INDUCTION OF LABOUR - CLINICAL GUIDELINE

Summary

- Individual risks & benefits discussed with woman
- Induction of labour booked via extension 5890

On admission:
- Full antenatal examination
- Consent given
- CTG performed

CTG: Dawes/Redman criteria met

Vaginal examination

Cervix uneffaced or 3cm or < dilated

Propess 10mg into posterior fornix

CTG for 1 hour

Repeat maternal observations & CTG if woman reports:
- Abdominal pain
- PV bleeding
- Reduced fetal movements
- SROM

If not in labour 24 hours post Propess insertion

Transfer to D/S for ARM & Syntocinon

Refer to D/S SpR

If on transfer to D/S ARM is not feasible, for review by Consultant for decision ripening Syntocinon then ARM or Foley's catheter insertion.

Induction of labour
1. **Aim/Purpose of this Guideline**
   This guideline gives guidance to midwives and obstetricians on induction of labour.

2. **The Guidance**
   2.1. **Background**
   Induction of labour (IOL) is only justified when there is greater benefit to the health of the mother and/or baby than if the pregnancy continues.

   Induction of labour constitutes an intervention in pregnancy and the decision for such an intervention must be made by a Consultant or experienced Middle Grade doctors. The exception is routine induction for prolonged low risk pregnancy which may be arranged by the Community Midwife.

   2.2. **Membrane sweep**
   Membrane sweeping should be offered to women prior to formal induction (provided low lying placenta is excluded). The woman should be informed that it might be associated with discomfort and light bleeding.

   All women should be offered membrane sweep at around 41 weeks. All primigravida women should in addition be offered a membrane sweep at the 40 week antenatal visit.

   If a low risk women request a membrane sweep, this can be performed at her routine antenatal appointments from 37 weeks onwards, without obstetric approval.

   2.3. **Induction of labour in specific circumstances**
   2.3.1. **Prolonged pregnancy**
   For a low risk women with a prolonged pregnancy the community midwife should discuss and offer induction of labour 12 days over the ultrasound scan (USS) determined EDD (i.e. 40 + 12). If all IOL appointments are full, offer 40 + 13 IOL. Inform the woman that induction of labour decreases the risk of subsequent inter-uterine death (IUD) associated with pregnancy over 42 weeks gestation.

   If the woman declines induction of labour then referral to DAU should be made at 40+14 for CTG, liquor volume assessment and further discussion re induction with SpR or consultant.

   If induction of labour is still declined then twice weekly CTG’s and weekly liquor volume measurements should be arranged. The woman should be informed of the need to monitor fetal movements due to the increase in risk of IUD and report any reduction in movements.

   2.3.2. **Induction of labour for maternal request**
   Induction of labour for maternal request/social reasons alone should be strongly discouraged, however, under exceptional circumstances induction may be considered at or after 40 weeks. This must be a consultant decision.

   If a woman requests IOL for social reasons then the midwife should fully inform the woman of the risk and disadvantages of IOL. If the woman still requests IOL then she
Induction of labour

2.3.3 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 person booking the induction and communicated accordingly. IOL should be avoided if there is severe growth restriction with confirmed fetal compromise.

2.3.4 Preterm Pre-labour Ruptured of Membranes (PPROM) and Pre-term Ruptured of Membranes (PROM)
For PPROM and PROM please see relevant RCHT guidelines.

Women, who have pre labour rupture of membranes (PROM) and are group strep B (GBS) positive, should be admitted to delivery suite for immediate IOL with Syntocinon as soon as ROM is confirmed.

2.3.5 Previous caesarean section
Induction of labour in a woman who has had a previous caesarean section should only be made by a senior obstetrician and a clear plan documented in the notes prior to admission. The decision must be by a consultant obstetrician if Propess is to be used. The increased risk of uterine rupture should be explained to the woman. It is not appropriate for a woman to be admitted, particularly over a weekend, for induction of labour without a plan having been agreed with the woman.

N.B: Prostaglandins are not licensed for use with ruptured membranes or with uterine scar therefore informed consent needs to be obtained and documented clearly before using Propess in these situations.

2.3.6 Maternal diabetes
Please see RCHT guideline management of type 1 and type 2 diabetes and gestational diabetes.

2.3.7 Intrauterine death
Please see RCHT guideline: Pregnancy Loss and Early Neonatal Death

2.3.8 Breech presentation
IOL should be a consultant decision only and will only be considered if caesarean section is declined and ECV is unsuccessful, declined or contraindicated (new 2016)

2.3.9 Suspected macrosomia
In the absence of any other indicators, IOL should not be carried out simply because a Healthcare Professional suspects a baby is large for gestational age.

2.3.10 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

2.3.11 Consultant authorisation only
In the following situations induction of labour with Propess should only be used if authorised by a consultant:-
• Uterine scar
• Cardiac, pulmonary, renal or hepatic disease
• Para 4 or greater.
• Multiple pregnancy
• Severe IUGR
• Severe asthma is a relative contraindication to prostaglandin administration and therefore the decision to use it must be made by the senior obstetrician

2.4 Method of and Arrangements for the Induction

• The woman should be given personalised information about the risks and benefits for them and their babies and alternatives to IOL. She should be informed that Induction of labour may be more painful than spontaneous onset.

• Healthcare Professionals should inform women that evidence does not support the use of:
  - Herbal supplements
  - Acupuncture
  - Homeopathy
  - Castor oil
  - Hot baths
  - Enemas
  - Sexual intercourse (New 2016)

• The indication for induction, the person authorising the induction and any specific management plan must be clearly documented in the woman’s hand held notes.

• The doctor or midwife requesting IOL should arrange this by contacting extension 5980 to book in the IOL diary, giving detailed clinical information. In the case of morbid obesity (BMI > 40), IOL at the weekend should be avoided unless there are very strong clinical indications to do so.

• If all spaces for IOL are taken for the required day clinical priority should be made for high risk pregnancies. Women with low risk pregnancies may be deferred to the following day if necessary. Discuss with Midwife –in-Charge/ on call consultant or SpR before postponing women for other than routine 40+12 or IOL for maternal request/SPD

• Women should be asked to attend Wheal Rose on the morning of the induction unless being induced for spontaneous rupture of membranes (SROM). Women with SROM should be advised to come in for IOL 24 hours after ruptured membranes (irrespective of time)

2.5 Procedure for Induction of Labour

2.5.1 On admission:

The midwife allocated to care for the woman is responsible for:
• Completing the admission process, including the admission on the PAS system.
• 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 (New 2016).

- Performing a full antenatal examination including documentation of maternal and fetal observations
- Requesting the SHO to review the woman`s maternity notes and prescribe Propess

### 2.5.2 Pre insertion of propess:

- The induction of labour should commence within two hours of admission (New 2016)
- 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.
- A CTG should be performed using the Dawes/ Redman criteria analysis (New 2016)
- If the antenatal assessment and Dawes/ Redman criteria met, a vaginal examination should be performed and cervical assessment made prior to the insertion of the Propess pessary (New 2016)

### 2.5.3 Insertion of Propess

- Women having induction of labour should receive Propess irrespective of cervical findings unless the cervix is found to be > 3cm dilated, fully effaced and well applied to the presenting part. These women should be admitted to Delivery Suite for ARM and Syntocinon. 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.
- 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.
- The woman should be recumbent for 20-30 minutes after insertion of Propess.

### 2.5.4 Post insertion of Propess:

A CTG is to be performed when the Propess pessary is inserted. If the Dawes/ Redman criteria is met after 1 hour, the CTG can be discontinued and the woman allowed to mobilise.

**Ongoing care:**

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)

- If intrapartum antibiotic prophylaxis for group B haemolytic streptococcus is indicated, this should be administered at the onset of any regular uterine activity.
• Women should have access to pain relief that is appropriate to their level of pain and of the type they request (New 2016)

• If contractions become strong and regular or if the woman requires further analgesia then a vaginal examination can be done with propess in situ. If the woman is not in labour do not remove the propess and continue the electronic fetal monitoring.

• If a woman is requesting Pethidine consider whether a labour assessment is required before administration.

• If labour is diagnosed i.e. the cervix is effaced, >3cm dilated and the woman is having strong and regular contractions, then remove the Propess. The woman should be transferred to delivery suite for further management. Monitoring should be continued as detailed in the ‘Further Management’ section below.

• If SROM occurs but labour is not established DO NOT remove pessary, perform a CTG, if the CTG is normal observe and continue the induction process until either labour does establish or 24 hours has elapsed since insertion.

• If at any point the Propess pessary inadvertently falls out then the same Propess can be reinserted provided it has remained clean. If this happens after ruptured membranes do not reinsert more than once and inform the Delivery Suite SpR.

### 2.6 Further Management:

Women with low risk pregnancies who have started in labour with Propess alone remain under midwifery led care. Intermittent auscultation of the fetal heart is appropriate provided that:

- The CTG remains normal for an hour post removal of Propess
- The woman is not started on syntocinon
- And there are no fetal or maternal reasons requiring continuous fetal monitoring

Women who have not established in labour with Propess will be transferred to consultant care and continuous CTG monitoring required.

### 2.7 Women who have not established in labour 24 hours after insertion of Propess

- The woman should be transferred to Delivery Suite 24 hours after the insertion of Propess and a CTG commenced, cannula inserted and FBC and G&S sent.

- A vaginal assessment should be performed and the Propess removed. An ARM should be performed and syntocinon commenced. There should be a 30 minutes period between removal of Propess and commencing syntocinon however syntocinon should not be delayed longer than this regardless of parity.

### 2.8 If ARM not possible

- A syntocinon infusion may be commenced to try to achieve cervical dilation sufficient for ARM. In this case Syntocinon 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

- If ARM is not feasible after a Syntocinon trial a Caesarean Section may be
  offered on the grounds of failed induction. The ARM must however be
  attempted by the most experienced person available prior to making this
decision.

- An alternative to a trial of syntocinon is the insertion of a Foleys or cervical
  catheter and an ARM performed once this falls out or 12 hours after insertion,
  whichever the sooner.

- The decision whether to use this or a Syntocinon trial should be made either by
  the woman’s Consultant or by the Consultant covering delivery suite.

- A further attempt to induce labour at a later stage may be appropriate for some
  women. The timing will depend on the clinical situation and the woman’s
  wishes. The decision for this should be made by a consultant.

2.9 Delay in transfer to delivery suite due to high activity

- 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 be informed and should try to facilitate transfer. In
  this situation, Propess should be left in until 30 hours post insertion.

- If transfer still not possible after 30 hours the senior obstetrician should review
  activity on Delivery Suite with the Co-coordinator and try and facilitate transfer by
  transferring women off Delivery Suite if possible. If transfer to delivery suite is not
  possible a datix should be undertaken.

- The Propess pessary should be removed and the senior obstetrician asked to
  review the woman.

- If on vaginal examination the cervix is still unfavourable then consideration should
  be given for inserting an intracervical foleys or Cookes balloon catheter. This may
  need to be done on Delivery Suite for positioning and light (but does not require
  regional analgesia). The woman may then be transferred back to Wheal Rose with
  the catheter in situ.

- If on vaginal examination the cervix is favourable, and ARM achievable then further
  efforts should be made to transfer the woman to Delivery Suite as soon as possible.
  The ARM should NOT be put off until the following morning as this will build up the
  work load and will reverse the effect that have been achieved with the Propess. The
  induction process should be continued as soon as there is a bed available on
  delivery suite, irrespective of the time.

- Women should not be sent home after having propess. In the exceptional
  circumstance that this may happen then the whole induction process will need to be
  started again.

- Women should not be given a second Propess due to delay in transfer.
SUSPECTED HYPERSTIMULATION FOLLOWING PROPESS ADMINISTRATION

Perform CTG immediately

PROLONGED BRADYCARDIA

Remove Propess and give 250 mcg Terbutaline S/C and transfer to delivery suite immediately for SpR/consultant review

ABNORMAL CTG

Remove Propess and give 250 mcg Terbutaline S/C if needed and transfer to delivery suite urgently for SpR/consultant review

NON REASSURING CTG

If in labour – remove Propess and transfer to delivery suite, continue CTG and get SpR/consultant review

If not in labour, leave Propess in situ and transfer to delivery suite for SpR/consultant review (the review may take place prior to transfer). Subsequent management will depend on SpR/consultant assessment

NORMAL CTG

Diagnosis of hyper stimulation is not confirmed- leave propess in and continue CTG. Women may remain on wheal rose provided adequate midwives to review the CTG. Discuss with the midwifery coordinator/SPR if concerned.
# 3. Monitoring compliance and effectiveness

| Element to be monitored | The audit will take into account record keeping by obstetric, anaesthetic and paediatric doctors, midwives, nurse, students and maternity support workers.  
|                         | The results will be inputted onto an excel spreadsheet  
|                         | The audit will be registered with the Trust’s audit department |
| Lead                    | Maternity risk management midwife |
| Tool                    | Was the woman offered induction of labour at T+12?  
|                         | Did the woman accept induction of labour at T+12?  
|                         | If the woman had a previous caesarean section was the decision for IOL using propess made by a consultant obstetrician?  
|                         | Were maternal observations of temperature, pulse and blood pressure and palpation carried out prior to the commencement of 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?  
|                         | Did a CTG meet the Dawes Redman criteria prior to insertion of the propess pessary?  
|                         | Was a CTG carried out for at least an hour following the insertion of the propess pessary?  
|                         | Was the decision made at consultant level for IOL for maternal request alone?  
|                         | Was IOL commenced within 2 hours of admission for IOL? |
| 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 risk management 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 risk management 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 risk management 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 risk management and clinical audit forum until all actions complete |
| Change in practice and lessons to be | 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
shared change forward where appropriate.
- The results of the audits will be distributed to all staff through the risk management 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.

4.2. **Equality Impact Assessment**

The Initial Equality Impact Assessment Screening Form is at Appendix 2.
# Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Induction of Labour guideline</th>
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<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>7th April 2016</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>15th April 2016</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>15th April 2019</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Karen Watkins, Karen Stoyles &amp; Louisa Tompkins Obs and gynaec directorate</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 252729 &amp; 01872 252140</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>This guideline gives guidance to midwives and obstetricians on induction of labour.</td>
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<tr>
<td>Suggested Keywords:</td>
<td>Induction of labour. Propess. ARM</td>
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<td>Target Audience</td>
<td>RCHT</td>
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<tr>
<td>Executive Director responsible for Policy:</td>
<td></td>
</tr>
<tr>
<td>Date revised:</td>
<td>7th April 2016</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Induction of Labour guideline</td>
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<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Maternity Guidelines Group Obs and Gynaec Directorate Divisional Board for Noting</td>
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<tr>
<td>Divisional Manager confirming approval processes</td>
<td>Head of Midwifery</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td></td>
</tr>
<tr>
<td>Signature of Executive Director giving approval</td>
<td></td>
</tr>
<tr>
<td>Publication Location (refer to Policy on Policies – Approvals and Ratification):</td>
<td>Internet &amp; Intranet</td>
</tr>
<tr>
<td>Document Library Folder/Sub Folder</td>
<td>Midwifery and obstetrics</td>
</tr>
<tr>
<td>Links to key external standards</td>
<td>CNST 2.7</td>
</tr>
<tr>
<td>Related Documents:</td>
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- NICE 2007: Intrapartum care: Care of healthy women and their babies during childbirth. London. NICE
- NICE 2011: Induction of labour London. NICE.
- NICE 2014: Quality Standard for Induction of Labour
- RCHT 2012: Guideline for the management of Type 1 and Type 2 Diabetes in Pregnancy
- RCHT 2014: Guideline for the management of preterm prelabour rupture of membranes
- RCHT 2014: Clinical Guideline for the Management of Prelabour Rupture of Membranes at Term (Term SROM)

**Training Need Identified?**  No

**Version Control Table**

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
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<tr>
<td>July 2004</td>
<td>V1.0</td>
<td>Initial Issue</td>
<td>Rob Holmes Consultant obstetrician</td>
</tr>
<tr>
<td>September 2009</td>
<td>V1.1</td>
<td>Change from prostaglandin pessary to propess pessary.</td>
<td>Karen Watkins Consultant obstetrician</td>
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<tr>
<td>March 2012</td>
<td>V1.2</td>
<td>Updated and compliance monitoring included</td>
<td>Karen Watkins Consultant obstetrician and Karen Stoyles DAU and ante natal inpatient manager</td>
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<td>August 2012</td>
<td>V1.3</td>
<td>Changes to compliance monitoring only</td>
<td>Jan Clarkson Maternity Risk Manager</td>
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<td>Author</td>
</tr>
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<td>--------------------------------------------------</td>
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<tr>
<td>7th August 2014</td>
<td>V 1.4</td>
<td>Changes to IOL proforma and changes to the time of admission</td>
<td>Louisa Tompkins Midwife</td>
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<tr>
<td>7th April 2016</td>
<td>V1.5</td>
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<td>Karen Stoyles DAU and ante natal inpatient manager</td>
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**All or part of this document can be released under the Freedom of Information Act 2000**

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

**Controlled Document**
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## Appendix 2. Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Directorate and service area:</th>
<th>Is this a new or existing Policy?</th>
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<td>Obs &amp; Gynae Directorate</td>
<td>Existing</td>
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<table>
<thead>
<tr>
<th>Name of individual completing assessment:</th>
<th>Telephone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jeanne Clarkson</td>
<td>01872-252270</td>
</tr>
</tbody>
</table>

### 1. Policy Aim*
Who is the strategy / policy / proposal / service function aimed at?

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 the outcome?
See compliance monitoring tool

### 5. Who is intended to benefit from the policy?
See compliance monitoring tool

### 6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?

b) If yes, have these *groups been consulted?

C). Please list any groups who have been consulted about this procedure.

### 7. The Impact

Please complete the following table.

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
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<tr>
<td>Age</td>
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<td>All pregnant women</td>
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<tr>
<td>Sex (male, female, transgender / gender reassignment)</td>
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Induction of labour
<table>
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<tr>
<th>Race / Ethnic communities /groups</th>
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<tr>
<td>Disability - learning disability, physical disability, sensory impairment and mental health problems</td>
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<td>All pregnant women</td>
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<tr>
<td>Religion / other beliefs</td>
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<td>Marriage and civil partnership</td>
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<td>Pregnancy and maternity</td>
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<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
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</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended. | Yes | No | X

9. If you are not recommending a Full Impact assessment please explain why.

n/a

Signature of policy developer / lead manager / director
Jeanne Clarkson

Date of completion and submission

Names and signatures of members carrying out the Screening Assessment
Karen Stoyles

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.

Signed: Sarah-Jane Pedler

Date: 7th April 2016