

Mid Essex Hospital Services

NHS Trust

ADMINISTRATION OF ANTENATAL STEROIDS	CLINICAL GUIDELINES Register No: 07065 Status: Public
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1.0	Julie Bishop	October 2002
2.0	Sarah Moon	October 2007
2.1	Sarah Moon - Front sheet, equality & diversity; audit & monitoring update	May 2010
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1.0 Purpose

- 1.1 Antenatal maternal administration of steroids in premature labour reduces the incidence of respiratory distress syndrome (RDS), necrotising enterocolitis and intra-ventricular haemorrhage in neonates resulting in reduced perinatal mortality and morbidity rates.
- 1.2 RDS is known to affect 40-50% of babies born before 32 weeks gestation.
- 1.3 The efficacy of neonatal surfactant therapy is enhanced by antenatal exposure to corticosteroids
- 1.4 Clear benefits have been cited regarding the use of antenatal corticosteroids after prolonged premature rupture of membranes (PPROM)

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 Indications for Antenatal Corticosteroids

- 3.1 Antenatal corticosteroid therapy in patients should be initiated between 24 weeks to 34 weeks and 6 days gestation with any of the following:
 - Threatened pre-term labour
(Refer to the guideline for the 'Management of preterm labour to incorporate the administration of intravenous atosiban'; register number 09002)
 - Antepartum haemorrhage if considered to be at risk of preterm delivery
(Refer to the guideline for the 'Management of a patient reporting antepartum Haemorrhage'; register number 07072)
 - Preterm rupture of membranes
- 3.2 Most benefit is obtained in terms of reduced respiratory morbidity when delivery occurs between 24 hours and 7 days after administration of the second dose of steroids. Steroids should be given even if birth within 24 hours anticipated as they reduce neonatal death.
- 3.3 Steroids may be given between 23 weeks and 23 weeks and 6 days gestation if threatened preterm birth but should be a consultant decision.
- 3.4 Patients undergoing elective Caesarean section prior to 39 weeks gestation should be offered a course of steroids to reduce neonatal respiratory morbidity.
- 3.5 Prophylactic corticosteroids should not be offered routinely to women with multiple pregnancy or history of previous preterm birth without signs of being at risk of preterm birth.
- 3.6 Pregnancies affected by fetal growth restriction between 24 weeks and 0 days gestation and 35 weeks and 6 days gestation at risk of delivery should receive a single course of antenatal corticosteroids.

- 3.7 The risk of respiratory distress (RDS) at 37, 38 and 39 weeks gestation is 3.9, 3.0 and 1.9 respectively. At MEHT the use of steroids prior to 39 weeks gestation will be assessed on an individual basis at the discretion of the obstetric consultant. The obstetric consultant requesting the steroids should be responsible for documenting the plan of care in the woman's health care records and prescription chart.
- 3.8 A repeat course of steroids should only be considered if the first dose was given before 26 weeks gestation and after discussion with a consultant obstetrician.

4.0 Cautions to the Use of Corticosteroids

- 4.1 A single course of antenatal corticosteroids does not appear to cause any significant maternal or fetal effects.
- 4.2 Caution should be used when giving steroids to women with active tuberculosis or sepsis. Corticosteroids may be given in overt chorioamnionitis but should not delay delivery if otherwise indicated.
- 4.3 Maternal diabetes is not a contraindication to steroid administration but close monitoring of blood sugars with a low threshold for insulin sliding scale is recommended.

5.0 Dosage and Route of Administration

- 5.1 Betamethasone is the steroid of choice to enhance lung maturation.
- 5.2 **Prophylaxis** will take the form of a **single course** of:
- **Two doses of betamethasone 12 mg, given intramuscularly (IM) 24 hours apart**
 - If delivery is expected within 12 hours, betamethasone 12mg IM should be given at an interval of 12 hours
- 5.3 In such circumstances where betamethasone is not available; dexamethasone can be administered in exactly the same dosage and route. Furthermore, if the first dose of betamethasone has been administered and subsequently becomes unavailable prior to the administration of the second dose; in this situation dexamethasone can be administered. (Refer to point 5.0, 5.1 and 5.2 for dosage and route of administration)

6.0 Staff and Training

- 6.1 Midwives are qualified to undertake this by reasons of their professional training
- 6.2 Midwifery and medical students may administer the antenatal corticosteroid intramuscular injection under the supervision of the midwife or obstetrician respectively

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 Infection Prevention

8.1 All staff should ensure that they follow Trust guidelines on infection prevention, using Aseptic Non-Touch Technique (ANTT) when carrying out this procedure.

9.0 Audit and Monitoring

9.1 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.

9.2 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.

9.3 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.

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

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

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 further training; possibly involving 'workshops' or to be included in future 'skills and drills' mandatory training sessions

11.0 Communication

- 11.1 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.
- 11.2 Approved guidelines are published monthly in the Trust's Staff Focus that is sent via email to all staff.
- 11.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.
- 11.4 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.

12.0 References

Royal College of Obstetricians and Gynaecologists. (2010) Antenatal corticosteroids to reduce neonatal morbidity and mortality; Green-top Guideline 7; October; RCOG: London.

Crowther, C; Alfirevic, Z; Haslam, R. (2007) Thyrotropin-releasing hormone added to corticosteroids for women at risk of preterm birth for preventing neonatal respiratory disease. Cochrane Database of Systematic Reviews, 2007, no. 3 (CD000019).