Sherwood Forest Hospitals
NHS Foundation Trust

TITLE: INDUCTION OF LABOUR GUIDELINE

Document Category:	**CLINICAL**
Document Type:	**GUIDELINE**

Keywords:	Pregnancy; birth; maternity; propess

Version:	Issue Date:	Review Date:
7.2	26th April 2024	January-2025 (ext2)

Supersedes:	Version 7.1, Issued 22nd November 2023 to Review Date July 2024		
Approved by (committee/group):	• V7.0, Maternity & Gynaecology Clinical Governance Group • V7.1, Maternity and Gynaecology CG Group • V7.2, Formal approval not required	**Date Approved:**	12/07/2021 16/10/2023 25/04/2024

Scope/ Target Audience: (delete as applicable and/ or describe)	**Specialty/ Department** • Maternity
Evidence Base/ References:	• National Institute for Health and Care Excellence "Inducing Labour" (NICE, 2014). • NHS England (2023) Saving Babies' Lives Version 3 NHS England » Saving babies' lives: version 3 [accessed 10.10.23]

Lead Division:	Women and Children's
Lead Specialty/ Department: (Or Division if 'divisionally' owned)	Maternity
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Sponsor (position/ role):	Head of Service – Obstetrics and Gynaecology

Name the documents here or record not applicable *(these are documents which are usually developed or reviewed/ amended at the same time – ie a family of documents)*	
Associated Clinical Policy	N/A
Associated Clinical Procedure(s)	N/A
Associated Clinical Pathway(s)	N/A
Associated Standard Operating Procedure(s)	N/A
Other associated documents e.g. documentation/ forms	N/A

Consultation Undertaken:	V7.2 • Minor amends following recommendations from a HSIB incident investigation to align guideline to NICE Inducing labour guideline [NG207] (2021). • Comments from Matron for Maternity governance and Obstetric Consultant V7.1 • Minor amends agreed as part of the validation of evidence by the ICB LMNS for Saving Babies' Lives V3 Implementation Tool

	V7.0 • Comments from consultant obstetricians • Labour Ward Forum • Maternity & Gynaecology Clinical Governance Group

Template control:	v2.0 September 2023

Amendments from previous version(s)

Version	Issue Date	Section(s) involved (author to record section number/ page)	Amendment (author to summarise)
7.2	April 2024	Sections 5.2.5, 5.6.1, and 5.9	• Amendments made as recommended from an incident investigation to align this guidance to section 1.7 'Prevention and management of complications' of the NICE Inducing labour guideline [NG207] (2021).
7.1	Nov 2023	Whole document, particularly sections 5.2.5 and 5.2.8	• Review undertaken to ensure content up to date in line with Saving Babies' Lives v3 and evidence base updated

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1 INTRODUCTION/ BACKGROUND

Induction of labour is a relatively common procedure. Every year in the UK approximately 1 in 5, or 122,000, labours are induced. Labour is induced when it is thought that the outcome of the pregnancy will be better if labour is artificially started. A variety of clinical circumstances may indicate the need for induction of labour, with a greater or lesser degree of urgency. The essential judgement that the clinician and the pregnant woman must make is whether the interests of the mother or the baby, or both, will be better served by inducing labour or continuing the pregnancy. The woman's wishes must be taken into account, and the relative risks of continuing the pregnancy compared with inducing labour discussed with her (NICE, 2014).

2 AIMS/ OBJECTIVES/ PURPOSE (including Related Trust Documents)

The aim of this guideline is to provide clarity on the management of both high and low risk induction of labour therefore this clinical guideline applies to:

Staff group(s)

- Midwives
- Obstetricians

Clinical area(s)

- Community Midwifery
- Pregnancy Day Care Unit
- Antenatal Clinic
- Maternity Ward
- Sherwood Birthing Unit

Related Trust Documents

- Guideline for Administration of Aromatherapy in Childbearing Women

3 DEFINITIONS/ ABBREVIATIONS

Below is a list provided of common definitions and abbreviations used during this document:

IOL	Induction of Labour
ANC	Antenatal Clinic
ARM	Artificial Rupture of Membranes
SROM	Spontaneous Rupture of Membranes
VBAC	Vaginal Birth After Caesarean
SBU	Sherwood Birthing Unit
MDT	Multidisciplinary Team
EPR	Electronic Patient Records

4 ROLES AND RESPONSIBILITIES

Roles and responsibilities of assigned midwife for induction of labour

- The midwife caring for women undergoing IOL should communicate any change in clinical condition to the SBU co-ordinator and the obstetric registrar. The maternity ward co-ordinator should be informed as required.

- The SBU co-ordinator and the maternity ward should communicate throughout the shift regarding the progress of women undergoing IOL.

5 GUIDELINE DETAILS (including Flowcharts)

5.1 Discussion with women

The information is able to support information given clinical and includes:

- The reasons for induction being offered
- When, where and how the induction could be carried out, highlighting the point about delays and realistic timings.
- The arrangements for support and pain relief (recognising that women are likely to find induced labour more painful than spontaneous labour).
- The alternative options if the woman chooses not to have induction.
- The risks and benefits of induction of labour in specific circumstances and the proposed induction methods.
- That induction may not be successful and what the woman's options would be.

Environments where women feel calm, safe and secure can improve their experience of IOL. The induction rooms are being adapted to include low-level lighting and information folders containing useful tips, highlighting the benefits of relaxation/ massage techniques, to encourage the production of oxytocin (the hormone responsible for uterine contractions). Oxytocin is also thought to promote the release of pain-relieving endorphins. If women experience fear-tension-pain cycle they are less likely to labour and may find the process more painful. In addition three aromatherapy oils; Mandarin, Frankincense and Lemon are available for midwives to offer during the induction of labour process, these oils have pain-relieving, anxiety-reducing effects and can involve the birth partner **(DO NOT USE OILS WITH EMMENAGOGIC EFFECTS PLEASE REFER TO THE AROMATHERAPY GUIDELINE).**

5.2 Induction of labour in specific circumstances

5.2.1 Induction of labour to prevent prolonged pregnancy

- Membrane sweeping should be offered to all women with low risk pregnancy between 40-41 weeks, another sweep can be offered dependant on findings. Aromatherapy should be offered to women accepting a membrane sweep. Induction of labour should be booked at T+12 the date given should be based on the woman's early dating scan to ensure accuracy

5.2.2 Preterm prelabour rupture of membranes (see separate guideline)

If a woman has preterm prelabour rupture of membranes after 34 weeks, the following should be considered before a decision about whether to induce labour:

- Risks to the woman (for example sepsis, possible need for caesarean)
- Risks to the baby (for example sepsis, problems relating to preterm birth)
- Local availability of neonatal intensive care facilities

5.2.3 Prelabour rupture of membranes at term (see separate guideline)

- Induction of labour should be planned at 24hrs after rupture of the membranes. However time to be considered – aim for 24hrs but may be earlier depending on time of ruptured membranes i.e. if 2am woman to come in at 21.00hrs.
- Induction should be carried out using Prostin for 6hrs followed by IV Syntocinon

5.2.4 Previous caesarean section

- If delivery is indicated, women who have had a previous caesarean section may be offered induction of labour with Propess®, caesarean section or expectant management. For post maturity, IOL should be offered at T+12.
- Women should be informed that induction of labour carries an increased risk of scar dehiscence or uterine rupture which would lead to emergency caesarean section.
- An individualised management plan for labour should be made by a senior obstetrician with the woman, and documented in the maternity notes.
- The consultant obstetrician on duty for SBU should be made aware of all women undergoing induction of labour following a previous caesarean section.
- Process as per **Flow chart in Appendix B**
- The woman should be reviewed by a senior obstetrician and a plan of care made as soon as regular uterine activity commences
- If using Propess®, the woman should be reviewed 12hrs after insertion. If the cervix is favourable an ARM should be performed and continuous fetal monitoring commenced. If unfavourable for ARM the Propess® may be reinserted for a further 12hrs.

5.2.5 Fetal growth restriction

- Growth restriction with normal Dopplers may warrant induction of labour but the timing should be decided on by the MDT reviewing IOL bookings – see Appendix A.
- In situations where the EFW <3rd centile, with no other concerning features, induction of labour should be arranged for between 37 and 37+6 weeks.
- In fetuses with an EFW between 3rd and 10th centile, delivery should be considered at 39+0 weeks. Birth should be achieved by 39+6 weeks. Other risk factors should be present for birth to be prior to 39 weeks, taking into account the mother's wishes (SBLV3).
- If there is severe fetal growth restriction with abnormal Dopplers, induction of labour is not recommended as a means of achieving delivery.
- In situations where there is a concern about suboptimal fetal growth that does not fall into the above categories, the IOL MDT review allows for a holistic

assessment of the baby that is not meeting its growth trajectory (supported by GROW 2.0). As well as taking into consideration any other pertinent risk factors, which support an evidence-based decision-making process to be carried out. This includes using SBLCBv3 recommendations to support decision-making.

5.2.6 Maternal diabetes

- Plans for induction of labour individualised depending on the mother's diabetic control, whether there are any fetal consequences of the diabetes and whether the woman has pre-existing diabetes or gestational diabetes.

5.2.7 Maternal age >40 years

- For women who are aged 40 years or more at 40 weeks gestation, induction of labour should be offered so that delivery is achieved by 40 weeks.
- This should be discussed with the woman in ANC with a senior obstetrician.

5.2.8 Altered Fetal Movements (see separate guideline)

- For women who have experienced altered fetal movements from 39+0 weeks, induction of labour should be discussed, even if this is the first episode. This is based on recommendations within the Saving Babies' Lives Care Bundle V3.
- For women who have recurrent episodes of altered fetal movements, induction of labour should be offered from 39+0 weeks, birth should be achieved by 39+6 weeks.

5.3 Booking induction of labour

5.3.1 Midwifery led care (low risk women)

A midwife can book induction for prolonged pregnancy, via telephone call directly to SBU. Full contact details for the woman should be provided, and advise her that she will be contacted to arrange admission time.

5.3.2 Maternity Team care (high risk women)

- An obstetrician should discuss in clinic about an offer of induction of labour (see **5.1**).
- The IOL referral form should be completed in full and **a copy of the individualised growth chart included via Badgernet**.
- If there are significant concerns about the woman's or baby's wellbeing, the woman should be admitted for monitoring whilst induction is arranged
- All other referrals will be discussed at the twice weekly MDT and the woman will be contacted directly with an induction date

5.4 Methods for induction of labour

- Propess® is the preferred method of induction of labour, unless there are specific clinical contraindications (in particular the risk of uterine hyperstimulation)
- Amniotomy, alone or with oxytocin, should not be used a primary method of induction of labour unless there are specific clinical reasons for not using vaginal prostaglandin (Propess® or Prostin®)

- If using oxytocin as part of induction of labour following ruptured membranes, this should be commenced as early as possible for primigravidas and within 2hrs of ruptured membranes for multigravidas in the absence of establishing labour
- If oxytocin is required following ARM or spontaneous rupture of membranes, the regime should be followed as per the labour dystocia guideline

If for any reason there are delays between the methods/ stages for induction of labour, such as a delay in amniotomy due to acuity, then an individual management plan must be made in regards to the monitoring of maternal and fetal wellbeing.

5.5 Process for induction of labour

5.5.1 Place of care

- The following women should be admitted directly to SBU:

  Gestation <37 weeks
  Parity ≥ 4
  Multiple pregnancies
  Previous caesarean section
  Any other women for whom this is agreed as part of their plan of care

- All other women should be admitted to one of the 4 induction rooms on the maternity ward

5.5.2 Assessment on admission

- Perform baseline maternal observations – BP, pulse, respirations and temperature; urinalysis and abdominal palpation to assess lie and presentation
- Perform fetal assessment; commence CTG. There should be a reassuring CTG obtained over 30 minutes prior to insertion of Propess® or Prostin®
- Perform vaginal examination and assess modified Bishop's score
- Record Bishop's score on IOL record
- Document assessment, administration of medication, plan of care and update SBU co-ordinator

5.5.3 Administration of vaginal prostaglandin

- All medications must be prescribed on the drug chart prior to administration
- It is good practice to prescribe simple analgesia when prescribing Propess® or Prostin®
- Prostaglandins should be placed in the posterior vaginal fornix and must lie transverse – if unable to reach the cervix on VE a senior colleague or obstetric registrar should perform the assessment
- Document findings and actions in the maternal notes and on the drug chart
- If the modified Bishop's score is ≥7, **do not administer Propess®**. A plan should be made for transfer to SBU for amniotomy.

5.6 Monitoring of maternal and fetal wellbeing

Once the IOL process is commenced, the Dawes Redman criteria is not valid if a woman has been given Propess®/ Prostin® or is having uterine contractions/ tightening's. A non-computerised CTG must be used to monitor fetal wellbeing.

- Woman to lie on the bed for an hour after administration of Propess® or Prostin®
- CTG for 60 minutes (30 minutes for routine post-dates IOL)
- After an hour, encourage mobilisation and normal diet/fluid intake
- After 6 hours, perform a further CTG. **If using Propess® and there is no uterine activity after 12hrs, perform vaginal examination and reposition Propess® as necessarily**
- Women undergoing induction of labour are risk-assessed as being either "at risk" or "high risk" and a plan for ongoing monitoring to be based on this
- For at risk women, monitor maternal and fetal wellbeing as a minimum 12hrly (including fetal heart auscultation with sonicaid)
- For high risk women, monitor maternal and fetal wellbeing as a minimum 6hrly (including 30min CTG)
- Perform full assessment of maternal and fetal wellbeing at the onset of regular uterine activity; increasing pain requiring analgesia; spontaneous rupture of membranes.
- Vaginal examination and removal of Propess® is indicated for vaginal bleeding, contractions requiring more than simple analgesia, and spontaneous rupture of membranes
- After 24hrs, perform vaginal examination to remove the Propess® and assess the cervix

    - Bishop's score ≥7 plan ARM
    - Bishop's score <7 - see **Unsuccessful induction 5.7**

5.6.1 Spontaneous rupture of membranes during induction

- In the event of spontaneous rupture of membranes during induction a full assessment of maternal and fetal wellbeing should be performed.
- A vaginal examination and removal of the Propess® is indicated.
- Document date, time and findings of SROM in the woman's EPR.
- In the event of SROM with an unstable presenting part or when it is not well-applied to the cervix continuous CTG must be carried out. In this situation, risks, and benefits of continuing with induction should be discussed with the woman, and a caesarean birth should be considered. If the presenting part stabilises and the CTG is normal, then CTG can be discontinued, unless there are other indications for the CTG to remain in place.
- Following SROM during the IOL process, the SBU co-ordinator and obstetric team should be updated and ongoing augmentation of labour should be prioritised, due to the change in risk.
- Advise the woman that they can choose when to commence oxytocin infusion, and opt to delay starting this, but there may be an increased risk of neonatal infection, and/or prolonged labour.
- **If for any reason there are delays in transfer to SBU to continue augmentation due to acuity, then an individual management plan must be made in regards to the monitoring of maternal and fetal wellbeing.**

5.7 Unsuccessful induction

- If after 24hrs of Propess® labour has not commenced, the woman's condition and the pregnancy in general should be fully reassessed by a senior obstetrician, and fetal wellbeing should be assessed with CTG.
- The subsequent management plan should be made by a senior obstetrician in consultation with the woman and these include:

    - Induction of labour with ARM and Syntocinon
    - Consider further Propess® if ARM is not possible
    - Caesarean section

5.8 Uterine hyperstimulation

- Uterine hypercontractility (ie >5 contractions in 10 minutes) may occur related to Propess®. In such cases a CTG should be performed. In the absence of CTG abnormalities, the Propess® should not be removed.
- Tocolysis should be considered if uterine hyperstimulation occurs during induction of labour using 0.25mcg terbutaline subcutaneously *if there is evidence of fetal compromise which does not improve on removal of the Propess®.*

5.9 High presenting part and risk of cord prolapse

- Take the following precautions to avoid the adverse effects of cord prolapse, which may occur if labour is induced:

    - before induction, abdominally assess the level and stability of the fetal head in the lower part of the uterus at or near the pelvic brim
    - during the preliminary vaginal examination, obstetricians and midwives should palpate for umbilical cord presentation and avoid dislodging the baby's head
    - carry out continuous CTG monitoring during induction after the membranes have ruptured, if the presenting part is not stable and not well-applied to the cervix. In this situation, discuss the risks and benefits of induction of labour with the woman, and if necessary consider caesarean birth. If the presenting part stabilises and the CTG is normal, use intermittent auscultation unless there are clear indications for further cardiotocography.

5.10 Women who decline induction of labour

- The woman's decision must be respected and an individualised management plan should be discussed with her at the earliest opportunity
- If not under the care of a consultant, transfer the woman to Maternity Team Care
- From 42 weeks, measurement of amniotic fluid volume and CTG should be performed at least twice weekly
- Consultant review at each visit
- If monitoring is abnormal, discuss IOL again

6 MONITORING COMPLIANCE AND EFFECTIVENESS

The numbers of Induction of Labour are collated monthly via the Maternity dashboard and any increases over the national data set are discussed through Maternity and Gynaecology Clinical Governance and actioned as appropriate.

7 EQUALITY IMPACT ASSESSMENT

- Guidance on how to complete an EIA
- Sample completed form

Name of service/policy/procedure being reviewed: Guideline for the Management of Induction of Labour			
New or existing service/policy/procedure: Existing Guideline			
Date of Assessment: March 2021			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?	b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?	c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality
The area of policy or its implementation being assessed:			
Race and Ethnicity:	None	N/A	N/A
Gender:	Female only	N/A	N/A
Age:	None	N/A	N/A
Religion:	None	N/A	N/A
Disability:	None	N/A	N/A
Sexuality:	None	N/A	N/A
Pregnancy and Maternity:	None	N/A	N/A
Gender Reassignment:	None	N/A	N/A
Marriage and Civil Partnership:	None	N/A	N/A
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation):	None	N/A	N/A

What consultation with protected characteristic groups including patient groups have you carried out? • None
What data or information did you use in support of this EqIA? • None

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments? • None

Level of impact From the information provided above and following EqIA guidance document please indicate the perceived level of impact: Low Level of Impact For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment:
Signature: Sharon Tao
Date: March 2021

7 APPENDICES

Appendix A – Induction of Labour Referral Form
Appendix B – Pathway for booking induction of labour in the community setting
Appendix C – Pathway for booking induction of labour in the antenatal clinic

Appendix A - Induction of Labour Referral Form

Name _____
Date of birth _____
Address _____
_____
District or NHS Number _____

Patient's contact number:			
Named consultant:			
Referring clinician:			
EDD		Parity	
If >37 weeks, has sweep been offered?			

Please tick all that apply

Reason for IOL		Risk factors	
T+12		Previous caesarean section	
Hypertension/PET		Parity > 3	
Diabetes		BMI > 35	
Obstetric cholestasis		Suspected or diagnosed fetal anomaly	
>1 episode altered fetal movements		**Have you included a copy of the customised growth chart? IOL for fetal growth cannot be considered without this.**	
Previous IUFD			
Fetal growth restriction / static growth			
Multiple pregnancy			
Maternal age >40			

Referring clinician's recommendation:

Has this request been discussed with the named consultant?

Please document any allergies/existing medications:

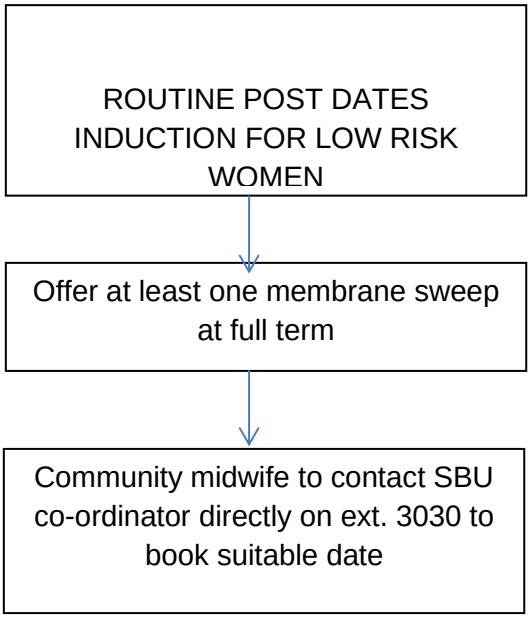
Plan (discuss with patient before end of appointment)

Contact after next MDT (Monday & Thursday)	
Arrange admission or monitoring plan	
Information leaflet provided	

MDT Date:
MDT Comments:

Appendix B

PATHWAY FOR BOOKING INDUCTION OF LABOUR IN THE COMMUNITY SETTING

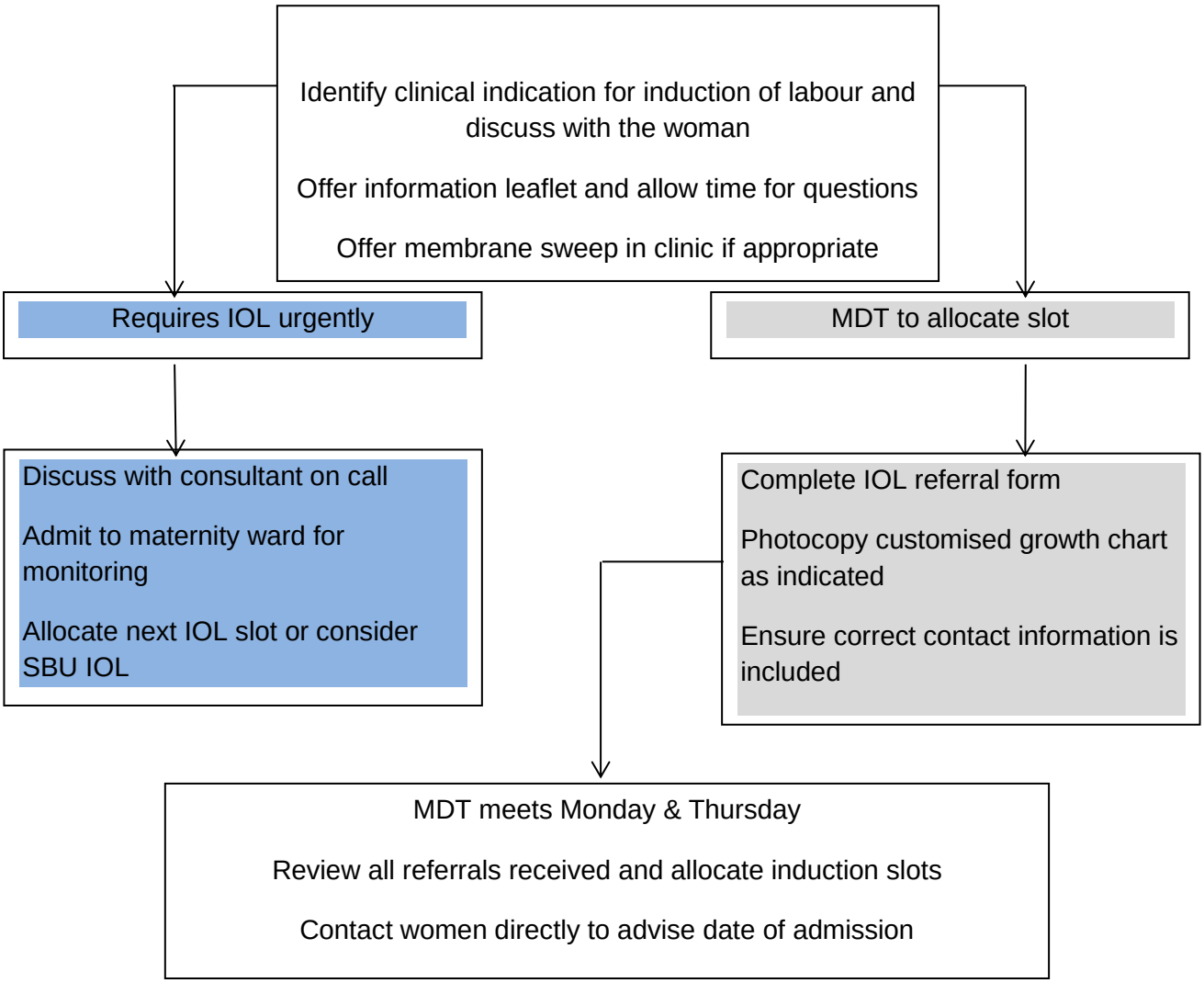


Pattern of booking Elective work:

Elective work	MON	TUES	WEDS	THURS	FRI	SAT	SUN
T+ IOL	1	1	1	1	1	1	1
High risk IOL	2	2	2	2	2	2	2
Elective CS	3	3	3	3	2	0	0
TOTALS	6	6	6	6	5	3	3

Appendix C

PATHWAY FOR BOOKING INDUCTION OF LABOUR IN THE ANTENATAL CLINIC



Pattern of booking Elective work:

Elective work	MON	TUES	WEDS	THURS	FRI	SAT	SUN
T+ IOL	1	1	1	1	1	1	1
High risk IOL	2	2	2	2	2	2	2
Elective CS	3	3	3	3	2	0	0
TOTALS	6	6	6	6	5	3	3