on call
- Prior to a vaginal examination
  (Refer to the guideline for the 'Management of normal labour and prolonged labour in low risk patients'; register number 09079)

9.0 Postnatal Examination

9.1 The National Institute for Clinical Excellence (NICE) do not recommend assessing for uterine involution at each postnatal check, unless otherwise indicated, and is therefore performed at the discretion of the practitioner caring for the patient postnatally.

10.0 Staffing and Training

10.1 All qualified midwifery and obstetric staff are fully trained to perform abdominal palpation and as this skill is carried out on a daily basis, Midwifery and medical students may undertake performing abdominal palpation while under the supervision of a midwife or obstetrician.

11.0 Supervisor of Midwives

11.1 The supervision of midwives is a statutory responsibility that provides a mechanism for support and guidance to every midwife practising in the UK. The purpose of supervision is to protect women and babies, while supporting midwives to be fit for practice'. This role is carried out on our behalf by local supervising authorities. Advice should be sought from the supervisors of midwives who are experienced practising midwives who have undertaken further education in order to supervise midwifery services. A 24 hour on call rota operates to ensure that a Supervisor of Midwives is available to advise and support midwives and women in their care choices

12.0 Infection Prevention

12.1 All staff should follow Trust guidelines on infection prevention by ensuring that they effectively 'decontaminate their hands' before and after each procedure.

12.2 All staff should ensure that they follow Trust guidelines on infection prevention. All invasive devices must be inserted and cared for using High Impact Intervention guidelines to reduce the risk of infection and deliver safe care. This care should be recorded in the Saving Lives High Impact Intervention Monitoring Tool Paperwork (Medical Devices).

13.0 Audit and Monitoring

13.1 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.

13.2 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.

13.3 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.

13.4 Key findings and learning points from the audit will be submitted to the Clinical Governance Group within the integrated learning report.

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

14.0 Guideline Management

14.1 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.

14.2 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.

14.3 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.

14.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for further training; possibly involving 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

15.0 Communication

15.1 A quarterly 'maternity newsletter' is issued and available to all staff including an update on the latest 'guidelines' information such as a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly.

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

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

15.4 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.

16.0 References

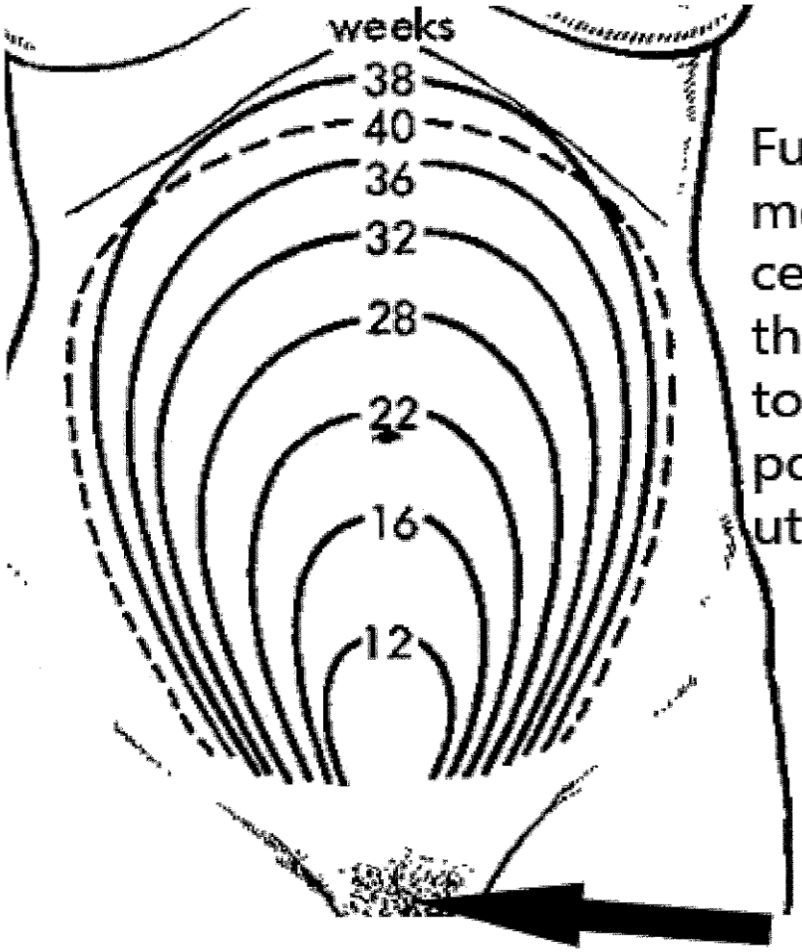
National Institute for Clinical Excellence (2014) Intrapartum Care: Care of healthy women and their babies during childbirth. December: NICE (CG190).

National Institute for Clinical Excellence (2010) Antenatal care. Routine care for the healthy pregnant woman. Clinical Guideline 62. NICE: London.

National Institute for Health and Clinical Excellence (2006) Routine postnatal care of women and their babies. NICE: London; July.

Fundal Height Measurement

Appendix A



Fundal height is measured in centimeters from the pubic symphysis to the top most portion of the uterus

Pubic Symphysis

Height of Fundus