1.0 Title
Prostaglandin Cervical Ripening prior to Induction of Labour

2.0 Purpose
This procedure outlines cervical ripening with prostaglandins prior to induction of labour. It does not cover indications for induction of labour or the management of labour.

3.0 Background
To facilitate induction of labour, cervical ripening is commonly initiated by the use of synthetic prostaglandins which facilitate the softening and dilation of the cervix via their actions on smooth muscle\(^1\).

Naturally occurring prostaglandin \(E_2\) (PGE\(_2\)) is known as dinoprostone. In Australia two commonly available forms are Prostin E\(_2\)\(^6\) vaginal gel and Cervidil\(^7\) pessary. PGE\(_2\) is widely used for cervical ripening prior to induction of labour for women who have an indication for induction of labour \(^2\).

The process of cervical ripening to facilitate induction of labour, as well as risks and benefits must be explained to the woman, and consent obtained \(^3\), \(^4\). The consent discussion and chosen management plan should be well documented \(^5\).

3.1 Membrane Sweeping
Procedures for cervical ripening, such as membrane sweeping, may be of benefit in triggering the release of prostaglandins at or beyond term. This can lead to softening of the cervix and augmenting oxytocin-induced uterine contractions\(^6\).

Membrane sweeping does not appear to increase the risk of maternal or fetal complications (e.g. infection). GBS colonisation is not a contraindication to membrane sweeping as there is no direct evidence of harm \(^7\).

Before formal induction of labour, women should be offered membrane sweeping, following a discussion of risks and benefits as per GL2014_015 Maternity – Management of Pregnancy Beyond 41 Weeks Gestation \(^8\).
4.0 Procedure for insertion of PGE\(_2\):

4.1 Absolute Contraindications to cervical ripening with PGE\(_2\):\(^4,7,9\)
- women with a known hypersensitivity to prostaglandins;
- vaginal birth is contraindicated for this woman, for example, genital herpes, placenta previa;
- the fetal lie is not longitudinal;
- any unexplained vaginal bleeding during the current pregnancy;
- there is a history of previous surgical operation on the uterus, for example, a caesarean section, myomectomy or surgical treatment of cornual ectopic.

4.2 Relative contraindications (may be used with caution under lead obstetrician supervision)\(^7\)
- there is suspicion or proven compromised fetal wellbeing;
- there is evidence or strong suspicion of marked cephalopelvic disproportion
- Bishop score \(\geq 6\);
- persisting maternal fever;
- women with untreated pelvic inflammatory disease;
- labour has already started;
- multiparous women particularly grand multiparity (> 5 previous births);
- previous uterine hyperstimulation;
- ruptured membranes;
- mobile presenting part;
- multiple pregnancy.

Practice notes:
Where contraindications exist, consider mechanical cervical ripening as an alternative, as per NNSWLHD Procedure - Balloon Catheter Cervical Ripening Prior to Induction of Labour.

Medication with aspirin and other non-steroidal anti-inflammatory drugs (known as NSAIDs) should be stopped before administration of Cervidil\(^\text{®}\). Some examples of NSAIDS are Ibuprofen (e.g. Nurofen\(^\text{®}\)) and diclofenac (Voltaren\(^\text{®}\))\(^7,9\).

**PGE\(_2\) must be used with Caution:** in women with compromised cardiovascular, hepatic or renal function and in women with asthma, epilepsy, glaucoma or raised intraocular pressure, or ruptured chorioamniotic membranes.

4.3 Timing
Optimal timing of the doses of prostaglandins needs to be determined locally. It is recommended that scheduling of cervical ripening should be by arrangement with the birthing unit team leader, in order to take into account the availability of staff, equipment, support services and expertise\(^2\).

Immediately prior to beginning any cervical ripening procedure the person (midwife, medical officer) undertaking cervical ripening should:
- Review the indications for cervical ripening;
- PGE₂ must be prescribed on the medication chart and signed by a Medical Officer.
- Ensure there are no contraindications;
- Set the room up in a manner that helps to reduce stress and is warm and welcoming. The woman may choose to be accompanied by a support person/people;
- Explain the procedure and obtain consent from the woman;
- Ask the woman to empty her bladder;
- Perform an abdominal palpation and confirm that the fetal lie is longitudinal with the presenting part over the pelvic inlet (does not have to be engaged);
- Perform baseline maternal observations: respiratory rate, oxygen, saturation, heart rate, blood pressure, temperature, level of consciousness as per PD2013_049 Recognition and Management of Patients who are Clinically Deteriorating and document on her Standard Maternity Observation Chart (SMOC);
- Perform a vaginal examination and Bishop Score calculation (Appendix A), share findings with the woman, and document in her progress notes.

**Practice note:** Verbal consent must be obtained prior to all vaginal examinations. The examiner must be alert to verbal and non-verbal indications of distress from the woman. A request to cease the examination is a withdrawal of consent and must be respected.

- Perform Electronic Fetal Monitoring (EFM), as per GL2018_025 Fetal Heart Rate Monitoring and PD2011_075 Oxytocin for the Induction of Labour at or Beyond Term, for at least 30 minutes prior to cervical ripening. Ensure EFM is reassuring before continuing.
- Position the woman on her back, slight left lateral tilt.

### 4.4 Equipment
- Cardiotocograph (CTG);
- Vaginal PGE₂ drug of choice, ordered on medication chart;
- Sterile gloves;
- Water soluble lubricant;
- Absorbent pad/sheet;
- Drawsheet.

### 4.5 Method
**For Prostin E₂® gel:**
- Remove the syringe containing the gel from refrigeration at least 30 minutes prior to use and allow it to come to room temperature;
- Lubricate the applicator with water soluble lubricant and insert into the vagina, expel the Prostin E₂ into posterior fornix of the vagina.
1st dose: 2 mg nulliparous; 1 mg multiparous
2nd dose: 1 or 2 mg nulliparous; 1 mg multiparous
3rd dose: 1 or 2 mg nulliparous; 1 mg multiparous

Practice Note: These dosages may be altered at the request of the prescribing medical practitioner depending on the Bishop Score.

The maximum dose, regardless of parity, is 3mg for all women in a 6 (six) hour period.

For Cervidil®:
- Remove the pessary containing the medication from the freezer immediately before insertion, do not allow it to come to room temperature;
- Hold the Cervidil® pessary firmly between the index and middle fingers and insert into the vagina, positioning it in the posterior vaginal fornix. Use minimal lubricant and avoid coating the pessary.

Practice Note: Care should be taken not to permit excessive contact or coating with lubricant which could prevent optimal swelling and release the dinoprostone slab from the vaginal insert.

- It is recommended that the attached withdrawal tape be tucked just inside the vagina to prevent it being accidentally pulled out.
The Cervidil® pessary should be removed immediately:
- If labour commences; or
- If uterine tachysystole with fetal heart rate changes occurs. Removing the PGE₂ vaginal insert usually reverses the effects of tachysystole.  

The Cervidil® pessary should also be removed:
- prior to amniotomy;
- after the spontaneous rupture of the membranes (please discuss with Medical Officer);
- if there is any suggestion of maternal or fetal compromise; or
- if unwanted side-effects occur.

**Practice note:** If after 12 hours the cervix has not changed adequately for induction of labour **DO NOT REMOVE THE PESSARY.** Please consult with the Consultant or the Medical Officer who will determine if the pessary should remain insitu or be removed. After removal ensure that the medication containing 'slab' has been removed as it may have separated from the knitted polyester retrieval system and will continue delivering the active ingredient if it remains insitu.

### 4.6 Post Procedure Care
- Women receiving Prostin E₂® gel should remain recumbent (to retain gel) in lateral position (to prevent supine hypotension) for at least 30 minutes.
- There should be an assessment of fetal wellbeing for 60 minutes post-administration and discontinued when the FHR is assessed and verified with a second clinician as reassuring.
- When assessing for uterine tachysystole consideration should be given to both the duration and frequency of the contractions. Contractions normally vary in duration from 30-60 seconds during the first stage of labour, to 90 seconds during the second stage of labour. The fetus needs
60-90 seconds between each contraction to restore normal fetal oxygenation. 

- After administration of vaginal PGE₂, when contractions begin, fetal wellbeing should be assessed with continuous electronic fetal monitoring. Once the EFM is confirmed as normal, intermittent auscultation should be used unless there are clear indications for continuous electronic fetal monitoring as described in PD2018_025 Maternity - Fetal Heart Rate Monitoring.

- If the fetal heart rate is non-reassuring or abnormal after administration of vaginal PGE₂, management of fetal compromise should be attended as per the recommendations in PD2018_025 Maternity – Fetal Heart Rate Monitoring. Appendix B: Antenatal Fetal Heart Rate Pattern Algorithm - Clinical Response and Management Plan.

- Document maternal observations post insertion every 4 hours, including: respiratory rate, oxygen, saturation, heart rate, blood pressure, temperature, level of consciousness as per PD2013_049 Recognition and Management of Patients who are Clinically Deteriorating and the presence and frequency of contractions, and vaginal loss on her SMOC, and progress notes until contractions establish.

- FHR should be auscultated every 4 hours and documented in the progress notes.

- Ensure the dose and time of PGE₂ vaginal administration is recorded and signed on the woman’s medication chart by the administering clinician.

5.0 Tachysystole recognition and immediate care

Prostaglandin preparations have up to a five percent rate of uterine tachysystole. Tachysystole occurs more frequently when higher doses of oxytocin or prostaglandins are used.

To reduce the risk of uterine tachysystole (hyperstimulation):

**For Prostin E₂® gel:**

- 1mg initial dose. If Prostin E₂® gel is used and a second dose is required, it must not be given within 6 hours of the first dose.

- For Prostin E₂® gel, the maximum dose, regardless of parity, is 3mg for all women in a 6 (six) hour period. There is no evidence that further doses of Prostin E₂® gel will have any benefit.

- Oxytocin (Syntocinon®), if used, must not be started for six hours following the administration of the last insertion of Prostin E₂® gel.

- Amniotomy should not be performed within four hours following the administration of the last insertion of Prostin E₂® gel.

**For Cervidil®:**

- Oxytocin (Syntocinon®) must not be commenced less than 30 minutes after removal of the pessary.

If tachysystole with fetal heart rate changes occurs:

- Removing the PGE₂ pessary can reverse the effects of tachysystole.

- If prostaglandin gel was applied locally, cervical/vaginal lavage is not helpful for removing the drug or reversing adverse effects.
• In the presence of a FHR pattern which is suspicious or pathological; Immediately CALL FOR HELP – request a clinical review or call a rapid response as per local CERS procedure and request obstetric assistance as per GL2018_025 Fetal Heart Rate Monitoring: Antenatal Fetal Heart Rate Pattern Algorithm clinical response and management plan (Appendix A).
  • Change the maternal position (roll the woman onto her left side);
  • Increase hydration or IV fluids to avoid dehydration;
  • Continue EFM;
  • Stay with the woman until FHR pattern returns to normal or a management plan has been defined.

If there is no prompt response to discontinuation of the uterotonic and supportive measures, tocolysis should be considered:
  Glyceryl trinitrate 50 micrograms administered intravenously followed by up to four (4) additional doses of 50 micrograms or two (2) metered sprays orally.
  Terbutaline 0.25 mg (250 micrograms) administered subcutaneously.
  Salbutamol 0.25 mg (250 micrograms) administered intravenously.

See Appendices C and D: Tocolysis for Uterine Hyperstimulation.

6.0 Required Knowledge and Assessment to Perform this Procedure
Cervical ripening for induction of labour should be undertaken within a maternity service with the appropriate service capability. Consultation and referral pathways should be in place to facilitate the woman’s movement between services within their Tiered Maternity Network.

All staff performing this procedure must be aware of adverse reactions of PGE2 and the contraindications for administration.

Insertion of prostaglandins for cervical ripening should only be undertaken by experienced registered midwives and medical officers. Students of the above disciplines may perform the procedure only under direct supervision of a RM/MO as applicable. Inexperienced staff should seek supervision from senior staff for this procedure.

All clinicians working in NNSW LHD acute maternity services are to complete all components of the NSW Health Fetal welfare, Obstetric emergencies and Neonatal; resuscitation Training (FONT©) program, once every three years. As outlined in IB2012_042 Fetal Welfare, Obstetric Emergency, Neonatal Resuscitation Training (FONT).

All clinicians are to be aware of their obligation to comply with NSW Health PD2007_036 Infection Control and PD2010_058 Hand Hygiene; including NC-NNSW-PRO-7611-15 NNSW LHD Standard Precautions Procedure, NC-NNSW-PRO-7641-15 NNSW LHD Occupational Blood and Body Substance Exposure and Potential Healthcare Associated Blood Borne Virus Infection Procedure and NC-AREA-POL-3728-08 08 NNSW LHD Safe Handling, Use
7.0 Monitoring and Evaluation
Cervical ripening leading to a significant adverse event are to be:
- notified in the IIMS system as per PD2009_003 Maternity Clinical Risk Management Program. Open disclosure regarding the incident must be undertaken as per PD2014_040 Open Disclosure.
- the subject of a multidisciplinary clinical review.

Midwifery Unit Managers are responsible for ensuring compliance with this procedure.

8.0 Definitions
Membrane sweeping involves the health professional introducing a finger into the cervical os and ‘sweeping’ it around the circumference of the cervix during a vaginal examination, with the aim of separating the fetal membranes from the cervix and triggering the release of prostaglandins. This can lead to softening of the cervix and may reduce the need for induction of labour.

GBS colonisation presence of Group B streptococcus (GBS) bacteria without having any symptoms; bacteria are particularly found in the gastrointestinal tract, vagina and urethra.

Bishops Score is a quantitative means of describing cervical status prior to induction, based upon the station of the presenting part and four characteristics of the cervix: dilatation, effacement, consistency, and position.

Posterior fornix is the area behind the neck of the cervix. The tampon-like end of the Cervidil® pessary, which holds the medicine, is placed transversely behind the posterior fornix to ensure it remains in place.

Prostaglandins PGE$_2$ soften and dilate the cervix may also stimulate contractility of the uterine and other smooth muscle.

Amniotomy artificial rupture of membranes

Uterine tachysystole (hyperstimulation) more than 5 contractions in ten minutes averaged over a 30 minute period.

Lavage irrigation or washing out of an organ or cavity.

Tocolysis inhibition of uterine contractions.

9.0 References
1. Kelly AJ, Kavanagh J, Thomas J. Vaginal prostaglandin (PGE$_2$ and PGF2a) for induction of labour at term. Cochrane Database of
2. PD2011_075 Oxytocin for the Induction of Labour at or Beyond Term.

3. PD2005_406 Consent to Medical Treatment – Patient Information


5. PD2012_069 Health Care Records - Documentation and Management


8. GL2014_015 Maternity – Management of Pregnancy Beyond 41 Weeks Gestation

9. Cervidil® Pharmaco (NZ) Ltd 2014 CERVIDIL® Dinoprostone Consumer Medicine Information

10. GL2018_025 Fetal Heart Rate Monitoring


10.0 Appendices

Appendix A: Modified Bishop Cervical Score System.

Appendix B: Antenatal Fetal Heart Rate Pattern Algorithm - Clinical Response and Management Plan.

Appendix C: Terbutaline Tocolysis Regime for Uterine Tachysystole.

Appendix D: Salbutamol Tocolysis Regime for Uterine Tachysystole.
Modified Bishop Cervical Score System as per NSW Health PD2011_075

In Australia, prostaglandins are promoted for cervical ripening with intact membranes and a modified Bishop Score <5.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>Score</th>
</tr>
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<tbody>
<tr>
<td>Dilatation cm)</td>
<td>&lt; 1</td>
<td>1 - 2</td>
<td>2 - 4</td>
<td>&gt; 4</td>
<td></td>
</tr>
<tr>
<td>Length (cm)</td>
<td>&gt; 4</td>
<td>2 - 4</td>
<td>1 - 2</td>
<td>&lt; 1</td>
<td></td>
</tr>
<tr>
<td>Consistency</td>
<td>Firm</td>
<td>Average</td>
<td>Soft</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Position of cervix</td>
<td>Posterior</td>
<td>Middle/anterior</td>
<td>-</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Station</td>
<td>- 3</td>
<td>- 2</td>
<td>-1 to 0</td>
<td>+1 to</td>
<td>+2</td>
</tr>
</tbody>
</table>

Do not insert Prostaglandins if Bishop Score if greater than 5 unless discussed with the Medical Officer.
# Antenatal Fetal Heart Rate Pattern Algorithm - Clinical Response and Management Plan

## Antenatal Fetal Heart Rate Pattern Interpretation and Management Algorithm

<table>
<thead>
<tr>
<th>Identified risk for Antenatal FHR Monitoring</th>
<th>Maternal</th>
<th>Fetal</th>
</tr>
</thead>
</table>
| Any change in maternal condition where you consider there may be compromise to fetal welfare. Conditions may include those covered in NSW Health’s 2013 PD Maternity – Fetal Heart Rate Monitoring, for example: | • Uncontrolled hypertension  
• Preterm labour | • Any obstetric condition that increases the risk of fetal compromise  
• Any condition that increases the risk of fetal compromise  
• Absent or decreased fetal movement  
• IUSSR  
• Non-reassuring finding on auscultation |

## Features

<table>
<thead>
<tr>
<th>Features</th>
<th>Contraction</th>
<th>Baseline Rate (bpm)</th>
<th>Variability (bpm)</th>
<th>Reactivity (Two accelerations present in 10 mins)</th>
<th>Decelerations</th>
</tr>
</thead>
</table>
| Reassuring | • Nil  
• Present >37/40 | 110–160 | ≥ 5 | Present | • None  
• Single isolated |
| Non-reassuring | • Present <37/40  
100–109  
161–179 | 100–109  
161–179 | < 5 for > 30 mins  
>25 for >15 mins | Absent >30 mins | • Repetitive  
• Shallow  
• Prolonged < 3 mins |
| Abnormal | • Tonic >2min  
• ≥6:10 | < 200  
> 180 | < 5 >40 mins  
< 5 >10 mins | Absent >60 mins | • Prolonged > 3 mins |

## Management Plan - Clinical Response

- **Reassuring features**: Cease monitoring. All features of the fetal heart rate pattern are reassuring, and/or there is no perceived risk of fetal compromise as the maternal condition stabilises, e.g. bleeding placenta praevia.

- **One or more non-reassuring features**: Keep monitoring with ongoing assessment. Escalate to the midwife in charge (Team Leader) or medical officer for a clinical review within 30 mins (do not give food or oral fluids).

- **One or more abnormal features**: Notify a medical officer for immediate review. Consider further fetal wellbeing assessment and/or consider expediting birth.

* A clinician may call for a clinical review at any time if they are concerned or unsure.
Terbutaline Tocolysis Regime for Uterine Tachysystole

**Indication**  Persistent uterine hyper contractility with fetal compromise

**Contraindications**
- Sympathomimetic amine hypersensitivity

**Relative contraindications**
- Cardiac disease
- Hypertension
- Hyperthyroidism
- Diabetes

<table>
<thead>
<tr>
<th>Terbutaline: 1 mL ampoule 500 micrograms / 1 mL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dosage and administration:</strong> May be given subcutaneously or intravenously</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subcutaneous administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Using a 1 mL syringe, draw up 0.5 mL (250 micrograms) of terbutaline and administer subcutaneously</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intravenous administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Using a 1 mL syringe, draw up 0.5 mL (250 micrograms) of terbutaline</td>
</tr>
<tr>
<td>• Add to a 10 mL syringe and make up to 10 mL with sodium chloride 0.9 % (final concentration 25 micrograms per mL)</td>
</tr>
<tr>
<td>• Administer 50 microgram (2 mL of preparation) boluses over 1-2 minutes. May be repeated up in 50 microgram increments (to 250 micrograms in total) after 5 minutes if hypertonus sustained</td>
</tr>
</tbody>
</table>

**Monitor maternal pulse whilst bolus doses are administered**
**Stop IV administration if maternal tachycardia > 140/min**

**Side effects**
Tremor, headache, nervousness, cardiovascular effects including arrhythmia, tachycardia, palpitation, muscle cramps, hypokalaemia.
Salbutamol Tocolysis Regime for Uterine Tachysystole

**Indication**  Persistent uterine hyper contractility with fetal compromise

**Contraindications**

A bolus dose of salbutamol is contraindicated in women with:

- Cardiac disease
- Hypertension
- Hyperthyroidism
- Salbutamol sensitivity

**Relative contraindication**

- Diabetes

<table>
<thead>
<tr>
<th>Salbutamol: 1 mL ampoule 500 micrograms / 1 mL</th>
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<tbody>
<tr>
<td><strong>Dosage and administration</strong></td>
</tr>
<tr>
<td>Salbutamol 100 micrograms intravenously</td>
</tr>
</tbody>
</table>

  - Using a 1 mL syringe, draw up 1 mL (500 micrograms) of salbutamol sulphate *(Not Ventolin Obstetric)*
  - add to a 10 mL syringe and make up to 10 mL with sodium chloride 0.9 % (final concentration 50 micrograms per mL)
  - Administer 100 micrograms (2 ml of preparation) over 1-2 minutes. May be repeated after 5 minutes if hypertonus sustained

<table>
<thead>
<tr>
<th>Monitor maternal pulse whilst bolus doses are administered</th>
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<tbody>
<tr>
<td>Stop IV administration if maternal tachycardia &gt; 140 /min</td>
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</tbody>
</table>

**Side effects**

Fetal and maternal tachycardia, maternal hypotension, ventricular ectopic beats, supra-ventricular tachycardia, ventricular fibrillation, pulmonary oedema, hypoxia – secondary to increased oxygen demands + / - fluid shift in lungs, hyperglycaemia
## 11.0 NNSW LHD Clinical Procedure Cover Sheet

<table>
<thead>
<tr>
<th>COVER SHEET</th>
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<tbody>
<tr>
<td>NNSW Local Health District CLINICAL Policy Framework</td>
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<table>
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<th>Name Of Document</th>
<th>Prostaglandin Cervical Ripening prior to Induction of Labour</th>
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<tr>
<td>Type of Document</td>
<td>Procedure</td>
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<tr>
<td>Document Number</td>
<td>NC-NNSW-PRO-7674-16</td>
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<tr>
<td>Superseded Document</td>
<td>Induction of Labour CP.12.037 Induction of Labour Prostaglandins W50</td>
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<td>Sites/Services where compliance with this procedure is mandatory.</td>
<td>All NNSW maternity sites medical and midwifery staff caring for pregnant women requiring cervical ripening prior to induction of labour.</td>
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<table>
<thead>
<tr>
<th>Related Ministry of Health PDs, LHD Documents or Australian Standards:</th>
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<tbody>
<tr>
<td>• PD2013_049 <a href="#">Recognition and Management of Patients who are Clinically Deteriorating</a></td>
</tr>
<tr>
<td>• <a href="#">NSW Health Risk Matrix</a></td>
</tr>
<tr>
<td>• PD2005_406 <a href="#">Consent to Medical Treatment – Patient Information</a></td>
</tr>
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<td>• PD2012_069 <a href="#">Health Care Records -Documentation and Management</a></td>
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<td>• GL2018_025 <a href="#">Fetal Heart Rate Monitoring</a></td>
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<td>• GL2014_015 <a href="#">Maternity – Management of Pregnancy Beyond 41 Weeks Gestation</a></td>
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<td>• PD2009_003 <a href="#">Maternity Clinical Risk Management Program</a></td>
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<td>• PD2014_040 <a href="#">Open Disclosure Policy</a></td>
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<td>• IB2012_042 <a href="#">Fetal Welfare, Obstetric Emergency, Neonatal Resuscitation Training (FONT)</a></td>
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<td>• PD2009_003 <a href="#">Maternity Clinical Risk Management Program</a></td>
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<td>• PD2014_028 <a href="#">Open Disclosure</a></td>
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<td>• NSW Health PD2010_058 <a href="#">Hand Hygiene Policy</a></td>
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<td>• NSW Health PD2007_036 <a href="#">Infection Control Policy</a></td>
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<td>• NC-NNSW-PRO-7611-15 NNSW LHD <a href="#">Standard Precautions Procedure</a></td>
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<td>• NC-NNSW-PRO-7549-15 NNSW LHD <a href="#">Aseptic Technique Procedure</a></td>
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<td>• NC-NNSW-PRO-7641-15 <a href="#">NNSW LHD Occupational Blood and Body Substance Exposure and Potential</a></td>
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<td>Risk Management</td>
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