

triggered local reviews in UK maternity units in order to inform future guidance for confidential case reviews of severe maternal morbidities.

Methods All consultant-led maternity units in the UK were contacted up to three times and asked to supply a copy of the checklist of incidents which triggered a local review. The lists were tabulated and compared with incidents recommended for review by the Royal College of Obstetricians and Gynaecologists (RCOG).

Results Among the 211 consultant-led maternity units in the UK, 72% provided an incident review trigger list. The conditions covered were highly variable, although those recommended by the RCOG were most highly represented. Over 90% of units who responded included maternal and neonatal deaths, stillbirths, intensive care admissions, severe haemorrhage (>1500 ml) and shoulder dystocia. Between 80–90% of units also listed eclampsia, uterine rupture, medication error and other organisational incidents. Only 73% of units listed hysterectomy, 66% cardiac arrest and 62% maternal sepsis or a severe infection.

Conclusions Significant variation exists between units in the number and type of conditions reviewed. Importantly, less than two thirds of units specifically review cases of severe infective complications, despite current concerns about a rising rate of maternal death due to sepsis.

PM.39 POSTNATAL RISK ASSESSMENT OF VENOUS THROMBOEMBOLISM (VTE)

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VTE is the third leading cause of maternal death in the UK¹. In our unit, risk of VTE is assessed using a scoresheet based on RCOG guidelines², and low molecular weight heparin (LMWH) prescribed according to risk. A recent case of VTE associated with incorrect scoring prompted this audit into the system's use.

This was a prospective audit, over a 2 week period in October 2012. Spot checks, carried out on the Postnatal ward, assessed how many women had a completed score sheet, the accuracy of their scores, and identified factors contributing to inaccuracies. When the score indicated a need for LMWH, prescriptions were evaluated.

60 sets of notes were reviewed: 24 women had vaginal deliveries (SVD), 24 delivered by Caesarean section (CS) and 10 had instrumental deliveries (ID).

Only 43 [72%] women had a completed scoresheet: 60% of IDs, 96% of CS, 50% of SVDs. Of these, 74% were scored correctly: 2 were given the wrong LMWH dose. Of the women with incorrect scores, 4 prescribing errors were identified. 2 women without completed scoresheets required LMWH. All 8 prescribing errors were corrected.

The audit showed three main types of scoring error: clinical subjectivity, administrative and human factor.

More work is required to encourage staff to consider VTE risk assessment a vital part of a woman's care. The scoresheet should be included in the delivery notes and become a compulsory part of patient handover. Its use will be reaudited.

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PM.40 LIFESTYLE INTERVENTION REDUCES THE NEED FOR INSULIN THERAPY AND MACROMIA IN GESTATIONAL DIABETES MELLITUS

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Introduction In 2011 "life style intervention" was introduced in addition to a low glycaemic diet and insulin (when required), for management of patients diagnosed with gestational diabetes (GDM) at the National Maternity Hospital.

Methods A prospective study of the potential benefit of lifestyle intervention versus standard management in the treatment of gestational diabetes mellitus.

Lifestyle management included group education on diet and exercise and a personal glucometer for home blood sugar monitoring, reinforced at least weekly contact with the diabetic team. Data on demographics, insulin use and macrosomia was collected.

Results In the period 2008–2010, 412 cases with GDM received standard management and from 2011 onwards, data was available on 353 cases of GDM following the introduction of life style intervention. Patient demographics were similar in both groups and there was no significant difference in mean age, BMI, gestational weight gain and ethnicity between the two groups. In the pre-intervention cohort, 40.7% (168/412) were treated with insulin, compared with 22% (78/353) post intervention ($p < 0.001$). The incidence of macrosomia (birth weight >90% centile for gestational age) was 20% prior to 2011 (84/412) and 13.8% (49/353) following intervention ($p < 0.04$) (Table 1).

Conclusion The results show that the intervention has almost halved the need for insulin treatment in patients with GDM without any compromise in fetal outcome. The results strongly suggest that a randomised trial of life style intervention should be conducted.

Abstract PM.40 Table 1

	Pre-intervention	Post-intervention	
Number	412	353	
Insulin treatment	168 (40.7%)	78 (22.9%)	$P < 0.001$
Macrosomia	84(20%)	49 (13.8%)	$P < 0.04$

PM.41 CAN PULSE WAVE ANALYSIS PREDICT ADVERSE OBSTETRIC OUTCOME IN PREGNANT WOMEN WITH CHRONIC HYPERTENSION?

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Introduction Complications of pregnancy including super imposed pre-eclampsia (PE), fetal growth restriction (FGR) and pre-term delivery are common in women with chronic hypertension. Outside of pregnancy measurement of arterial stiffness using pulse wave analysis is highly predictive of future cardiovascular events. We aimed to assess the utility of pulse wave analysis in pregnancy in a cohort of women with chronic hypertension.

Methods Using the Tensioclinic™ arteriograph, women with hypertension attending a specialist clinic had longitudinal haemodynamic measurements taken at three time points from early pregnancy. Measurements included peripheral BP, central BP and pulse wave velocity (PWV).

Results To date pregnancy outcome data are available in 24 women. In women with an adverse obstetric outcome (preterm