1. Summary

Eclampsia and Severe Pre-eclampsia Clinical Guideline v2.0

Used following permissions from PROMPT 2018.
2. The Guidance

This document gives guidance to Obstetricians, Anaesthetists, Midwives and Delivery Suite Nurses on the recognition and management of Eclampsia and Severe Pre-eclampsia.

2.1. Hypertensive disorders during pregnancy occur in women with pre-existing primary or secondary chronic hypertension, and in women who develop new-onset hypertension in the second half of pregnancy. Hypertensive disorders complicate up to 7% of all pregnancies and continue to be major cause of maternal death in the UK.

- **Pre-eclampsia** is new hypertension presenting after 20 weeks of pregnancy with significant proteinuria
- **Severe Pre-eclampsia** is pre-eclampsia with severe hypertension and/or with symptoms, and/or biochemical and/or haematological impairment
- **Eclampsia** is a convulsive condition associated with pre-eclampsia

2.2 Indications for transfer to DELIVERY SUITE:

- Uncontrollable blood pressure (BP)
- Eclampsia
- Severe maternal symptoms
- Fetal compromise
- Renal failure

2.3. Treatment for Severe Pre-eclampsia/Eclampsia on Delivery Suite

The following clinicians should be informed, by the Delivery Suite Coordinator

- Obstetric Registrar
- Obstetric Consultant on call
- Anaesthetist on call for Delivery Suite

2.4. The decision for and mode of delivery will depend on the severity of the condition. The initial aim is to stabilise the woman. Involve the obstetric anaesthetic team at the earliest opportunity and consider elective placement of an epidural catheter.

2.5. Maternal and Fetal Monitoring/assessment

2.5.1. Midwifery

- A MEOWS chart must be used.
- Half hourly blood pressure, pulse, respiratory rate and pulse oximetry
- 4 hourly temperature
- Strict fluid balance, with hourly urine output
- All women should have electronic fetal monitoring but only after the maternal condition is stabilised and should be continually monitored unless a decision made by a senior obstetrician to discontinue
2.5.2. Obstetric

The Obstetric Registrar will review the woman on admission to Delivery Suite and will document a management plan including the timing of the next review. Initially the review should be at least hourly and once stabilised review should be at least every 4-6 hours. At each review the following should be undertaken and documented in the health records:

- Change in symptoms, especially confusion and persistent visual disturbance
- Observations – blood pressure, maternal heart rate, respiratory rate and Oxygen saturation
- Full chest examination, including jugular venous pressure (JVP) assessment
- Level of consciousness, reflexes and clonus
- Fluid balance
- Six-hourly blood investigations (full blood count, platelets, clotting, urea and electrolytes, liver function tests and uric acid) unless otherwise indicated
- Fetal condition
- If conservative management is planned then further assessment of the fetus with ultrasound measurements of fetal size, Umbilical Artery Doppler and liquor volume should be undertaken.

2.6 Blood Pressure Control

Aim to keep BP <150/100 mmHg. Oral antihypertensives should be used in the initial treatment however intravenous antihypertensives will be needed as well if BP doesn’t respond to oral therapy or if there is severe hypertension e.g. BP>170/110.

2.7 Intravenous Treatment

If BP control requires intravenous treatment the level of care should be increased to enhanced Level 1.

- **Hydralazine Infusion**: Hydralazine is incompatible with Dextrose. It should be infused via a syringe driver as follows:
  - Mix 40 mg of Hydralazine (2 ampoules) with Normal Saline to make up to 40 ml, i.e. 1 mg/ml.
  - Loading dose 5mgs over 15 minutes
  - Re-check BP after 20 minutes and give further 5mgs over 15 minutes if BP >160 mmHg.
  - Start infusion at 5mls/hr titrating systolic BP 140-150 mmHg.
  - Maximum infusion rate 18 mls/hr.
  - The blood pressure should be lowered slowly as rapid alterations of the blood pressure can cause cerebral hypoxia
  - The fetal heart rate should be continuously monitored as Hydralazine can cause fetal distress
NOTE: Never use sublingual ‘crush’ to lower BP. The sudden fall can cause severe fetal compromise.

2.8 Labetalol IV Treatment for BP control (caution in Asthma)
   Labetalol Bolus
   50 mg over a period of 2 minutes slow intravenous administration, recheck BP every 5 minutes (maximum 4 doses) until BP controlled.

   Labetalol Infusion
   • Draw up 40mls (2 ampoules) Labetalol (5mg/ml)
   • Start infusion at 20mg/hr (i.e. 4 ml/hr)
   • Double every 30 minutes until a satisfactory response, (BP <150/100 mmHg) or to a maximum infusion rate of 160mg/hour

2.9 Fluid Balance

   It is essential that fluid balance is closely monitored
   • Total fluid input of 80 mls/hr, except for acute replacement of blood loss
   • Infused drugs should be administered in concentrated solutions
   • Insert Foley catheter and assess fluid output hourly
   • If urine output <20 mls/hour request review by experienced obstetrician and assessment of fluid balance
   • If after 4 hours urine output <100 mls inform experienced obstetrician to review woman. Manage as per flow chart on page 5
   • If anuria (no urine output over 1 hour) at any point request review by experienced obstetrician and assessment of fluid balance
   • Management plan should be documented in the woman’s notes

2.10 Fluid Management Regimen for Severe Pre-Eclampsia/Eclampsia

   2.10.1 Intravascular volume expansion Initial volume expansion should be given only after discussion at consultant level and in the following situations:

   2.10.2 Indications:
   • In conjunction with vasodilator therapy for acute blood pressure control
   • Acute symptomatic liver involvement
   • Oliguria
   • Fetal distress (without delaying delivery if mother sufficiently stable)

   2.10.3 Contraindications:
   • IV fluids have already been administered
• Cardiac disease
• Any signs of pulmonary oedema / fluid overload

2.10.4 Colloids should NOT be used for intravascular volume expansion. Use Hartmann’s 500ml over 1 hour with continuous oxygen saturation monitoring.

2.10.5 Any further fluid **administration should be very cautious** because the Pre-eclamptic patient is very readily overloaded. Pulmonary Oedema kills - oliguria and renal tubular acidosis does not.

Fluid should be given according to the protocol flow chart below Figure 2

**Maintenance Fluids**

2.11. **Magnesium Sulphate**

Magnesium Sulphate should be used for women with Eclampsia and considered in Severe Pre-eclampsia.

Discuss all cases with the on-call Obstetric Consultant.

2.11.1 **Indications**

2.11.1.1 Eclampsia- Magnesium Sulphate rarely required to stop fit – usually self-limiting

2.11.1.2 Any woman with severe pre-eclampsia where the decision to deliver has been made and where there is **one other of the following criteria:**

- Hypertension with diastolic BP ≥ 110 mm Hg or systolic BP 170 mm Hg on two occasions and proteinuria ≥ 3+
- Hypertension with diastolic BP ≥ 100 mg Hg or systolic BP ≥ 150 mm Hg on two occasions and proteinuria ≥ 2+ (0.3 g/day) and at least two of the following:
  a. Epigastric pain, vomiting, liver tenderness,
  b. Headache, visual disturbance, Clonus (≥ 3 beats)
  c. Haematological or biochemical evidence of developing HELLP Syndrome: platelet count < 100, ALT (Alanine Aminotransferase) >50 iu/l
  d. Creatinine > 100 or Creatinine Clearance <80

Clinical discretion should be used to include women who present with atypical symptoms.

**(New 2019) Magnesium Sulphate Regimen:** Magnesium Sulphate (MgSO₄) is the treatment of choice for the first fit.

**Loading dose: Magnesium Sulphate 4 grams**
- Draw up 20mls of MgSO4 20% (4 grams) *(New 2019)*
- Give manually over 5 minutes IV. *(New 2019)*

**Maintenance dose: Magnesium Sulphate 1 gram per hour**
- Draw up 50mls of MgSO₄ 20% (10 grams)
- Give IV using syringe driver at rate of 5mls/hour (New 2019)

If there is a supply issue with 20% MgSO₄ then see Appendix 3 (New 2019)

2.11.2 Recurrent seizures whilst on Magnesium Sulphate
- Further bolus 2 grams (10ml of the 20% injection). Give IV over 5 minutes
- If possible take blood for Magnesium levels before bolus
- Notify Obstetric and Anaesthetic Consultants

2.11.3 If further seizures occur
- Inform Consultants
- Consider other causes of fits including intracranial haemorrhage
- Consider using other drugs, including general anaesthesia

2.11.4 Management of a woman receiving Magnesium Sulphate
- Experience from the Collaborative Eclampsia and Magpie Trials indicates that Magnesium Sulphate (according to the above regime) can be used safely without the need to monitor any levels
- Magnesium toxicity causes loss of tendon reflexes, followed by respiratory depression and ultimately, respiratory arrest
- Toxic levels are unlikely to be reached with a maintenance dose of 1 gram per hour and urine output of > 100mls/4 hours

2.11.5 Monitoring of a woman receiving Magnesium Sulphate (MgSO₄)

2.11.5.1 Deep tendon reflexes hourly (Biceps tendon if epidural in situ)
- If loss of reflexes - STOP infusion and send levels
- Recomence infusion if level < 4mmol/l or reflexes return at 0.5gms per hour

2.11.8.2 Hourly Urine Measurements
- If oliguria (urine output <20 mls for >4 hrs) or urea > 10, Magnesium levels should be taken 6 hourly (therapeutic range 2-4 mmol/l).
- Magnesium levels > 4mmol/l - STOP infusion and seek consultant opinion
Figure 2. Maintenance Fluids

80 ml Hartmann's / hour
NB. Reduce if other infusions e.g. Mg SO₄
(80 ml TOTAL fluid / hour = ‘maintenance’)

Urine output
>100ml / 4 hrs

Continue maintenance fluids

Urine output
<100 ml / 4 hrs

250 ml Hartman’s over
15 mins (if O₂ sats and
chest exam are OK)

Urine output
>20 ml over
next hour

Repeat 250 ml
Hartman's over 15 mins
(ONLY if O₂ sats and
chest exam are OK)

If <20ml/hr to discuss
with consultant
anaesthetist. To
consider CVP to guide
further fluid
management

If oliguria persists to
repeat U &E’s
and consider
Nephrology
2.11.8.3 **Hourly Urine Measurements**
- If oliguria (urine output <20 mls for >4 hrs) or urea > 10, magnesium levels should be taken 6 hourly (therapeutic range 2-4 mmol/l).
- Magnesium levels > 4mmol/l - STOP infusion and seek consultant opinion

2.11.9 **Continuous Pulse Oximetry**
- Oxygen saturation < 95% in air should raise concern regarding magnesium toxicity or pulmonary oedema

2.11.10 **Cardiopulmonary Arrest**
- Stop Magnesium Infusion
- Start basic life support
- Give 1 gram Calcium Gluconate IV (10mls 10% solution) over 10 minutes
- Intubate early and ventilate until respirations resume

2.12 **Management of Blood Clotting:**

For those women who chose not to receive decline blood products please refer to the following guideline: Women Declining Blood Products


2.12.1 If the platelet count is less than $50 \times 10^9 /l$ a platelet transfusion should be considered and if for caesarean section this should be in consultation with the consultant haematologist

2.12.2 A platelet count less than $100 \times 10^9/l$ (or rapidly falling count) warrant a baseline clotting screen

2.12.4 Consult Haematologist early where there is clinical or haematological evidence of coagulopathy

2.12.5 If a platelet transfusion is indicated as above, one adult dose of platelets should be administered prior to incision, plus a further adult dose at uterine closure

2.12.6 If the woman is bleeding, check fibrinogen as a low fibrinogen is an important indicator of Disseminated Intravascular Coagulation (DIC)

2.12.7 Cryoprecipitate should be given if bleeding and fibrinogen is less than 1.0g/l.

2.12.8 Fresh frozen plasma should be used to correct a prolonged prothrombin time (PT) or activated partial thromboplastin time (APTT) if bleeding is not controlled
2.13. Delivery Planning

2.13.1 The decision to deliver should not be made until the woman is stable, blood pressure control is achieved and appropriate senior personnel are present, even for fetal concerns.

2.13.2 If there are fetal concerns ensure that the neonatal unit have been informed to enable them to prepare for the baby.

2.13.3 If the fetus is less than 35+0 weeks of gestation and delivery can be deferred, corticosteroids should be given, although after 24 hours the benefits of conservative management should be reassessed.

2.13.4 Conservative management at very early gestations may improve perinatal outcome but must be carefully balanced with maternal wellbeing.

2.13.5 The mode of delivery should be determined after considering the presentation of the fetus and the fetal condition, together with the likelihood of success of induction of labour after assessment of the cervix.

2.13.6 The third stage should be managed with Syntocinon/Carbetocin.

2.13.7 Syntometrine/Ergometrine should not be given, as this can further increase the blood pressure.

2.14. Management Post Delivery

2.14.1 After delivery the woman must remain on DELIVERY SUITE for a minimum of eight hours.

2.14.2 The decision to transfer to the wards must be made by a Senior Obstetrician.

2.14.3 If Magnesium Sulphate given, this needs to continue for at least 24 hours post-delivery and the woman will remain on delivery suite during this time.

2.14.4 Avoid NSAIDs.

2.15. Post Natal Management

2.15.1 All the patients who had severe Pre-eclampsia/Eclampsia should be reviewed by a doctor within 24 hours of transfer to Wheal Fortune.

2.15.2 To stay in the Wheal Fortune for at least 3 days unless discharged earlier by Senior Obstetrician. All women with severe pre eclampsia or Eclampsia should be given an appointment for the Consultant Antenatal Clinic (ANC) appointment in 4 weeks. It is the responsibility of the discharging doctor to ensure this appointment is arranged. ANC is not appropriate if pregnancy resulted in an intrauterine death (IUD), in this case individualized followed up will be arranged by the named consultant.

2.15.3 BP must have been <140/90 for at least 24 hours prior to discharge unless decision for discharge made by a senior obstetrician. Most women
should continue on their antihypertensive therapy particularly if needed pre delivery. They should be advised to continue this until reviewed in the consultant clinic. Women in whom serum biochemistry is still deranged on discharge should be given a form and instructions to have the bloods repeated prior to the consultant appointment.

2.15.4 Community Midwife to be informed of discharge and to monitor BP daily for the first week

2.15.5 Women will be seen in the consultant clinic in 6 weeks to debrief clinical events and discuss implications for future pregnancies. If on antihypertensives then these should be reviewed as to the need to continue. The blood results should also be reviewed. A letter should be written to the GP at this appointment with clear instructions regarding the antihypertensive therapy and BP monitoring +/- investigation of proteinuria/deranged biochemistry if persistent.

2.15.6 Consideration of preconceptual counseling for the next pregnancy

### 3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>The audit will take into account record keeping by Obstetric, Anaesthetic and Neonatal doctors, Midwives, Nurse, Students and Maternity Support Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The results will be inputted onto an Excel spreadsheet</td>
</tr>
<tr>
<td></td>
<td>The audit will be registered with the Trust’s audit department</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Lead</th>
<th>Audit Midwife</th>
</tr>
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<table>
<thead>
<tr>
<th>Tool</th>
<th>The following will be monitored for women with a diagnosis of Severe Pre-eclampsia and Eclampsia:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Was a plan for blood pressure control written in the woman’s notes</td>
</tr>
<tr>
<td></td>
<td>Was fluid balance monitored hourly</td>
</tr>
<tr>
<td></td>
<td>Was an indwelling Foley’s catheter inserted</td>
</tr>
<tr>
<td></td>
<td>If urine output &lt;80 mls in 4 hours, was an obstetrician informed and a management plan documented in the woman’s notes</td>
</tr>
<tr>
<td></td>
<td>If an Eclamptic fit occurred was Magnesium Sulphate used</td>
</tr>
<tr>
<td></td>
<td>If Severe Pre-eclampsia was Magnesium Sulphate considered</td>
</tr>
<tr>
<td></td>
<td>Was a CTG performed on admission to Delivery Suite and discontinued appropriately</td>
</tr>
<tr>
<td></td>
<td>If conservation management planned, was an ultrasound assessment performed for fetal size, Umbilical Artery Dopplers and liquor volume</td>
</tr>
<tr>
<td></td>
<td>Was blood pressure control achieved prior to delivery</td>
</tr>
<tr>
<td></td>
<td>If there were fetal concerns, was the neonatal team informed prior to delivery</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Frequency</th>
<th>To be audited over the lifetime of the guideline or earlier if</th>
</tr>
</thead>
</table>
### Reporting arrangements
- A formal report of the results will be received annually at the Patient Safety Forum or clinical Audit Forum, as per the audit plan.
- During the process of the audit if compliance is below 75% or other deficiencies identified, this will be highlighted at the next Patient Safety Forum or Clinical Audit Forum and an action plan agreed.

### Acting on recommendations and Lead(s)
- Any deficiencies identified on the annual report will be discussed at the Patient Safety Forum and an action plan developed.
- Action leads will be identified and a time frame for the action to be completed.
- The action plan will be monitored by the Patient Safety until all actions complete.

### 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 of the audits will be distributed to all staff through the Patient Safety Newsletter / Clinical 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>Eclampsia and Severe Pre- eclampsia Clinical Guideline V2.0</th>
</tr>
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<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>7&lt;sup&gt;th&lt;/sup&gt; February 2019</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>7&lt;sup&gt;th&lt;/sup&gt; February 2019</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>7&lt;sup&gt;th&lt;/sup&gt; February 2022</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Helen Le Grys, Obstetric Registrar, Sophie Haynes, Obstetric Consultant.</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 25 2937</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>This document gives guidance to Obstetricians, Anaesthetists, Midwives and Delivery Suite Nurses on the recognition and management of Eclampsia and Severe Pre-eclampsia</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Eclampsia, Severe, Pre-eclampsia, PET, hypertension, pregnancy, blood, pressure</td>
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<td>Target Audience</td>
<td>RCHT</td>
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<td></td>
<td></td>
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<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Date revised:</td>
<td>January 2019</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Clinical guideline for the management of a woman with eclampsia and/or severe pre eclampsia. V1.4</td>
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<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Maternity Guidelines Group Obs and Gynae Directorate Divisional Board for noting</td>
</tr>
<tr>
<td>Divisional Manager confirming approval processes</td>
<td>Debra Shields, Care Group Manager</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td>Not Required</td>
</tr>
<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</td>
</tr>
<tr>
<td>Document Library Folder/Sub Folder</td>
<td>Clinical/Midwifery and Obstetrics</td>
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</tr>
<tr>
<td>Links to key external standards</td>
<td>CNST 3.1 &amp; 3.2</td>
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Training Need Identified?
Robust plan in place to ensure widespread communication of change to magnesium sulphate regime, and incorporated into PROMPT training programme

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>
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<tr>
<td>August 2007</td>
<td>V1.0</td>
<td>Initial Issue</td>
<td>Rob Holmes, Consultant obstetrician</td>
</tr>
<tr>
<td>June 2009</td>
<td>V1.1</td>
<td>Updated guideline.</td>
<td>Karen Watkins, Consultant obstetrician</td>
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<tr>
<td>May 2012</td>
<td>V1.2</td>
<td>Updated and compliance monitoring included</td>
<td>Karen Watkins, Consultant Obstetrician</td>
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<tr>
<td>August 12</td>
<td>V1.3</td>
<td>Changes to compliance monitoring only</td>
<td>Karen Watkins, Consultant Obstetrician</td>
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<tr>
<td>20th October 2015</td>
<td>V1.4</td>
<td>Reviewed no major changes</td>
<td>Karen Watkins, Consultant Obstetrician</td>
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<tr>
<td>January 2019</td>
<td>V2.0</td>
<td>Full review. Additions highlighted. Amendments to MgS04 regime following a National Patient Safety Alert and appendix 4 added in case previous regime needing to be followed in the rare instance of the new ampule not being available</td>
<td>Helen Le Grys, Obstetric Registrar, Sophie Haynes, Obstetric Consultant</td>
</tr>
</tbody>
</table>

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document
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>Directorate and service area:</th>
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<tbody>
<tr>
<td>Eclampsia and Severe Pre-eclampsia Clinical Guideline V2.0</td>
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</table>

<table>
<thead>
<tr>
<th>Is this a new or existing Policy?</th>
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<tbody>
<tr>
<td>Existing</td>
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<table>
<thead>
<tr>
<th>Name of individual completing assessment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helen Le Grys, Sophie Haynes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Telephone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>01872 252937</td>
</tr>
</tbody>
</table>

1. **Policy Aim***

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

- This document gives guidance to Obstetricians, Anaesthetists, Midwives and Delivery Suite Nurses on the recognition and management of Eclampsia and Severe Pre-eclampsia.

2. **Policy Objectives***

To ensure that pregnant women who develop Eclampsia or Severe Pre-eclampsia are recognised and treated in line with national guidance.

3. **Policy – intended Outcomes***

To ensure that women with HIV who are pregnant are cared for as per this guideline.

4. *How will you measure the outcome?*

- Compliance Monitoring Tool

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

- All pregnant women with HIV.

6a Who did you consult with

<table>
<thead>
<tr>
<th>Workforce</th>
<th>Patients</th>
<th>Local groups</th>
<th>External organisations</th>
<th>Other</th>
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<tr>
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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.**

<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>
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<td></td>
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<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
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<td>x</td>
<td></td>
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<tr>
<td>Race / Ethnic communities /groups</td>
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<td>Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.</td>
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<td>Religion / other beliefs</td>
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<td></td>
<td>x</td>
<td>Women declining blood products due to religious beliefs would be referred to another policy, &quot;Women declining Blood Products&quot; policy.</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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</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

---

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

<table>
<thead>
<tr>
<th>Please record specific names of groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity Guidelines Group</td>
</tr>
<tr>
<td>Obs and Gynaec Directorate</td>
</tr>
<tr>
<td>Policy Review Group</td>
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</table>

What was the outcome of the consultation?

Guideline agreed.
8. Please indicate if a full equality analysis is recommended. | Yes | No x

9. If you are not recommending a Full Impact assessment please explain why. Not required.

<table>
<thead>
<tr>
<th>Signature of policy developer / lead manager / director</th>
<th>Date of completion and submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sophie Haynes, Consultant Obstetrician.</td>
<td>February 2019</td>
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<thead>
<tr>
<th>Names and signatures of members carrying out the Screening Assessment</th>
<th></th>
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<tr>
<td>2. Human Rights, Equality &amp; Inclusion Lead</td>
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</tbody>
</table>

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 7th February 2019
Appendix 3

When MgSo4 20% is unavailable

If MgSo4 20% is unavailable please use 50% MgSo4 following the same Regimen:

**Magnesium Sulphate Regimen:** Magnesium Sulphate (MgSO₄) is the treatment of choice for the first fit.

**Loading dose: Magnesium Sulphate 4 grams**
- 8mls of MgSO₄ (50%) diluted with 12mls Normal Saline (0.9%)
  = Total 20mls
- Give IV over 20 minutes using syringe driver rate of 60 mls/hour

**Maintenance dose: Magnesium Sulphate 1 gram per hour**
- 20mls MgSO₄ (50%) diluted with 30mls Normal Saline (0.9%)
  = Total 50mls
- Give IV using syringe driver at rate of 5mls/hour