Outpatient Induction of Labour
Clinical Guideline

V1.3

January 2020
1. **Aim/Purpose of this Guideline**

1.1. This guideline is intended to give guidance to Midwives and Obstetricians on the outpatient induction of labour (IOL). The guideline will apply to women with uncomplicated pregnancies and at low risk of developing intrapartum complications.

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

1.3. **Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation**

The Trust has a duty under the DPA18 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed and documented. We can’t rely on Opt out, it must be Opt in.

DPA18 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the DPA18 please see the ‘information use framework policy’, or contact the Information Governance Team rch-tr.infogov@nhs.net

2. **The Guidance**

2.1. **Background**

Induction of labour (IOL) is a relatively common procedure with approximately 25-30 per cent of deliveries in the UK being induced. The induction rate in England continues on an upward trend as more women undergo induction of labour on a yearly basis which can increase the pressure on maternity resources and can sometimes lead to a poor patient experience.

A small number of audits have concluded that the practice of out-patient induction of labour is safe and effective when compared to inductions in inpatient settings and there is no significant difference in fetal or maternal outcome.

Although studies of outpatient induction of labour are still limited, comparative studies to date show that the procedure carries a number of benefits for healthcare providers and women including:

- Reduction in length of antenatal stay in hospital
- Less strain on antenatal unit/resources
- Higher maternal satisfaction
- Avoidance of unnecessary hospital admission
2.2. **IOL definition**
Outpatient induction is the process of induction that starts as an inpatient procedure for women who are then discharged to home. Women then return to the hospital for the birth of their baby.

It is essential that induction of labour in an outpatient setting is only carried out for low risk women.

2.3. **IOL pathway**

2.3.1. **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+5 (New 2018) or from EDD for social reasons (Decision by experienced obstetrician, (New 2018)
- 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 (New 2019)
- Patient has a reliable home mobile/landline phone
- Number of previous births less than or equal to 2.
- Reassuring pre and post prostaglandin fetal heart rate monitoring
- A reliable birth companion to remain with the woman at home

2.3.2. **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.

2.3.3. **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 hand held 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. (NEW 2019)
- Women should be asked to attend Wheal Rose on the morning of the induction at their allocated time
2.3.4. Procedure for Induction of Labour

2.3.4.1. 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) (NEW 2019)
- Requesting the SHO to review the woman’s maternity notes and prescribe Proposs
- Ensure that they are appropriate to undergo an outpatient IOL – check the exclusion criteria
- If the cervix is 3cm dilated and fully effaced a propess should not be used and arrangements made to transfer to delivery suite for ARM at earliest opportunity
- Time of Proposs 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 2.3.4.2 (NEW 2019) The details must be written into ward diary for every patient.
- Following Proposs, the patient will be allowed 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 (NEW 2019).
- 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 (NEW 2019)

2.3.4.2. All women who have an out patient 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

2.3.4.3. 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 E3 (new 2019).

2.3.4.4. 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 (NEW 2019). 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 (New 2019).

2.3.4.5. Patients must be readmitted directly to Wheal Rose 24 hours after propess insertion.

2.3.5. Patient exclusions
• Gestational age <40 weeks or >41+5
• More than 2 term pregnancies
• Age under 18 or over 40 years at due date
• 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-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
• Lack of consent
• Lack of comprehension/reading of outpatient IOL leaflet
• Significant APH from 24 weeks (Obstetrician to decide)
• Medical disorders which have led the patient to require consultant led care during the pregnancy (for example epilepsy, severe asthma, diabetes) – confirm with Obstetrician if uncertain
• BMI over 35 or less than 18 at booking
• Any contraindication to the use of Propess
• Safeguarding concerns require a plan from safeguarding midwifery team

2.4. Check list for practice – see appendix 3

3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>See appendix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Audit midwife</td>
</tr>
<tr>
<td>Tool</td>
<td>Audit tool used by Audit Midwife</td>
</tr>
<tr>
<td>Frequency</td>
<td>During the Life time of the guideline</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>A formal report of the results will be received annually at the maternity Patient Safety and clinical audit forum, as per the audit plan</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>Any deficiencies identified on the annual report will be discussed at the maternity Patient Safety and clinical audit forum and an action plan developed</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Required changes to practice will be identified and actioned within a time frame agreed on the action plan</td>
</tr>
</tbody>
</table>

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, Inclusion & Human Rights 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

<table>
<thead>
<tr>
<th><strong>Document Title</strong></th>
<th>Outpatient Induction of Labour Clinical Guideline V1.3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date Issued/Approved:</strong></td>
<td>December 2019</td>
</tr>
<tr>
<td><strong>Date Valid From:</strong></td>
<td>January 2020</td>
</tr>
<tr>
<td><strong>Date Valid To:</strong></td>
<td>October 2021</td>
</tr>
<tr>
<td><strong>Directorate / Department responsible (author/owner):</strong></td>
<td>Trudie Roberts, Obs and Gynae Directorate</td>
</tr>
<tr>
<td><strong>Contact details:</strong></td>
<td>01872 25 26 84</td>
</tr>
<tr>
<td><strong>Brief summary of contents</strong></td>
<td>This guideline is to inform all midwifery staff and doctors on the appropriate management of the use of outpatient induction of labour.</td>
</tr>
<tr>
<td><strong>Suggested Keywords:</strong></td>
<td>Induction of labour</td>
</tr>
<tr>
<td><strong>Target Audience</strong></td>
<td>RCHT</td>
</tr>
<tr>
<td><strong>Executive Director responsible for Policy:</strong></td>
<td>Medical Director</td>
</tr>
<tr>
<td><strong>Date revised:</strong></td>
<td>December 2019</td>
</tr>
<tr>
<td><strong>This document replaces (exact title of previous version):</strong></td>
<td>Outpatient Induction of Labour Clinical Guideline V1.2</td>
</tr>
<tr>
<td><strong>Approval route (names of committees)/consultation:</strong></td>
<td>Maternity Guidelines Group Obs and Gynae Directorate Care group Board Policy Review Group</td>
</tr>
<tr>
<td><strong>Care Group General Manager confirming approval processes</strong></td>
<td>Debora shields, Care Group Manager</td>
</tr>
<tr>
<td><strong>Name and Post Title of additional signatories</strong></td>
<td>Not required</td>
</tr>
<tr>
<td><strong>Name and Signature of Care Group/Directorate Governance Lead confirming approval by specialty and care group management meetings</strong></td>
<td>{Original Copy Signed} Name: Caroline Amukusana</td>
</tr>
<tr>
<td><strong>Signature of Executive Director giving approval</strong></td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td><strong>Publication Location (refer to Policy on Policies – Approvals and Ratification):</strong></td>
<td>Internet &amp; Intranet</td>
</tr>
</tbody>
</table>
Midwives should ensure that they have acquired the requisite knowledge and skills to support women who choose outpatient IOL. They should keep themselves updated on the research evidence in this area. (NMC, 2006).

### 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>
</tr>
</thead>
<tbody>
<tr>
<td>04/01/2018</td>
<td>V1.0</td>
<td>New Issue</td>
<td>Trudie Roberts, Community Matron Obs &amp; Gynae Directorate</td>
</tr>
</tbody>
</table>
| 10/08/2018 | V1.1       | • Uncomplicated pregnancy requiring induction for post maturity at 41+5 (previously 40 +0-42 +0) or from EDD (previously from 37-42 weeks) for social reasons, decision by experienced obstetrician.  
• Appendix 3 updated in line with parity and gestation throughout body of guideline. Telephone number to book IOL updated and Bishop Score removed as no longer in use.  
• Amendment to the distance that the patient lives from the hospital from 30 to 45 minutes. | Magda Kudas, Antenatal Ward Manager  
Rob Holmes, Obstetric Consultant |
| October 2019 | V1.2.     | Inclusion of 2.3.4.2. – 45 minutes from hospital in all conditions  
2.3.4.5. – need for CTG to be performed on re-admission to the unit location of where admission CTG is to be performed | Maternity Guidelines Group decision |
2.3.4.1. altered to include stickers usage
2.3.4.5. 30 minutes CTG before going to the birth centre required.

Sarah Harvery-Hurst
Antenatal Ward Manager
Appendix 2. Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed</th>
<th>New or existing document:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Induction of Labour Clinical Guideline V1.3</td>
<td>Existing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Directorate and service area:</th>
<th>Obs and Gynae</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of individual completing assessment:</td>
<td>Julie Walton</td>
</tr>
<tr>
<td>Telephone:</td>
<td>01872 25 26 84</td>
</tr>
</tbody>
</table>

1. **Policy Aim***
   *Who is the strategy / policy / proposal / service function aimed at?*
   - To inform all midwifery staff on the appropriate management Outpatient induction of labour

2. **Policy Objectives***
   - Ensure the correct methods of management of the use of Outpatient induction of labour

3. **Policy – intended Outcomes***
   - To ensure maternal and neonatal wellbeing.

4. **How will you measure the outcome?**
   - Monitoring through incident reporting.

5. **Who is intended to benefit from the policy?**
   - Women and babies

6a **Who did you consult with**
   - Workforce
   - Patients
   - Local groups
   - External organisations
   - Other
   - X

   b). Please identify the groups who have been consulted about this procedure.
   - Maternity Guidelines Group
   - Obs and Gynae Directorate
   - Care group Board
   - Policy Review Group

What was the outcome of the consultation? Guideline agreed

7. **The Impact**

   Please complete the following table. **If you are unsure/don't know if there is a negative impact you need to repeat the consultation step.**

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

Outpatient Induction of Labour Clinical Guideline V1.3
Page 10 of 12
### Sex (male, female, trans-gender / gender reassignment)
- X

### Race / Ethnic communities /groups
- X

### Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.
- X

### Religion / other beliefs
- X

### Marriage and Civil partnership
- X

### Pregnancy and maternity
- X

### Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian
- X

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 this relates to service redesign or development

8. Please indicate if a full equality analysis is recommended.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>X</th>
</tr>
</thead>
</table>

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

Not indicated

### Date of completion and submission
- December 2019

### Members approving screening assessment

### Policy Review Group (PRG)
- ‘APPROVED’

This EIA will not be uploaded to the Trust website without the approval of the Policy Review Group.

A summary of the results will be published on the Trust’s web site.
Appendix 3.

Check list for Outpatient IOL

<table>
<thead>
<tr>
<th>For completion at time of Propess insertion</th>
</tr>
</thead>
</table>

- Confirmation that suitable for OP IOL
- Verbal information given (document this in the hand held records)
- Written information given (document this in the hand held records – read and understood)
- Patients return location and time written on the patient information leaflet
- Pre-Propess CTG and full set of observations recorded on MEOWS chart
- Abdominal and Vaginal examination documented
- Post Propess (60 min) full set of observations recorded on MEOWS chart recorded.
- Time of Propess insertion
- Patient telephone number

Assessing suitability

<table>
<thead>
<tr>
<th>Indication</th>
<th>At 41+5 for post dates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>From EDD for social reasons (Decision by experienced obstetrician)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maternal age</th>
<th>&gt;18 years, &lt;40 years at EDD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language</td>
<td>Fluent English</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Findings</th>
<th>Singleton</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cephalic</td>
</tr>
<tr>
<td></td>
<td>Presenting part engaged</td>
</tr>
<tr>
<td></td>
<td>SFH measures appropriate on GROW chart/recent scan confirming EFW &gt;10th centile</td>
</tr>
<tr>
<td></td>
<td>Intact membranes</td>
</tr>
<tr>
<td></td>
<td>Reassuring pre-Propess CTG</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Past Obstetric/gynaecological History</th>
<th>No more than 2 previous term pregnancies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No previous Caesarean section</td>
</tr>
<tr>
<td></td>
<td>No previous uterine surgery</td>
</tr>
<tr>
<td></td>
<td>No previous precipitate delivery</td>
</tr>
<tr>
<td></td>
<td>Uncomplicated antenatal period (no APH/PET etc.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Past Medical History</th>
<th>Well controlled asthma, thyroid diseases are suitable. If unsure, ask a Consultant.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Social</th>
<th>Lives within 45 mins of the hospital at busiest traffic times (decision to be made by community midwife that the distance is achievable prior to booking IOL), has transport, a phone and a responsible adult to stay with them at all times and has no complex social factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI</td>
<td>&gt;18 and &lt;35 at booking</td>
</tr>
<tr>
<td>Patient consent</td>
<td>Verbal consent, document discussion and provision of leaflet with phone numbers added</td>
</tr>
<tr>
<td>Allergies</td>
<td>Exclude all who are allergic to Propess</td>
</tr>
</tbody>
</table>