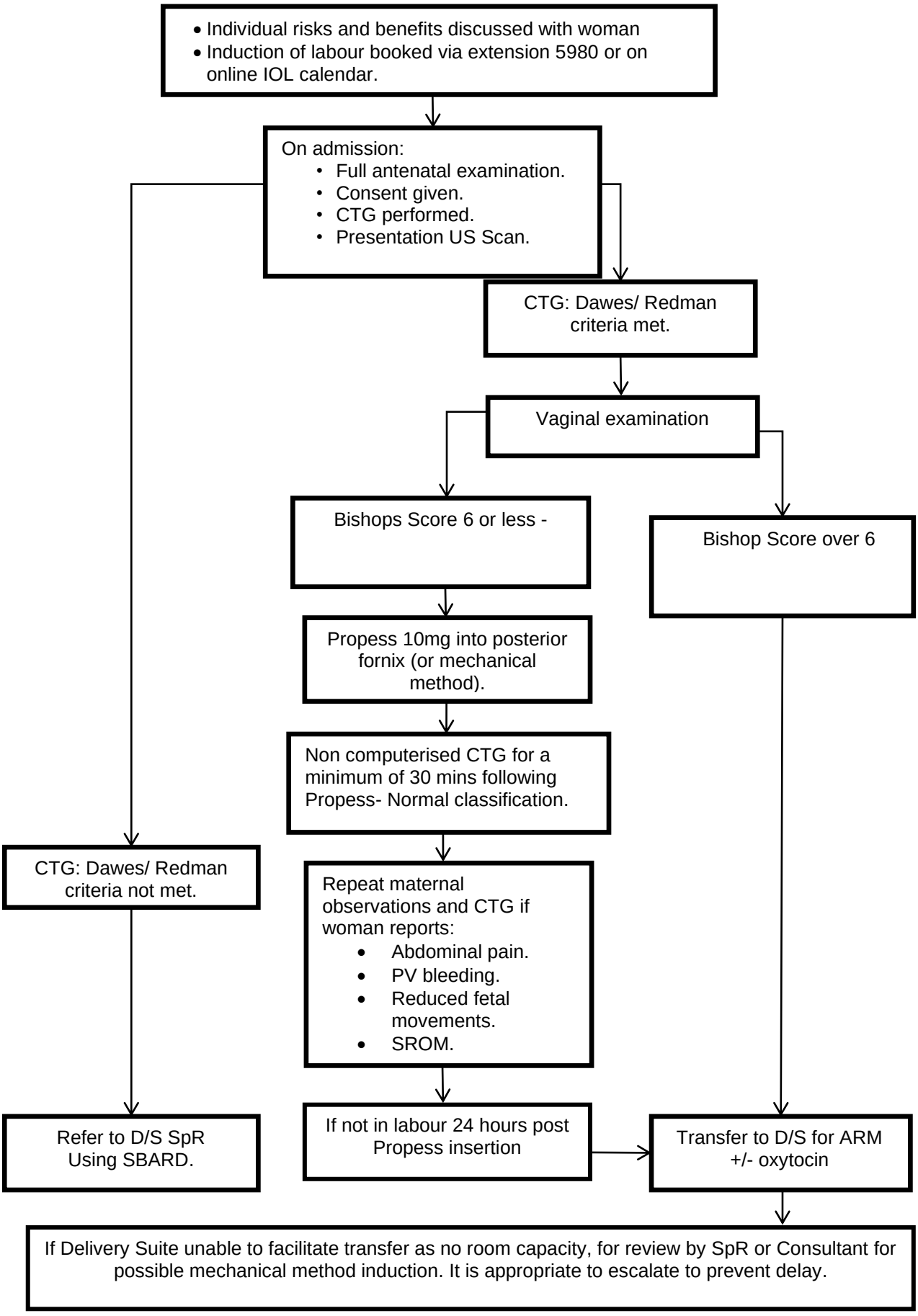
Royal Cornwall Hospitals
NHS Trust

Induction of Labour Clinical Guideline

V3.2

September 2024

Summary


• Individual risks and benefits discussed with woman
• Induction of labour booked via extension 5980 or on online IOL calendar.
On admission:
• Full antenatal examination.
• Consent given.
• CTG performed.
• Presentation US Scan.
CTG: Dawes/ Redman criteria met.
Vaginal examination
Bishops Score 6 or less -
Bishop Score over 6
Propess 10mg into posterior fornix (or mechanical method).
Non computerised CTG for a minimum of 30 mins following Propess- Normal classification.
CTG: Dawes/ Redman criteria not met.
Repeat maternal observations and CTG if woman reports:
• Abdominal pain.
• PV bleeding.
• Reduced fetal movements.
• SROM.
Refer to D/S SpR Using SBARD.
If not in labour 24 hours post Propess insertion
Transfer to D/S for ARM +/- oxytocin
If Delivery Suite unable to facilitate transfer as no room capacity, for review by SpR or Consultant for possible mechanical method induction. It is appropriate to escalate to prevent delay.

1. Aim/Purpose of this Guideline

1.1. This guideline gives guidance to midwives and obstetricians on induction of labour.

1.2. This guideline is also intended give guidance to Midwives and Obstetricians on outpatient induction of labour (IOL) for women with uncomplicated pregnancies and at low risk of developing intrapartum complications (NEW 2022).

1.3. This version supersedes any previous versions of this document.

1.4. This guideline makes recommendations for women and people who are pregnant. For simplicity of language the guideline uses the term women throughout, but this should be taken to also include people who do not identify as women but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman, please ask them their preferred pronouns, and then ensure this is clearly documented in their notes to inform all health care professionals.

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2. The Guidance

2.1. **Background**

Induction of labour (IOL) is offered when there is a medical indication or maybe offered where it the personal choice of the woman after careful discussion with an experienced obstetrician.

The exception is routine induction for prolonged low risk pregnancy or term rupture of membranes which may be arranged by a midwife.

2.2. Membrane sweep

2.2.1. Membrane sweeping should be offered to all women at routine antenatal clinic appointments from 39 weeks (NEW 2022) (provided low lying placenta is excluded and there are no other clinical contraindications). An additional appointment for a stretch and sweep alone is not recommended.

2.2.2. All stretch and sweeps should be documented in full on a vaginal examination sticker (NEW 2022).

2.2.3. The woman should be informed that it might be associated with discomfort and light bleeding.

2.2.4. Women should be advised to contact maternity triage if they experience any bleeding that is not light or does not settle, any altered fetal movements, rupture of membranes or suspected labour (NEW 2022).

2.2.5. Discuss with women whether they would like to have additional membrane sweeping if labour does not start spontaneously following the first sweep (NEW 2022).

2.3. Induction of labour in specific circumstances

2.3.1. Preferences about mode of birth should be discussed with women early on in their pregnancy taking into account their individual circumstances. Options for birth that should be discussed and documented include:

- Expectant management.
- Induction of labour.
- Planned caesarean birth.

2.3.2. Confirm a woman's preferences for birth at antenatal visits towards the end of pregnancy, as these may have changed since earlier discussions.

2.3.3. **Prolonged pregnancy**

- For a low-risk women with a prolonged pregnancy the community midwife should discuss and offer induction of labour from 41+0 weeks by the ultrasound scan (USS) determined EDD (NEW 2022)
- Discuss with women that IOL from 41+0 weeks may reduce risks, but that they will also need to consider the impact of IOL on their birth experience (NEW 2022).
- Ensure the information contained in points 2.14.2, 2.14.3 and 2.14.4 is communicated to enable informed choice (NEW 2022).

2.3.4. **Women who intend to decline IOL for prolonged pregnancy (NEW 2024)**

- CMW to offer to book a scan through 01872 252682 (fetal medicine administrator) and a maternity triage appointment on 08172 252916. This can be booked from 40+0 weeks for women **INTENDING** to decline IOL at T+12.

- Aim to do this scan at T+12/T+13 followed by obstetric review in maternity triage.

- Scan should be liquor and dopplers (UA +MCA) with an offer of growth (if not done within last 2 weeks) and discussion re limitations.

2.3.5. **Women who decline an IOL**

Women should be referred to Maternity Triage to discuss the option of additional monitoring at 42 weeks with an SpR or Consultant. Advise women that:

- Monitoring only gives a snapshot of the current situation, and cannot predict reliably any changes after monitoring ends, but provides information on how their baby is at the moment and so may help them make a decision on options for birth.

- Adverse effects on the baby (including stillbirth), and when these events might happen, cannot be predicted reliably, or prevented even with monitoring.

- Fetal monitoring by twice weekly cardiotocography and weekly ultrasound estimation of maximum amniotic pool depth would be offered.

- Women who would decline an induction of labour and who's gestation exceed 42+0 weeks gestation, would be recommended to labour and birth on Delivery Suite with continuous fetal monitoring.

2.4. **Induction of labour for maternal request**

Consider requests for induction of labour only after discussing the benefits and risks with the woman and taking into account the woman's circumstances and preferences. Any IOL for maternal request must only be approved by an experienced obstetrician (NEW 2022).

2.5. **Small for Gestational Age (SGA) / Fetal Growth Restriction (FGR) or other fetal concerns**

If the indication for induction is severe SGA/ FGR or other fetal concerns, then induction on the delivery suite should be considered. This decision should be made by the obstetrician booking the induction and communicated accordingly. A caesarean section should only be recommended for an SGA fetus by a consultant and fetal medicine input is advised where there is a possibility that IOL may be tolerated by the fetus (NEW 2022).

2.6. **Preterm Pre-labour Ruptured of Membranes (PPROM) and Pre-labour rupture of membranes at term (PROM)**

2.6.1. For PPROM and PROM, please see Preterm Prelabour Rupture of Membranes (PPROM) Diagnosis and Management Clinical Guideline V3.1 (cornwall.nhs.uk) and Prelabour Rupture of Membranes at Term (Term PROM) Clinical Guideline (cornwall.nhs.uk).

2.6.2. Women who have pre labour rupture of membranes (PROM) and are group strep B (GBS) positive, should be offered an immediate IOL on Delivery Suite with oxytocin as soon as Ruptured of Membranes (ROM) is confirmed.

2.7. **Previous caesarean section**

2.7.1. Induction of labour for a woman who has had a previous caesarean section should only be made by a senior obstetrician and a clear plan documented in her maternity records prior to admission. The increased risk of uterine rupture should be explained to the woman.

2.7.2. Induction should be by artificial rupture of membranes (ARM) if possible. The woman should be offered mechanical induction if ARM is not possible (NEW 2022). Propess is contraindicated for induction of labour for women with a uterine scar.

2.8. **Maternal diabetes**

Please see Diabetes Mellitus (pre-existing) in Pregnancy Clinical Guideline (cornwall.nhs.uk) and Gestational Diabetes Mellitus (GDM) Clinical Guideline (cornwall.nhs.uk).

2.9. **Intrauterine death**

Please see Stillbirth Management Clinical Guideline (cornwall.nhs.uk) and Maternity Unit Neonatal Death (Early) Clinical Guideline (cornwall.nhs.uk).

2.10. **Breech presentation**

IOL should be a consultant decision only and will only be considered if caesarean section is declined and external cephalic version (ECV) is unsuccessful, declined, or contraindicated, see Breech Presentation, External Cephalic Version (ECV) and Breech Presentation in Labour Clinical Guideline V3.1 (cornwall.nhs.uk).

2.11. **Para 4 or more**

Induction should be via ARM or mechanical method. The decision to use Propess should only be made at consultant level.

2.12. **Suspected macrosomia**

Options for induction of labour with suspected macrosomia should be discussed with women, as well as expectant management and caesarean birth (NEW 2022) (NICE 2021). Please see Large for Gestational Age/Suspected Fetal Macrosomia Clinical Guideline (cornwall.nhs.uk).

2.13. **Assisted Conception**

Women whose pregnancy is from successful assisted conception, could be offered an Induction of Labour at 40 weeks gestation (NEW 2022).

2.14. **To avoid unattended birth**

IOL to avoid a birth unattended by a Healthcare Professional should **not** be routinely offered to women with a history of precipitate labour**.** However geographical location and maternal anxiety should be considered (NEW 2022).

2.15. **Maternal Age**

Women who are 40 years of age at booking, should be offered an induction of labour at 40 weeks gestation unless there is a secondary indication to offer IOL earlier. If IOL is declined at 40 weeks additional monitoring should be offered as in 2.3.5 from 40+2. Ensure 40-week growth scan has been undertaken and reviewed. If there has not been a scan at 40 weeks, book one through the fetal medicine admin on 01872 252682 (NEW 2022).

2.16. **Method of and Arrangements for the Induction**

2.16.1. The woman should be given personalised information about the risks and benefits for them and their babies and alternatives to IOL.

All women who are considering an induction of labour should be provided with the following information (NEW 2022):

- Induction of labour is a medical intervention that may affect their birth options and their experience of the birth process.
- Vaginal examinations to assess the cervix are needed before and during induction to determine the best method of induction and to monitor progress.
- Choice of place of birth will be limited.
- There may be a need for an assisted vaginal birth with the associated increased risk of obstetric anal sphincter injury although evidence suggests this risk is no higher than spontaneous labour.
- Pharmacological methods of induction can cause hyperstimulation.
- An induced labour may be more painful than a spontaneous labour.
- Hospital stay may be longer than with a spontaneous labour.

- An induction of labour may reduce the chance of needing a caesarean section.

2.16.2. **Discuss with women being offered induction of labour (NEW 2022):**

- The reasons for induction being offered.
- When where and how induction could be carried out.
- The arrangements for support and pain relief (see also recommendations on pain relief).
- The alternative options if the woman chooses not to have induction of labour or decides at a later stage that she no longer wishes to proceed with the induction process.
- The risks and benefits of induction of labour in specific circumstances, and the proposed induction methods.
- Induction may not be successful, and how this would affect the woman's options.

2.16.3. **When offering induction of labour (NEW 2022):**

- Give women time to discuss this information with others (for example, their partners, birthing companion, or family) if they wish to do so before making a decision.
- Encourage women to look at other information (for example, by providing written information leaflets or encouraging them to look at information on the NHS website).
- Ensure women have the opportunity to ask questions, and time to think about their options.
- Recognise that women can decide to proceed with, delay, decline or stop an induction.
- Respect the woman's decision, even if healthcare professionals disagree with it, and do not allow personal views to influence the care they are given.

2.16.4. **Healthcare Professionals should inform women that evidence does not support the use of the following to encourage the onset of labour:**

- Herbal supplements.
- Acupuncture.
- Homeopathy.
- Castor oil.

- Hot baths.
- Enemas.
- Sexual intercourse.

2.16.5. The indication for induction, the person authorising the induction and any specific management plan must be clearly documented in the woman's maternity records.

2.16.6. The doctor or midwife requesting IOL should arrange this by using the online IOL calendar or contacting extension 5980, giving detailed clinical information (NEW 2022). In the case of BMI > 40, based upon the measurement of BMI at the dating scan, IOL should commence Monday-Thursday unless there are very strong clinical indications to do so.

2.16.7. Pregnancies that are considered as 'high risk' must be given priority for the two earlier slots in the day (NEW 2022).

2.16.8. There are three available slots per day for an inpatient Induction of Labour. Where capacity is outstripped by demand, prioritisation of cases should be made by an experienced obstetrician.

2.16.9. Women should be asked to attend Wheal Rose at a planned appointment time for induction unless being induced for spontaneous rupture of membranes (SROM). Women with SROM should be offered an induction once SROM has been confirmed or advised to come in for IOL no later than 24 hours after ruptured membranes (irrespective of time).

2.16.10. **Procedure for Induction of Labour**

On admission:

The midwife allocated to care for the woman is responsible for:

- Completing the admission process, including the admission on the PAS system and an antenatal admission on the patient's electronic health records.
- Ensuring the woman has read the induction of labour leaflet and is aware of the risks and benefits of IOL individualised to her clinical situation before signing the IOL consent form.
- Performing a full antenatal examination including documentation of maternal and fetal observations using the Modified Early Obstetric Warning Score (MEOWS) chart.
- A presentation USS must be undertaken for all women to confirm presentation (NEW 2022).
- Requesting the junior doctor to review the woman`s maternity notes and electronically prescribe the IOL protocol.

2.16.11. **Pre insertion of Propess:**

2.16.11.1. The induction of labour should commence within two hours of admission.

2.16.11.2. The Midwife and prescribing doctor will check the pregnancy gestation, reason for IOL and any risk factors for induction. Any concerns regarding this need to be discussed with the SpR or Consultant on Delivery Suite.

2.16.11.3. A Cardiotocography (CTG) should be performed using the Dawes/ Redman criteria analysis and a CTG assessment sticker completed to classify the CTG (CHA3944).

2.16.11.4. If the antenatal assessment of the CTG is normal and Dawes/ Redman criteria met, a vaginal examination should be offered and performed, and cervical assessment made prior to the insertion of the Propess pessary.

2.16.12. **Insertion of Propess**

2.16.12.1. A vaginal examination should be undertaken, and a Bishops score determined (NEW 2022).

2.16.12.2. For women with a bishop score of 6 or less:

- Offer induction of labour with a Propess or
- Consider a mechanical method to induce labour if:
  - Pharmacological methods are not suitable (for example if women are at a higher risk or from hyperstimulation, or those who have had a pervious cesarean birth.
  - The woman chooses a mechanical method.

Score	0	1	2
Cervical dilatation (cm)	<1	1-2	3-4
Length of cervix (cm)	>2	1-2	<1
Station of presenting part (cm)	Spines -3	Spines -2	Spines -1
Consistency	Firm	Medium	Soft
Position	Posterior	Central	Anterior

2.16.12.3. Women who have a bishops score of OVER 6, should be admitted to Delivery Suite for ARM and oxytocin if required at the earliest possible time. The aim should be to transfer the woman to Delivery Suite within a 2-hour time frame, but it should be explained to the woman that this may be longer if there is high activity on delivery suite. (NEW 2022).

2.16.12.4. Propess should be inserted into the posterior fornix of the vagina using a small amount of water-soluble gel. There should always be sufficient tape outside the vagina to allow removal. The assessment, the vaginal examination and findings should be recorded on the induction of labour proforma and vaginal examination sticker**.**

2.16.13. **Post insertion of Propess:**

- A CTG is to be performed when the Propess pessary is inserted. Dawes Redman analysis is **NOT** valid following Propess insertion.
- **Non computerised** CTG is recommended for a minimum of 30 minutes following Propess insertion. An antenatal CTG assessment sticker (CHA 3944) should be used to classify the CTG. If the CTG is classified as normal it can be discontinued and the woman allowed to mobilise.
- **If** the CTG is abnormal:
    - The Propess should be removed.
    - An obstetric review requested using the SBARD method of escalation.
    - Consideration of the administration of Terbutaline.

2.16.13.1. The woman should remain semi-recumbent during the post-Propess CTG.

2.16.13.2. Ongoing care: Women undergoing an IOL must be discussed at the obstetric handover on Delivery Suite and a plan made as to how a transfer can be facilitated at 24 hours post Propess.

Maternal pulse and blood pressure should be taken and a CTG recommenced if the woman reports any of the following:

- Abdominal pain.
- Painful uterine activity.
- PV bleeding.
- Reduced fetal movements.
- Spontaneous rupture of membranes (SROM).

- A change in behavior.

The CTG must be classified using the CTG Assessment Sticker (CHA3944) and **NOT** using Dawes Redman.

2.16.13.3. **MEOWS**:

All women undergoing an inpatient IOL must have 4 hourly observations and a MEOWs score.

2.16.13.4. If the woman starts to experience any contractions, a CTG should be performed and classified using the antenatal CTG sticker for classification (NEW 2022).

2.16.13.5. If intrapartum antibiotic prophylaxis for group B haemolytic streptococcus is indicated, this should be administered at the onset of any regular uterine activity.

2.16.13.6. If contractions become strong and regular or if the woman requires any analgesia, then a CTG should be commenced, and vaginal examination should be considered with Propess in situ. If the woman is not in labour do not remove the Propess and continue the electronic fetal monitoring. The CTG should be classified using an antenatal sticker until the point that established labour has been diagnosed.

2.16.13.7. If labour is diagnosed or there has been a change in the dilation of the cervix and the woman is having strong and regular contractions, the Propess should be removed. The woman should be transferred to the appropriate place for ongoing labour care. Monitoring should be continued as detailed in the 'Further Management' section below. If there is a delay in transfer once labour has been diagnosed, a partogram should be commenced and fetal heart monitored using intrapartum classification.

2.16.13.8. If SROM occurs but labour is not established DO NOT remove the pessary. Delivery suite should be informed and a CTG should be commenced. If the CTG is normal, observe and continue the induction process until either labour does establish or 24 hours has elapsed since insertion.

2.16.13.9. If at any point the Propess pessary inadvertently falls out, then the same Propess can be reinserted provided it has remained clean. For women with intact membranes, a Propess can be re-inserted twice. If the Propess falls out after this, Delivery Suite should be advised, and a transfer arranged at the earliest possible time according to clinical need.

2.16.13.10. For women, whose membranes have ruptured, the Propess can only be re-inserted once.

2.17. Mechanical Induction of Labour

Women who are not having Propess as their primary method of induction of labour and who's bishops score is 6 or less may be offered or choose to have a mechanical induction of labour.

2.17.1. The admission process is the same as with a propess. A post mechanical method insertion CTG is not required.

2.17.2. Post insertion of the mechanical method, the fetal heart should be auscultated and documented.

2.17.3. Transfer should be accommodated at 12-16 hours post insertion. If transfer is not possible, the mechanical method can stay in situ for up to 24 hours. Transfer should be facilitated as soon as possible after the initial 12 hours.

2.17.4. Further management remains the same as for induction of labour with Propess.

2.18. Outpatient IOL pathway

2.18.1. Criteria for outpatient IOL

It is essential that there is a careful risk profiling of women eligible for outpatient induction of labour and that it is only offered to low risk women who meet the following criteria:

- Uncomplicated pregnancy requiring induction for post maturity at 41+0 (NEW 2022) or for maternal request (Decision by experienced obstetrician.
- The woman has transport available and lives within 45 minutes of the hospital (at the busiest time of the day or season) and is in a position to leave their home as soon as there is an indication to do so.
- Patient has a reliable home mobile/landline phone.
- Number of previous births 3 or fewer.
- Reassuring pre and post Propess fetal heart rate monitoring.
- A reliable birth companion to remain with the woman at home.

2.18.2. Information given to patients

Women should be given clear verbal and written information on outpatient induction of labour containing:

- The reasons for induction being offered.
- When where and how induction could be carried out.
- The arrangements for support and pain relief.

- The alternative options if the woman chooses not to have induction of labour.

- The risks and benefits of outpatient IOL in specific circumstances and the proposed induction.

- That induction may not be successful and what options are available to the woman.

2.18.3. **Method of and Arrangements for the Induction**

- The indication for induction, the person authorising the induction and any specific management plan must be clearly documented in the woman's handheld notes.

- The doctor or midwife requesting IOL should arrange this by contacting extension 2916 to book in the IOL diary, giving detailed clinical information.

- Only two outpatient inductions of labour can be booked per day. If both available slots are booked, an inpatient induction of labour can be offered as an alternative.

- Women should be asked to attend Wheal Rose on the morning of the induction at their allocated time.

2.18.4. **Procedure for Outpatient Induction of Labour**

2.18.4.1. **On admission:**

The midwife allocated to care for the woman is responsible for:

- Completing the admission process, including admission on the PAS system.

- Ensuring the woman has read the IOL leaflet and is aware of the IOL risks and benefits of IOL individualised to her clinical situation before signing the IOL consent form.

- Performing a full antenatal examination including documentation of a full set of observations on a MEOWS chart, abdominal palpation, urinalysis, and a CTG.

    - The pre-Propess CTG must meet Dawes Redman Criteria and should be documented on the CTG assessment sticker (CHA3944).

- Request the junior doctor reviews the woman`s maternity notes and electronically prescribe the IOL protocol.

- Ensure that they are appropriate to undergo an outpatient IOL – check the exclusion criteria.

- If the Bishops Score is more than 6, a Propess should not be used, and arrangements made to transfer to delivery suite for ARM at earliest opportunity.

- Time of Propess insertion, parity, and indication for IOL and patient phone number will be taken, and the patient advised to return to Wheal Rose 24 hours after Propess insertion unless the woman experiences any of the symptoms in 2.4.9.2. The details must be written into ward diary for every patient.

- Following Propess, the patient can go home after 60 mins of normal post Propess CTG. The CTG assessment sticker (CHA3944) must be used to assess the CTG, and the sticker applied into the handheld records.

- Maternal observations must all be within normal parameters and documented on the MEOWS chart prior to discharge home.

- The women must be 'sent on leave' on PAS and not discharged to ensure her prescription information remains active.

2.18.4.2. All women who have an outpatient induction of labour must be advised to return to the hospital as soon as:

- Experience any contractions.

- Bleeding more than show.

- Rupture membranes.

- Reduced fetal movements.

- Need for analgesia (more than paracetamol).

- Anxiety or patient wishes to return.

- Propess falls out.

- Or any concerns.

2.18.4.3. Any calls from the patient will be documented via Wheal Rose 01872 252149. This information will form part of the audit and will need to include the time of call, the reason for call and the outcome of call and documented on the electronic health record.

2.18.4.4. If the woman labours from her Propess and is suitable for care on the Birth Centre, she will require CTG monitoring for a minimum of 30 minutes prior to transfer to the Birth Centre for labour care.

- The CTG assessment sticker (CHA3944) must be used to assess the CTG and stuck into the handheld records. The CTG monitoring will take place on the antenatal ward (as per all women who are an in-patient IOL requiring a CTG for contractions starting with IOL).

- If the woman appears to be in advanced labour upon arrival, consider either undertaking a VE to confirm or immediate transfer to Delivery Suite if performing a VE or CTG on the antenatal ward could cause a delay and lead to a birth on the antenatal ward.

- A Partogram must be commenced upon suspected or confirmed active labour without waiting for a cervical assessment. (NEW 2023).

2.18.4.5. Patients must be readmitted directly to Wheal Rose 24 hours after Propess insertion if they have not laboured (NEW 2023).

2.18.5. **Patient exclusions for Outpatient Induction of Labour**

- Gestational age 37+0 weeks or >41+5.
- More than 3 term pregnancies.
- Age over 40 years at booking where gestation is over 40+2.
- Poor English (must be able to understand, communicate effectively and be able to read the patient information).
- Multiple gestation.
- Malpresentation.
- Previous uterine surgery (including caesarean section, myomectomy and hysterotomy).
- Previous precipitate delivery (labour less than 2 hours).
- Ruptured membranes.
- SFH measuring under 10th centile on GROW chart or confirmed estimated fetal weight on ultrasound of less than 10th centile.
- Non reassuring pre- or post-Propess CTG.
- Induction of labour due to maternal co-morbidities.
- Induction of labour due to fetal concerns.
- Lives over 45 minutes from hospital in traffic (allow the patient to judge this).

- No phone.
- No responsible adult to stay with them.
- Significant learning difficulties/disability that would prohibit them or their support person from seeking advice or returning to the hospital.
- Significant APH from 24 weeks (Obstetrician to decide).
- Any contraindication to the use of Propess.
- Safeguarding concerns require a plan from safeguarding midwifery team.

2.19. **Further Management of all Induction of Labour (Outpatient/Inpatient):**

2.19.1. Women with low-risk pregnancies who have started in labour with Propess, or a mechanical method, alone can remain under midwifery led care. Intermittent auscultation of the fetal heart is appropriate provided that:

- The CTG remains normal for 30 minutes post removal of Propess.
- The woman is not started on oxytocin.
- And there are no fetal or maternal reasons requiring continuous fetal monitoring.
- If a woman is suitable for care on Truro Birth Centre, a CTG must be performed prior to transfer for a minimum of 30 minutes and classified using intrapartum classification (NEW 2022).

2.19.2. Women who have not established in labour with Propess or who do not meet the above criteria for intermittent auscultation due to additional risk factors, will be transferred to consultant led care on Delivery Suite. Women who have not established in labour 24 hours after insertion of Propess or 12-16 hours after mechanical method insertion.

2.19.3. The woman should be transferred to Delivery Suite 24 hours after the insertion of Propess or 12-16 hours after the insertion of a mechanical method and a CTG commenced.

2.19.4. An obstetric review should take place within 30 minutes of transfer to Delivery Suite. Confirmation to continue with the ongoing elements of induction of labour should be obtained and any further questions answered.

2.19.5. A vaginal assessment should be offered and the Propess removed.

2.19.6. Advise women that they can have an amniotomy and choose whether they would prefer to start an oxytocin infusion or delay starting this, but a delay may mean labour takes longer and there may be an increased risk of neonatal infection. There should be a minimum 30-minute period from removing the Propess to starting oxytocin.

2.19.7. Women who are suitable to labour on Truro Birth Centre, including those with a clearly documented individualised plan, could transfer to Truro Birth Centre if an ARM induces labour. This must be agreed by an obstetrician during the induction process (NEW 2022).

2.19.8. A partogram must be commenced at the onset of regular contractions following an ARM, regardless of dilatation (NEW 2023).

2.19.9. Consideration should be given to the appropriate time to insert a cannula and take bloods for FBC and Group and Save (NEW 2022).

2.20. **If ARM not possible**

2.20.1. If the midwife is unable to perform an ARM, the Registrar or Consultant should attempt an ARM. If neither are available, this can be undertaken by the Delivery Suite (DS) Coordinator.

2.20.2. A discussion should take place with the woman about her next options which would include:

- An oxytocin infusion to try to achieve cervical dilation sufficient for ARM. In this case oxytocin is delivered in accordance to the protocol and should be titrated against frequency and strength of uterine contractions as normal, contraction strength and frequency should be determined by palpating the uterus for a 10 minute period. A partogram must be commenced at the beginning of the oxytocin infusion (NEW 2023).

- A mechanical method induction. (an ARM should then be performed 12 hours after insertion). A consultant should be involved in this decision (NEW 2022).

- A caesarean section (NEW 2022).

A further attempt to induce labour at a later stage may be appropriate for some women if an ARM has not been performed and oxytocin has not been started. The timing will depend on the clinical situation and the woman's wishes. The decision for this should be made by a consultant.

2.20.3. If ARM is not feasible after an oxytocin trial a caesarean section may be offered on the grounds of unsuccessful induction. The ARM must however be attempted by the most experienced person available prior to making this decision.

2.21. **Delay in transfer to Delivery Suite 24 hours post Propess**

2.21.1. Women should be transferred to Delivery Suite 24 hours after Propess insertion. If there is a delay in transferring the women to Delivery Suite, the Delivery Suite Consultant or SpR must try to facilitate transfer.

If there is a delivery room available, transfer should not be delayed as 1:1 care is not required for Artificial Rupture of Membranes (ARM) to occur.

If the woman is unable to be transferred to Delivery Suite, she should be reviewed by the SpR/Consultant at 24hours post Propess with an SBARD sticker used when the delay is escalated to the obstetrician (NEW 2022). The woman must have a CTG using antenatal CTG sticker classification).

- An obstetric review should be requested 24 hours post Propess if there is a delay in transfer to Delivery Suite.
- A cervical assessment should be offered to assess if mechanical method induction is appropriate.
- A mechanical method should be offered and if accepted can be inserted on Wheal Rose. The insertion of a mechanical method should not further delay a transfer to Delivery Suite if they are able to facilitate.
- Women who are having an induction for pre-labour rupture of membranes should be prioritised to avoid delays after Propess and Propess can be left in for up to 30 hours in total. A mechanical method should not be offered for PROM.
- The woman must be transferred to Delivery Suite as soon as a delivery room becomes available irrespective of whether or when the mechanical method was inserted. Transfer should not be delayed due to staffing. The escalation policy may be triggered for a delayed induction.

2.21.2. If transfer to Delivery Suite is delayed by more than 6 hours, a DATIX must be completed.

2.21.3. Women should not go home after having Propess unless undergoing an Outpatient Induction of Labour having had a full risk assessment. In the exceptional circumstance that this may happen, then the whole induction process will need to be started again.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	• Was the woman offered induction of labour at T+7 for low-risk pregnancies? • Were appropriate alternatives offered if induction of labour was declined? • Were maternal observations documented on the MEOWS chart and antenatal check carried out prior to the commencement of the IOL? • Was a presentation USS completed prior to commencing the IOL? • Were maternal observations repeated and a CTG commenced if the woman reported any painful uterine activity, PV bleeding, reduced fetal movements or spontaneous rupture of membranes? • Was the decision made at consultant level for IOL for maternal request alone? • Was a partogram commenced at the correct time?
Lead	Audit midwife
Tool	Excel spreadsheet
Frequency	1% or 10 sets, whichever is the greater, of all health records of women who have had their labour induced will be audited over a 12-month period.
Reporting arrangements	• A formal report of the results will be received annually at the maternity Patient Safety meeting and 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 maternity Patient Safety meeting and 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 maternity Patient Safety meeting and clinical audit forum and an action plan developed. • Action leads will be identified and a time frame for the action to be completed by. • The action plan will be monitored by the maternity Patient Safety meeting and clinical audit forum until all actions complete.

Information Category	Detail of process and methodology for monitoring compliance
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/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 And Inclusion 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

Information Category	Detailed Information
Document Title:	Induction of Labour Clinical Guideline V3.2
This document replaces (exact title of previous version):	Induction of Labour Clinical Guideline V3.1
Date Issued/Approved:	September 2024
Date Valid From:	September 2024
Date Valid To:	September 2025
Directorate / Department responsible (author/owner):	Sophie Haynes, Consultant Obstetrician Antenatal Ward Manager
Contact details:	01872 25 5036
Brief summary of contents:	This guideline gives guidance to midwives and obstetricians on induction of labour.
Suggested Keywords:	Induction of labour. Propess. ARM.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Maternity Guideline Group
General Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming approval by specialty and care group management meetings:	Tamara Thrilby
Links to key external standards:	CNST 2.7
Related Documents:	• NICE 2007: Intrapartum care: Care of healthy women and their babies during childbirth. London. NICE

Information Category	Detailed Information
	• NICE 2021: Induction of labour London. NICE. • NICE 2014: Quality Standard for Induction of Labour. • Diabetes Mellitus (pre-existing) in Pregnancy Clinical Guideline (cornwall.nhs.uk) • Gestational Diabetes Mellitus (GDM) Clinical Guideline (cornwall.nhs.uk). • Stillbirth Management Clinical Guideline (cornwall.nhs.uk) • Maternity Unit Neonatal Death (Early) Clinical Guideline (cornwall.nhs.uk). • GBS Maternal Management Clinical Guideline (cornwall.nhs.uk) • Redman C. Statement on the use of Dawes Redman. 30/09/2019.
Training Need Identified?	None
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Midwifery and Obstetrics

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
July 2004	V1.0	Initial Issue	Rob Holmes, Consultant obstetrician
September 2009	V1.1	Change from prostaglandin pessery to propess pessary.	Karen Watkins, Consultant obstetrician
March 2012	V1.2	Updated and compliance monitoring included	Karen Watkins, Consultant obstetrician and Karen Stoyles, DAU and ante natal inpatient manager

Date	Version Number	Summary of Changes	Changes Made by
August 2012	V 1.3	Changes to compliance monitoring only.	Jan Clarkson, Maternity Risk Manager
7 August 2014	V 1.4	Changes to IOL proforma and changes to the time of admission.	Louisa Tompkins, Midwife
7 April 2016	V1.5	Updated and compliance monitoring included.	Karen Stoyles, DAU and ante natal inpatient manager
5 April 2018	V1.6	Benchmarked to NICE CG70 and IOL to be book between 40+12-14 days overdue date. Undertake post propess CTG until Dawes Redman Criteria met (previously stated for 60 minutes).	Magda Kudas, Antenatal Ward manager
27 August 2019	V1.7	Additions to sections 2.3.4, 2.3.5, 2,7,2 and 2.8.4 regarding escalation and patient review by an obstetrician following recommendation from the Health Safety Investigation Branch (HSIB).	Sarah Jane Pedler, Practice Development Midwife
October 2019	V 2.0	Additions to section 2.14.4 regarding the calculation of the BMI at the dating SCAN.	Sarah Jane Pedler, Practice Development Midwife
December 2019	V2.1	Following a statement by Professor Redman. Dawes Redman analysis is not valid post Propess insertion. Changes from Syntocinon (drug brand) to oxytocin (generic drug name).	Sally Budgen, Fetal Monitoring Lead midwife
June 2020	V2.2	1.3. Inclusion statement. 2.17.2. ARM, recommencement of CTG. 2.17.3. Assessment and actions following normal CTG; oxytocin or 2 hour mobilization. 2.17.4. Birth Centre choice following ARM. Updated Trust templates.	Sophie Haynes, Consultant Obstetrician

Date	Version Number	Summary of Changes	Changes Made by
September 2020	V2.3	Escalation to SpR/Cons to take place at 24 hours (not 30hrs). Process for delayed IOL altered to include option for balloon catheter insertion and ARM on Wheal Rose.	Sarah Harvey-Hurst, Wheal Rose Ward Manager
July 2022	V3.0	Benchmarked against new NICE guidance including use of bishop score and offering IOL from 41 weeks. Amalgamated outpatient and inpatient guidelines. Addition of use of balloon catheters for delay.	Sarah Harvey-Hurst, Maternity Matron
May 2024	V3.1	Addition of timings to correct partogram added. Terminology of mechanical method inserted.	Julie Walton, Audit midwife
September 2024	V3.2	Addition of 2.3.4 women intending to decline IOL	Helen Le Grys, Consultant Obstetrician

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance, please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Induction of Labour Clinical Guideline V3.2
Directorate and service area:	Obstetrics and Gynaecology Directorate
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Catherine Wills, Practice Development Midwife.
Contact details:	01872 255019

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	This guideline gives guidance to midwives and obstetricians on induction of labour.
2. Policy Objectives	To ensure induction of labour is carried out as per national guidance.
3. Policy Intended Outcomes	Safe induction of labour.
4. How will you measure each outcome?	See compliance monitoring tool.
5. Who is intended to benefit from the policy?	See compliance monitoring tool.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Maternity Guidelines Group
6c. What was the outcome of the consultation?	Guideline approved
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	
Marriage and civil partnership	No	

Protected Characteristic	(Yes or No)	Rationale
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment:

Catherine Wills, Practice Development Midwife.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis