Preterm Labour and Delivery
Clinical Guideline V1.6

July 2018
1. **Aim/Purpose of this Guideline**

Preterm labour is defined as labour after 24 weeks gestation and before 37 weeks gestation and is a major cause of perinatal morbidity and mortality. This guideline gives guidance to Obstetricians and Midwives on identifying those at risk of preterm labour, the recognition of preterm labour and the management of established preterm labour and delivery should this arise.

This guideline also gives guidance to obstetricians and midwives on the use of Magnesium Sulphate for fetal neuroprotection in preterm birth, including preterm labour, induction of labour and emergency caesarean section before 34 weeks gestation.

2. **The Guidance**

2.1 **Antenatal Referral for Cervical length scanning**

There is no evidence for cervical cerclage in low risk women with an incidental finding of shortened cervix on ultrasound. Therefore cervical length scanning should only be offered to women deemed at risk of preterm labour (see below). Before referral for cervical length ultrasound, discuss with the woman how this information may impact on her pregnancy. Inform her that expectant management is a reasonable alternative as there are no studies comparing ultrasound with expectant management; and majority of women after one preterm birth will deliver after 33/40.

Women with a singleton pregnancy who can be offered referral for a single cervical length between 16-24 weeks gestation are:

- Women with a history of mid-trimester loss or preterm birth between 16-34 weeks gestation
- Women with a history of preterm pre-labour rupture of membranes in a previous pregnancy
- Women with a previous LLETZ of >10mm depth.

If an ultrasound shows a cervical length <25mm the woman should have a discussion with her consultant about the risks and benefits of vaginal progesterone, cervical cerclage or expectant management.

If progesterone is to be used, prescribe Cyclogest Vaginal Pessaries PV until 34/40 gestation.

Cervical length scans should be organised through The Fetal Medicine Unit.

All women who had had a preterm birth should be advised of the symptoms and signs of preterm labour and advised to contact her midwife/GP if she experiences any of them.
2.2 **Diagnosing Preterm Labour**

2.2.1 **Memoire for routine gestation limits for interventions**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Gestation from 24+0 until:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Magnesium Sulphate</td>
<td>33+6</td>
</tr>
<tr>
<td>Atosiban</td>
<td>33+6</td>
</tr>
<tr>
<td>Steroids</td>
<td>34+6</td>
</tr>
<tr>
<td>Fetal Fibronectin</td>
<td>34+6 (for transfer) 33+6 (for Atosiban)</td>
</tr>
</tbody>
</table>

2.2.2 **Initial Management**

- Establish accurate gestational age
- Take history to include character of any pain, vaginal loss, fetal movements and any non-obstetric symptoms
- General examination relevant to presenting symptoms
- Abdominal palpation for tenderness, palpable contractions to include strength and length, fundal height, fetal lie, presentation and descent
- Abdominal ultrasound if presentation not clear on palpation
- Mid-stream urinalysis to exclude infection. Send for culture if positive for leucocytes and nitrites and treat with antibiotics pending result (not co-Amoxiclav because of the risk of Necrotising Enterocolitis)
- Consider necessity for Fibronectin testing (See Section 2.2.4.1) before proceeding to vaginal examination

2.2.3 **Vaginal Examination**

- Undertake vaginal cusco speculum to assess the cervix, presence of liquor or blood. Fetal Fibronectin to be undertaken (FFN) if no contraindications (see section 2.2.4.1)
- If pooling of amniotic fluid is observed, do not perform any diagnostic test but offer care consistent with the woman having PPROM (see guideline)
- If there is uncertainty as to whether the fluid observed is amniotic fluid or discharge consider performing an Actim PROM test if the history is strongly suggestive of PPROM
- If the Actim PROM is positive, do not use the test results alone to decide what care to offer the woman, but also take into account her clinical condition, her medical and pregnancy history and gestational age, and either:
offer care consistent with the woman having PPROM

re-evaluate the woman's diagnostic status at a later time point.

- If the Actim PROM is negative or there is no pooling of fluid then explain to the woman that it is unlikely that she has PPROM, but that she should return if she has any further symptoms suggestive of PPROM or preterm labour.

- Digital vaginal examination (if PPROM or placenta praevia not suspected) for cervical consistency, position, station of presenting part, effacement and dilatation. This should not be performed prior to FFN

2.2.4 Fibronectin Testing

2.2.4.1 Who to Test

- Women who are being considered for tocolysis
- Women who are being considered for in utero transfer
- Fibronectin levels are higher in multiple pregnancies so thresholds for treatment are more likely to be reached. However, a low level may assist conservative management (New 2018)

2.2.4.2 Contraindications to Testing

- Vaginal bleeding (microscopic spots of blood cause false positive tests)
- Ruptured membranes (amniotic fluid contains a large amount of Fibronectin)
- Intercourse or vaginal examination with lubricant with the last 24 hours (false positives more likely, although negative result still useful)
- Gestation <24 weeks or >34+6 weeks

2.2.4.3 How to Test (See Appendix 3)

- Read the instructions in the kit prior to commencing
- Perform a speculum examination to visualise the cervix. DO NOT use lubricants, use tap water
- Gently soak the swab in the secretions of the posterior vaginal fornix for 10 seconds, avoiding getting large amounts of mucus on the swab
- Process the swab according to the kit instructions

2.2.4.4 Interpretation of Fibronectin Results

Use quantitative fetal fibronectin when interpreting fibronectin results and counselling patients. The positive predictive value increases with increasing fibronectin results. When considering steroids or intrauterine transfer use a threshold of 200.
<table>
<thead>
<tr>
<th>fFN level</th>
<th>N (%)</th>
<th>≤ 7 days</th>
<th>≤ 14 days</th>
<th>≤ 34 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 10 ng/ml</td>
<td>170 (57%)</td>
<td>1%</td>
<td>1.8%</td>
<td>1.5%</td>
</tr>
<tr>
<td>11-49 ng/ml</td>
<td>62 (21%)</td>
<td>0%</td>
<td>1.6%</td>
<td>8.2%</td>
</tr>
<tr>
<td>50-199 ng/ml</td>
<td>41 (14%)</td>
<td>0%</td>
<td>7.7%</td>
<td>11.5%</td>
</tr>
<tr>
<td>200-499 ng/ml</td>
<td>14 (5%)</td>
<td>14%</td>
<td>29%</td>
<td>33%</td>
</tr>
<tr>
<td>≥500 ng/ml</td>
<td>13 (4%)</td>
<td>38%</td>
<td>46%</td>
<td>75%</td>
</tr>
</tbody>
</table>

2.3 **Administration of Corticosteroids**

2.3.1 Maternal antenatal corticosteroids reduce the risk of neonatal respiratory distress syndrome, intraventricular haemorrhage and death. Optimal benefit is observed if delivery is between 24 hours and 7 days of administration but benefits may occur before and after these times.

2.3.2 The decision to prescribe steroids should be made by an experienced obstetrician. It is a balance between the clear benefits of the medication and the potential to waste that benefit if given when likelihood of delivery is low (especially for the women who deliver >2 weeks later and still <34+6 weeks). Steroids will usually be given only after objective evidence of cervical change but in cases of a convincing past and present history this is not mandatory.

2.3.3 Steroids should be offered at 24+0-34+6 weeks gestation to women at risk of preterm birth. The decision to prescribe them at earlier gestations should be made by the Obstetric Consultant with input from the neonatal team.

2.3.4 Dexamethasone/Betamethasone 12mg IM, two doses, 24 hours apart should be administered.

2.3.5 DO NOT reduce the interval between doses to 12 hours. There is no evidence of additional benefit and the benefit of the second dose may be wasted (receptors may still be saturated by the first dose).

2.3.6 For women with diabetes please see Management of Diabetes in Pregnancy Guideline.

2.4 **Tocolysis**

2.4.1 **Using Tocolysis**
RCOG guidance states that it is reasonable not to use tocolytic drugs, as there is no clear evidence that they improve outcome. However both NICE and RCOG recommend tocolysis should be considered to
complete a course of steroids or for intrauterine transfer providing there are no contraindications.

2.4.2 **Atosiban (Tractocile®) is the tocolytic of choice**
- Licensed for use in pregnancy to delay preterm delivery
- Oxytocin antagonist
- IV administration
- Initial bolus, then high dose infusion for 3 hours followed by low dose infusion for <45 hours
- Half-life is 13 minutes so there is no additional risk of Post Partum Haemorrhage.
- If contractions re-commence after atosiban has been stopped, it can be restarted if steroid course is incomplete

2.4.3 **Atosiban Side Effects**
Nausea is very common (decreased by giving bolus slowly). Hyperglycaemia headache and dizziness, tachycardia, hot flush, hypotension, vomiting and injection site reaction are common. Insomnia, pruritis, rash, pyrexia and allergic reaction are uncommon

2.4.4 **Prerequisites for Using Atosiban**
- Regular uterine contractions lasting 30 seconds at a rate of ≥ 4 in 30 minutes
- Cervical dilation of 0 to 3 cm
- Gestation from 24+0 to 33+6 weeks
- Normal fetal heart rate
- Fetal Fibronectin >200units (if appropriate to test)
- Agreement from consultant on call (who may also consider use at >3cm, <24weeks or >33+6 weeks)

2.4.5 **Discussion and Documentation of risks and benefits with verbal consent.**
Acknowledge absence of licence for Preterm Pre-Labour Rupture of Membranes (PPROM) < 30 weeks and limited experience of use in multiple pregnancies

2.4.6 **Contra-indications to Using Atosiban**
- Fetal Fibronectin <200ng/ml
- Evidence of fetal compromise
- Intrauterine infection
- Any maternal or fetal condition that warrants delivery (e.g. pre eclampsia)
- Known hypersensitivity to Atosiban or any of the contents in Tractocile®

2.4.7 **Relative Contra-indications to using Atosiban**
- Rupture of membranes – unless requiring transfer out to another unit
- Antepartum haemorrhage, unless reviewed by an Obstetric Consultant
- Fetal Growth Restriction

### 2.4.8 Administration of Atosiban

Give 6.75mg (0.9ml of 7.5mg/ml of solution from vial) IV over 1 minute via a 1ml syringe

- **Prepare infusion in 0.9% sodium chloride**
  - Withdraw 10ml from 100ml bag and discard
  - Add 10ml of 7.5mg/ml concentrate (From 2 vials) to the bag and mix well*
  - Resulting solution contains 750micrograms/ml

- Set pump to run infusion at **24ml/hr for 3 hours**
  - I.e. set ‘volume to be infused’ to 72ml
  - When pump alarms at end of 72 ml DO NOT discard remaining solution

- Decrease rate to **8ml/hr**

  *For subsequent bags withdraw 5ml from a 50ml 0.9% sodium chloride bag and discard
  - Add 5ml of 7.5mg/ml concentrate (i.e. 1 vial) to the bag and run at **8ml/hour** for 50ml

- Discontinue if labour establishes

- Review after 24 hours. In most cases, discontinuation is reasonable

- Total duration of treatment should not exceed 48 hours

### 2.4.9 Monitoring whilst on Atosiban

- MEOWS chart record maternal blood pressure every 15 minutes for the first hour then hourly until the infusion rate is reduced. Then continue 4 hourly.
- Blood Glucose at start of treatment and 4 hourly thereafter
- A plan for the assessment of fetal wellbeing should be determined by the Obstetrician and will depend on gestation and cause for preterm labour
2.5 **Magnesium Sulphate**

Magnesium Sulphate should be considered in women in established preterm labour (cervical dilatation of >4cm with regular contractions) or having a planned preterm delivery 24 and 33+6 weeks gestation.

Magnesium Sulphate given to mothers shortly before delivery reduces the risk of cerebral palsy and protects gross motor function in those infants born preterm. The effect may be greatest at early gestations (<30 weeks) and is not associated with adverse long-term fetal or maternal outcome.

2.5.1 **Regime**

- A loading dose of 4 grams (8 ml of 50% magnesium sulphate), diluted with 12 ml of saline 0.9% (total 20 ml), is given IV over 5-10 minutes using a 20 ml syringe
- A maintenance dose of 10 grams (20ml Magnesium Sulphate), diluted with 30 ml of saline 0.9% (total 50 ml) is set up to deliver 1 gram per hour (5mls/hr) using a syringe driver, until delivery.
- If delivery is imminent it is appropriate to give only the loading dose
- For a planned LSCS delivery start the regime 4 hours prior to expected delivery time

2.5.2 **Care of the Women**

- Women should receive routine care for preterm labour; this should be recorded on a partogram and on the obstetrics pages.
- In addition a MEOWS chart must be commenced for hourly maternal observations of temp, respiratory rate, pulse and blood pressure, tendon reflexes, fluid intake and urine output. If the MEOWS score begins to rise, there are any concerns about urinary output or tendon reflexes are slow or are absent there must be a medical review.
- Women should be advised of an increased risk of hypotension and tachycardia and minor adverse effects, such as facial flushing, nausea, vomiting, sweating and injection site problems.
- If there are signs of magnesium toxicity (oligouria, respiratory depression or supressed/absent reflexes), medical review should be requested and if this is not possible the infusion stopped. Calcium Gluconate should be used if evidence of magnesium toxicity.
2.6 Fetal Monitoring

- There is an absence of evidence that the use of cardiotography (CTG) improves the outcome for a preterm baby compared with intermittent auscultation. A woman in established preterm labour with no other risk factors, after discussion about the role of different monitoring, can be offered a choice of either continuous CTG or intermittent auscultation. Additional risk factors include maternal hypertension, meconium stained liquor, fresh vaginal bleeding, suspected chorioamnionitis, oxytocin use or prolonged rupture of membranes.

- In high risk cases CTG should be used from 28/40. Prior to this gestation the decision about fetal monitoring should be made by a senior obstetrician and in some circumstances no monitoring may be appropriate.

- Fetal scalp electrodes should not be routinely used prior to 34/40

- Fetal blood sampling should not be performed prior to 34/40 and with caution under 37 weeks gestation.

- ST Analysis should not be used prior to 36 weeks

2.7 Management of Labour and Delivery

- If cephalic presentation and no additional risk factors aim for a vaginal birth. The safety of ventouse delivery prior to 36/40 is uncertain, and it is contraindicated prior to 34/40

- The decision about mode of delivery in non-vertex presentations should be made with the oncall obstetric consultant after a consideration of the risks and benefits of caesarean section.

- Ensure neonatal team are present at delivery

- If mother and baby are stable, delay cord clamping for 3mins- ensure baby is positioned level or below the placenta prior to cord clamping.

- If immediate cord clamping is required consider milking the cord

- Keep cord long as it may be required for venous access

- Babies delivered at less than 32/40 gestation should be placed in a plastic bag without drying, a hat placed on baby’s head (after drying) and nursed under a heat source.
2.8 **IV antibiotics for labour**

- All women, irrespective of Group B Streptococcus (GBS) history or status, should be offered Intrapartum antibiotic prophylaxis (IAP), to prevent a possible transmission of GBS, once labour has established with regular contractions and cervical dilatation > 4cm. This is regardless of PPROM or intact membranes (NEW 2017)

- Antibiotics should not be offered for threatened preterm labour in the absence of membrane rupture (NEW 2017)

- IAP is not required for preterm caesarean section in the absence of membrane rupture (New 2017)

2.9 **Neonatal Issues**

- Inform Neonatal Unit of threatened / established preterm labour

- An experienced neonatal practitioner should discuss anticipated neonatal management with the woman and her partner

- The decision for in utero transfer should be made after discussion with Consultant Obstetrician and Neonatologist

- Management of extremes of viability should involve the Consultant Obstetrician and Neonatologist in discussion with the parents. Ideally with a current ultrasound determined EFW.

- If the gestation is certain, resuscitation is usually commenced >24/40 and the neonatal team should attend delivery. Below 23/40 it is generally considered not in the best interests of the baby to commence resuscitation and neonatal attendance is not required. Gestations of 23+0 - 23+6 the decision to commence resuscitation is individualised.
3. Monitoring compliance and effectiveness

| Element to be monitored | • Atosiban  
|                         | • Magnesium Sulphate Regime  
|                         | • Antibiotics for preterm labour  

| Lead | Obstetric Audit Lead |

| Tool | • Women who receive Atosiban fit the criteria as identified in the guideline  
|      | • Are all women who present in established preterm labour offered Magnesium Sulphate  
|      | • Are all women in established preterm labour offered intrapartum antibiotics  
|      | • Is a MEOWS chart commenced for hourly maternal observations of temp, respiratory rate, pulse, blood pressure, tendon reflexes, fluid intake and urine output  

| Frequency | 10 sets of notes. Further audit to be commenced if need identified through Risk management process  

| Reporting arrangements | • To be presented at perinatal audit meeting  

| Acting on recommendations and Lead(s) | • Any deficiencies identified will be discussed at the Patient Safety Meeting and clinical audit forum and an action plan developed  
|                                      | • An action plan lead will be identified and a time frame for the action  
|                                      | • The action plan will be monitored by the Patient Safety Meeting and clinical audit forum  

| Change in practice and lessons to be shared | • Required changes to practice will be identified and actioned within a time frame agreed on the action plan  
|                                               | • A lead member of the forum will be identified to take each change forward where appropriate.  
|                                               | • The results will be distributed to all staff through the Patient Safety newsletter/audit forum as per the action plan.  

4. Equality and Diversity

4.1 This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the ‘Equality, Diversity & Human Rights Policy’ or the Equality and Diversity website.

4.2 Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.
# Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Preterm Labour and Delivery Clinical Guideline V1.6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>13th July 2018</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>13th July 2018</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>13th July 2021</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Karen Watkins &amp; Rob Holmes Consultant Obstetrician</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 252270</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>This guideline gives guidance to Obstetricians and Midwives on identifying those at risk of preterm labour, the recognition of preterm labour and the management of established preterm labour and delivery should this arise. This guideline also provides guidance for the use of magnesium sulphate prior to preterm Caesarean Section</td>
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<tr>
<td>Suggested Keywords:</td>
<td>Preterm labour, premature birth, fetal Fibronectin, Atosiban, Magnesium Sulphate, neuro protection, steroids</td>
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<tr>
<td>Target Audience</td>
<td>RCHT</td>
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<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Date revised:</td>
<td>5th July 2018</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Pre-term Labour and delivery - Clinical Guideline V1.5</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Maternity Guidelines Group Maternity Governance Obstetrics and Gynaecology Directorate Policy Review group Divisional Board</td>
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<tr>
<td>Divisional Manager confirming approval processes</td>
<td>Tunde Adewopo</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
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</tr>
<tr>
<td>Name and Signature of Divisional/Directorate Governance Lead confirming approval by specialty and divisional management meetings</td>
<td>{Original Copy Signed}</td>
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<tr>
<td>---------------------------------------------------------------</td>
<td>------------------------</td>
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<tr>
<td>Signature of Executive Director giving approval</td>
<td>{Original Copy Signed}</td>
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<tr>
<td>Publication Location (refer to Policy on Policies – Approvals and Ratification):</td>
<td>Internet &amp; Intranet ✓ Intranet Only</td>
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<tr>
<td>Document Library Folder/Sub Folder</td>
<td>Clinical / Midwifery and Obstetrics</td>
</tr>
<tr>
<td>Links to key external standards</td>
<td>CNST 2.1</td>
</tr>
</tbody>
</table>

**Related Documents:**

- RCOG Clinical guideline No 60 (2011). Cervical Cerclage
- NICE guidance (2015) Preterm labour and birth
- RCHT Clinical guideline (2014) Newborn Life Support
- The Management of Babies born Extremely Preterm at less than 26 weeks of gestation A Framework for Clinical Practice at the time of Birth (2008). British Association of Perinatal Medicine
- Antenatal Corticosteroids to prevent Respiratory Distress Syndrome- Clinical Guideline (2004) RCOG
- Prevention of Early Onset Neonatal Group B Streptococcal Disease – Clinical Guideline (2003) RCOG
### Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
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<tr>
<td>January 2007</td>
<td>V1.0</td>
<td>Initial issue</td>
<td>Mr R Holmes, Consultant Obstetrician</td>
</tr>
<tr>
<td>November 2010</td>
<td>V1.1</td>
<td>Addition of Atosiban and Fetal Fibronectin</td>
<td>Mr R Holmes, Consultant Obstetrician</td>
</tr>
<tr>
<td>March 2012</td>
<td>V1.2</td>
<td>Addition of Magnesium Sulphate regime</td>
<td>Dr Karen Watkins, Consultant Obstetrician and Jan</td>
</tr>
<tr>
<td>20th January 2016</td>
<td>V1.3</td>
<td>Minor changes including advice on Interpretation of Fibronectin results and Deferred Cord Clamping.</td>
<td>Dr Karen Watkins, Consultant Obstetrician</td>
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<tr>
<td>17th February 2017</td>
<td>V1.4</td>
<td>Updated in line with latest NICE, 2016 evidence (cervical screening) and merged with Magnesium Sulphate for Fetal</td>
<td>Mr Rob Holmes, Consultant Obstetrician Dr Helen Le Grys,</td>
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<tr>
<td>7th December 2017</td>
<td>V1.5</td>
<td>Section 2.8; updated in line with latest RCOG guidance</td>
<td>Mr Rob Holmes, Consultant Obstetrician</td>
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<tr>
<td>13th July 2018</td>
<td>V1.6</td>
<td>Minor amendment to Fibronectin Testing see section 2.2.4 (New 2018)</td>
<td>Mr Rob Holmes, Consultant Obstetrician</td>
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This document is only valid on the day of printing

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## Appendix 2. Initial Equality Impact Assessment Form

*This assessment will need to be completed in stages to allow for adequate consultation with the relevant groups.*

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed</th>
<th>Preterm Labour and Delivery Clinical Guideline V1.6</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Directorate and service area:</strong></td>
<td>Obs &amp; Gynaecology Directorate</td>
</tr>
<tr>
<td><strong>Is this a new or existing Policy?</strong></td>
<td>Existing</td>
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<tr>
<td><strong>Name of individual completing assessment:</strong></td>
<td>Rob Holmes</td>
</tr>
<tr>
<td><strong>Telephone:</strong></td>
<td>01872 250000</td>
</tr>
</tbody>
</table>

1. **Policy Aim***

   *Who is the strategy / policy / proposal / service function aimed at?*

   This guideline gives guidance to Obstetricians and Midwives on the recognition of preterm labour, how to arrest preterm labour and the management of established preterm labour and delivery should this arise.

2. **Policy Objectives***

   To ensure threatened or suspected preterm labour is managed in line with current evidence based practice

3. **Policy – intended Outcomes***

   To identify preterm labour early enough to arrest it and if labour progresses to achieve the best possible outcome for the preterm baby.

4. **How will you measure the outcome?**

   Compliance Monitoring Tool

5. **Who is intended to benefit from the policy?**

   Women in preterm labour

6a. **Who did you consult with**

   - Workforce
   - Patients
   - Local groups
   - External organisations
   - Other

   x

   **Please record specific names of groups**

   - Maternity Guidelines Group
   - Maternity Governance
   - Obstetrics and Gynaecology Directorate
   - Policy Review group
   - Divisional Board

6b. **Please identify the groups who have been consulted about this procedure.**

   - Guideline agreed

   What was the outcome of the consultation?

7. The Impact
Please complete the following table. **If you are unsure/don’t know if there is a negative impact you need to repeat the consultation step.**

Are there concerns that the policy **could** have differential impact on:

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Rationale for Assessment / Existing Evidence</th>
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<tr>
<td>Age</td>
<td></td>
<td>X</td>
<td></td>
<td>All women in threatened or established pre-term labour</td>
</tr>
<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
<td>X</td>
<td></td>
<td></td>
<td>All women in threatened or established pre-term labour</td>
</tr>
<tr>
<td>Race / Ethnic communities /groups</td>
<td></td>
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<td></td>
<td>All women in threatened or established pre-term labour</td>
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<tr>
<td>Disability -</td>
<td></td>
<td>X</td>
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<td>All women in threatened or established pre-term labour</td>
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<tr>
<td>Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.</td>
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<tr>
<td>Religion / other beliefs</td>
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<td>All women in threatened or established pre-term labour</td>
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<tr>
<td>Marriage and Civil partnership</td>
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<td>Pregnancy and maternity</td>
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<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
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<td>All women in threatened or established pre-term labour</td>
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</table>

**You will need to continue to a full Equality Impact Assessment if the following have been highlighted:**
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this excludes any policies which have been identified as not requiring consultation. or
- Major this relates to service redesign or development

8. Please indicate if a full equality analysis is recommended.  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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<tbody>
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<td></td>
<td>X</td>
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9. If you are not recommending a Full Impact assessment please explain why.

No areas indicated
Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

This EIA will not be uploaded to the Trust website without the signature of the Human Rights, Equality & Inclusion Lead.

A summary of the results will be published on the Trust’s web site.

Signed Sarah-Jane Pedler
Date 13th July 2018
Appendix 3: Procedure for Fibronectin Swabs

Fibronectin swab indicated do NOT do a VE

Symptoms of preterm labour, for tocolysis or for inutero transfer

No contraindications to Fibronectin swab

Contraindications are: <24 weeks gestation, bleeding, rupture of membranes

Visualise cervix with a speculum (do not use a lubricant for the speculum, use water only)

Do not proceed if visible bleeding or if ruptured membranes (ROM)

If no bleeding or ROM then ask for assistance to open swab from Fibronectin swab kit, soak swab in secretions in posterior fornix for 10 seconds

Place patient ID label and date on the sheet of paper in the swab box to allow audit of the swab use

Electronic analyser

Agitate swab in buffer solution and remove

Enter Patients details, User ID and cassette lot into analyser and press Enter. Insert cassette and press Enter

Pipette 200µL from buffer solution into well of cassette and Press Enter

Print Result from analyser Stick 1 result in patient records and 1 in the diary