

I. PURPOSE

To guide the RN in an amnioinfusion, this may be used for patients with ruptured membranes to ameliorate repetitive variable or prolonged decelerations unresponsive to conservative measures.

II. DEFINITIONS

None.

III. POLICY

RNs trained in labor and delivery and familiar with intrauterine pressure catheters (IUPC) monitoring may administer an amnioinfusion with a CNM or physician order.

IV. PROCEDURES

CRITICAL POINTS

- A. Continuous FHR monitoring is indicated for the duration of the amnioinfusion.
- B. Contraindications:
 - 1. Non-vertex presentation
 - 2. Prolapsed cord (proceed to emergent cesarean section)
- C. Proceed with caution:
 - 1. Chorioamnionitis
 - 2. Previous uterine scar

PROCEDURAL STEPS

- A. Gather the following equipment:
 - 1. Infusion pump (optional)
 - 2. 1000 ml room temperature normal saline
 - 3. IV tubing (for the infusion pump or for gravity flow)
 - 4. Intrauterine pressure catheter and monitoring cable
 - 5. Absorbent underpads
- B. Place several absorbent pads under patient.
- C. Explain procedure and obtain patient consent.
- D. Assist CNM/physician with sterile vaginal exam and placement of IUPC per protocol.
- E. Obtain a baseline assessment of uterine tone prior to initiating Amnioinfusion.
- F. Hang 1000 ml bag of room temperature normal saline solution. Prime tubing and attach to an infusion pump (optional) or hang to gravity (as decided by bedside team). Label bag and tubing "Amnioinfusion" and consider taping off all injection ports to visually distinguish it from the IV fluid bags.

- G. Attach tubing to IUPC at the tubing port near the end of the catheter. Per manufacturer recommendations, open blue cap to allow for amniotic fluid to backfill IUPC tube before connection to avoid infusion of air into uterus.
- H. The amnioinfusion usually begins with an initial bolus of 500 ml over 60 min until the variable decelerations resolve, followed by a continuous infusion of 100-200 ml/hr to a maximum of one liter. The amnioinfusion is written as a treatment order per CNM or physician. The initial bolus amount and administration time may be modified by the CNM or physician.
- I. Assess and document resting uterine tone and fluid return from the vagina at least hourly.
- J. The amnioinfusion bolus may be repeated with an order if variable decelerations are not extinguished.
- K. Prior to initiating additional amnioinfusion boluses and periodically during a maintenance infusion, ensure that adequate fluid return from the vagina is demonstrated and that the resting uterine baseline tone is maintained.
- L. Observe patient for lack of fluid return from the vagina and persistent rise in baseline tone. If absence of fluid return and/or persistent increased baseline tone > 15mmHg above baseline is noted, stop the infusion and request a bedside CNM or physician evaluation.

V. REFERENCES

- A. Rogue, H., Gillen-Goldstein, J., & Funai, E.F. Amnioinfusion: Technique. UpToDate.com retrieved on 12/14/2017 – content last updated 12/1/2017.
- B. ACOG (2006). Amnioinfusion does not prevent meconium aspiration syndrome. ACOG Committee Opinion #346, Washington DC: American College of Obstetricians and Gynecologists.

VI. RESPONSIBILITY

For questions regarding this policy contact the Birthing Center Clinical Nurse Specialist.

VII. HISTORY OF POLICY

Author:

Issue Date:

Reviewed and Revised: Mar 2014, M. Killion RN CNS, M.P. Thiet MD

Last Revision/Review: July 2022, W. Pubien, RN; A. De Leon, RN

VIII. APPENDIX

None

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