Results Satisfaction that women have during labour and delivery is beyond their expectations. As follows from the hospital, expectations and satisfaction of women to improve. However, the expectation of women was not a predictor of perception, as opposed to satisfaction.
Conclusion Creating a space for reflection among professionals and managers of health institutions, indicating paths to follow and encouraging behavioural changes.

PL.96 AN AUDIT ON MAJOR POSTPARTUM HAEMORRHAGE AT QUEENS HOSPITAL, ROMFORD

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Introduction Haemorrhage is a leading cause of maternal death and morbidity. Major postpartum haemorrhage (PPH) is loss of more than 1 Litre of blood from the genital tract postnatally.
Objectives To undertake a retrospective audit of patients who underwent a major PPH. Identify areas of good practise and make recommendations to improve standard of care.
Materials and Methods 197 cases were identified from the electronic database (September 2011 to March 2012) and 127 notes reviewed retrospectively. Data was analysed for patient demographics, risk factors, delivery and documentation. Reference was made to the RCOG Green-Top Guideline No. 52 and a previous local audit.
Results The majority were Caucasian (40%), nulliparous (50%), aged 18–30 (61%) with a normal BMI (47%). Most were delivered by Caesarean section (69%) at term (61%). 60% of babies weighed between 3 and 4 kg and 10% of women were estimated to have lost 2.5 L or more. 27 patients required blood transfusion of up to 10 units. There were 6 manual removals of placentae and 8 other surgical interventions, including one hysterectomy.
Discussion There was no correlation between the number of risk factors and total blood loss. An improvement in the completion PPH proformas and patient debriefing was found. However, there appeared to be deterioration in emergency call-out (2222) and incident reporting in comparison to previous audit data.
Recommendations We recommend refresher training and emergency drills for identification and management of the critically ill patient. Improve awareness of local and regional guidelines and re-audit in one year.

PL.97 PROSPECTIVE AUDIT FOR INDUCTION OF LABOUR WITH PROPESS

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Aim to assess the success rate of IOL using propess.
Method A prospective audit of IOL was carried out in a large teaching hospital. Special data sheet was used for collection of data. We have included women with a singleton viable pregnancy in a cephalic presentation and who were admitted for IOL at ≥37 weeks gestation. We have excluded cases with history of rupture of membranes.
Results Despite of 24 hours of propess use, 31/100 (31%) additionally needed Prostin as adjuvant method for IOL. 54/100 (54%) needed syntocinon for augmentation of labour. Hyperstimulation syndrome with CTG changes were observed in 7/100 (7%) of cases (five after propess and two after oxytocin infusion). Vaginal delivery was achieved in 73/100 (73%). It was observed that 73/100 (73%) of women delivered between 48 hours of IOL. Primary postpartum haemorrhage was noted in 15/100 (15%). There was no neonatal admission.
Conclusion IOL with proess is successful method with about 73% success rate. However, clinicians should be aware that up to 30% of cases will need extra prostin. Cost analysis is required to evaluate methods that could be used to reduce cost and duration of admission.

PL.98 INDICATIONS AND OUTCOMES IN CAESAREAN SECTION – A PROSPECTIVE AUDIT

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The PCT required an audit to be completed across the University Hospitals Leicester Trust in the light of new NICE guidance on Caesarean section for maternal request. This was combined with an audit of infection control and thromboprophylaxis measures for CQUIN targets. An audit of Vaginal Birth After Caesarean as compared with projected outcome of VBACs published by the RCOG was opportunistically carried out at the same time.

Data were prospectively collected on patients undergoing CS in January 2012 by the theatre team in 171/191 (89%) of all patients undergoing caesarean section and VBAC data were collected from the patients' computerised and paper notes.

Targets were met for Antibiotic prophylaxis and use of clippers, VTE prophylaxis, Diabetic control and counselling against CS for maternal request.

Targets were not met for written and verbal debriefing post CS, nor prescribing of Stellisept.

Additional findings

- Diabetes rate 6% across UHL
- Hypertension rate 16% across UHL
- 100% UHL patients had an AN discussion about mode of delivery
- CS Rate 21% across UHL
- Only 24% those that could have attempted VBAC chose ERCS (LRI)
- VBAC success rate 64.3% in those who attempted it (LRI)
- CS Maternal request - 4 cases/171 2.3%
  - NICE CG 132 1.2.9.2
  - Documented adequate counselling 100%
  - Explored reasons for request 100%

Conclusion The audit was reassuring in not only its prophylactic measures but also that very reasonable successful VBAC rates and CS rates are achievable in even a tertiary unit.

PL.99 FETAL BLOOD SAMPLING DOCUMENTATION – REAUDIT

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Introduction The intrapartum assessment of fetal well-being remains a challenge to obstetricians, especially given the on-going concern for increasing caesarean section rates and malpractice litigation. Several techniques may be used to evaluate the fetus during labour including direct analysis of fetal blood obtained from via scalp sampling. It is important that when fetal blood sampling (FBS) is performed, clear documentation should be done. At Darlington Memorial Hospital (DMH), a re-audit was performed to assess the documentation on FBS, according to the recommendations stated in the Trust Guidelines.
Aim To determine whether there are any improvements in documentation on FBS compared to previous audit performed in 2010.
Methods A retrospective audit of the 22 cases was performed from 1st July to 30th September 2011 at DMH. Data were collected from the labour ward register, fetal blood sampling record and medical notes.
Results A total of 22 cases were included. Compared to 2010, there was improvement in the documentation of the cord blood being

taken at deliveries (91%) and the results stored (100%). However, there are some areas where improvements are needed such as the documentation of consent, reasons for FBS, results, and the documentation of review at 30 minutes post FBS.

Conclusion Despite being indicated in the trust guideline, some of the essential documentations regarding FBS are still missing. Therefore, for these cases any future claims for cerebral palsy would be indefensible. FBS proforma was developed and are used for all FBS cases. This recommendation was subsequently adopted by DMH.

PL.100 TIME TO DISCHARGE FOLLOWING UNCOMPLICATED ELECTIVE OR EMERGENCY CAESAREAN SECTION: IS PATIENT MOTIVATION THE MAJOR DETERMINING FACTOR?

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Anticipated increase in the rate of Caesarean birth following the publication of recent National Institute of Health and Clinical Excellence guidance[1] prompted investigation into the causes of delay in discharge from hospital following an uncomplicated elective or emergency Caesarean section. A retrospective audit of the patient health record at the Royal Devon and Exeter Hospital revealed that time to discharge appeared to be independent of parity, urgency of delivery (elective or emergency Caesarean section) or intended feeding method (breast of artificial feeding).

In patients without medical or surgical complications following Caesarean delivery, it was expected that delay in medical and midwifery staff performing routine care needs would be responsible for any delay in discharge. Routine and measurable care needs, identified as being compulsory prior to discharge were: 1. Removal of the indwelling urinary catheter and successful trial without catheter (TWOC), 2. Documented confidence and competence at breastfeeding, for those choosing this method, 3. Ability to administer low molecular weight thromboprophylaxis independently of a midwife or health professional, and, 4. Ability to self-administer postoperative analgesia. On no identifiable occasion did unnecessary delay in the performance of these needs adversely affect time to discharge.

These results suggest that in our unit patient motivation factors as well as individual expectation of the recovery period may be the biggest determinants of time to discharge following Caesarean section.

REFERENCE

1. National Institute for Health and Clinical Excellence. NICE clinical guideline 132, Caesarean Section: November 2011.

Pregnancy Outcome Posters

PP.01 PERINATAL OUTCOME OF IUGR PREGNANCIES WITH NORMAL AND ABNORMAL DOPPLER STUDIES – THE PROSPECTIVE MULTICENTRE PORTO TRIAL

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Objective The objective of this analysis, as part of the multicentre prospective PORTO Trial, was to describe and compare perinatal outcomes of IUGR pregnancies with normal and abnormal umbilical artery (UA) Doppler studies.

Study design The PORTO Trial recruited over 1,100 consecutive ultrasound-dated singleton IUGR pregnancies, defined as EFW < 10th centile. All fetuses underwent serial sonographic assessment until birth. Perinatal outcomes were documented for all participants.

Abstract PP.01 Table 1 Comparison of groups with normal and abnormal UA Doppler

	Normal Doppler	Abnormal Doppler	p-value
GA (enrolment)	30.4 ± 4.0	29.6 ± 3.8	0.0007
GA (delivery)	38.4 ± 2.2	36.6 ± 3.5	<0.0001
Birthweight	2641 ± 553	2203 ± 725	<0.0001
NICU admission	121 (20%)	191 (37%)	<0.0001
Adverse perinatal outcome*	11 (2%)	49 (10%)	<0.0001
Perinatal mortality	4 (0.7%)	6 (1%)	0.3652
Induction	303 (50%)	217 (42%)	0.0110
CS	190 (32%)	256 (50%)	<0.0001
Instrumental	66 (11%)	41 (8%)	0.1025
NVD	350 (58%)	215 (42%)	<0.0001

*composite outcome of IVH, PVL, HIE, NEC, BPD, sepsis and death

Results Of the 1,118 recruited patients, 606 (54%) had normal UA Doppler studies and 512 (46%) had abnormal UA Dopplers, defined as UA PI > 95th centile or AREDF. The group with abnormal UA Doppler was delivered earlier and more commonly by CS, had more admissions to NICU and adverse perinatal outcomes (Table 1). The 4 mortalities with normal Doppler all had EFW < 3rd centile.

Conclusion IUGR fetuses with normal UA Doppler studies have better perinatal outcomes than those with abnormal UA Doppler, however adverse perinatal outcome can occur with normal UA in more severe IUGR cases (EFW < 3rd centile).

PP.02 EFFECT OF METHOD AND GESTATIONAL AGE AT TERMINATION OF PREGNANCY ON FUTURE OBSTETRIC AND PERINATAL OUTCOMES: A RETROSPECTIVE COHORT STUDY

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Induced abortion (IA) is believed to increase the risk of spontaneous preterm labour. Few studies have investigated the impact of method used (medical versus surgical) or the gestational age at IA. In a population based retrospective cohort study using data from the Aberdeen Maternity Neonatal Databank, the outcome of a subsequent viable pregnancy in 3186 women who underwent IA in their first pregnancy was compared with 42446 primigravid women. The exposed cohort was stratified according to method and gestational age at IA. Perinatal outcomes following medical IA was compared to those following surgical IA, as well as those in primigravid women. Similarly, women who underwent IA at <13 weeks were compared to women with history of IA at >= 13 weeks and primigravid women. Univariate and multivariate logistic regression adjusted for maternal age at delivery, smoking and socioeconomic status were used to analyse the data. No statistically significant association was found between previous IA and spontaneous preterm labour (aOR 1.05 (0.88–1.27)). Neither the method of termination (aOR 0.95 (0.72 to 1.25)) nor gestational age (aOR 1.00 (0.99 to 1.00)) at IA appeared to affect the risk of spontaneous preterm delivery. IA increased the risk of antepartum haemorrhage (p < 0.001; aOR 1.22 (1.09 to 1.36) in the next pregnancy. Previous IA appeared to protect against pregnancy induced hypertension (aOR 0.67 (0.60–0.74)). Method and gestational age at IA largely did not affect future obstetric and perinatal outcomes. Evidence remains conflicting on pregnancy outcomes following termination of pregnancy.