Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Document Type: **GUIDELINE**	**Unique Identifier:** OBS/GYNAE/GUID/111
Title: **Induction of Labour (IOL)**	**Version Number:** 3.2
	Status: Ratified
Target Audience: All medical staff and midwives in Obstetrics	**Divisional and Department:** Obstetrics and Gynaecology Directorate
Author / Originator and Job Title: Dr Eric Mutema, Consultant Obstetrician & Gynaecologist Dr Johnson Amu, Consultant Obstetrician & Gynaecologist Dr Alison Linton, ST6 O+G Angela Fletcher, Lead midwife Carol Tiffin, Maternity Ward Manager	**Risk Assessment:** Not Applicable

Replaces: Version 2, OBS/GYNAE/GUID/111, Induction of Labour (IOL)	**Description of amendments:** Amendments throughout Introduction of Cook's Cervical ripening balloon (CRB) 10/07/2017 – Version 3.1 minor change to 'indications' at Appendix 2 29/03/2018 – Version 3.2 minor changes to Appendix 2.	
Validated (Technical Approval) by: Obstetrics and Gynaecology Policy Group Women's Health Departmental Meeting Version 3.1 Version 3.2 by Chairman's Action (Mr Johnson Amu)	**Validation Date:** 31/01/2017 27/06/2017 16/03/2018	**Which Principles of the NHS Constitution Apply?** 1 - 4
Ratified (Management Approval) by: Medicine Management and Safety Review Committee	**Ratified Date:** 20/04/2017	**Issue Date:** 20/04/2017
Review dates and version numbers may alter if any significant changes are made		**Review Date:** 01/01/2020

Blackpool Teaching Hospitals NHS Foundation Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that they are not placed at a disadvantage over others. The Equality Impact Assessment Tool is designed to help you consider the needs and assess the impact of your policy in the final Appendix.

CONTENTS

1 PURPOSE

All staff involved in the Induction of labour process will have clear evidence based information.

2 TARGET AUDIENCE

This guideline applies to all medical staff and midwives within the Maternity Services working within Blackpool Teaching Hospitals NHS Foundation Trust.

3 GUIDELINE

The total number of inductions per day are:-

Outpatient Induction of Labour (IOL) - refer to OBS/GYNAE/PROT/027:

- One (1) induction is allowed per day.
- Monday – Friday on maternity day unit.

Inpatient Induction of Labour (IOL):

- Four (4) inductions are allowed per day.
- Every day including weekend and bank Holiday,
- Excluding Christmas Day and New Year's Day.

3.1 Uncomplicated Pregnancy

3.1.1 When Membrane Sweeping Should Occur

The midwife / obstetrician should offer sweeping of the membranes prior to formal induction of labour for post-maturity, to nulliparous women at the 40 week antenatal visit and all women at the 41 week antenatal visit.

An additional sweep may be offered if labour does not start spontaneously.

3.1.2 Gestation at Which Induction of Labour Should Take Place

Low risk women with an uncomplicated pregnancy will be offered outpatient IOL if deemed suitable or admitted for induction of labour at term+12.

- The doctor/midwife arranging the admission will sign-post the woman to the Induction of Labour leaflet on the intranet and complete the 'Planning Induction of Labour checklist' (see Appendix 1).
- Midwife will determine eligibility for outpatient induction of labour by referring to OBS/GYNAE/PROT/027.

3.2 Induction of Labour in Specific Circumstances

3.2.1 Prolonged Pregnancy

Low risk pregnancy – follow induction process outlined in Appendix 2.

High risk pregnancy – an individual management plan must be formulated and documented in the health record by the Obstetrician (ST3 or above) – Appendix 2.

3.2.2 Preterm Pre-Labour Rupture Of Membranes

Prior to 34 weeks gestation, induction of labour will be offered by the consultant obstetrician if there are other obstetric complications.

Between 34 and 37 weeks gestation, an individual management plan must be documented by Obstetrician (ST3 or above) after discussing the risk to the woman and her baby. The plan will include paediatric discussion.

- In the absence of Chorioamnionitis, the use of one Prostin gel or tablet should be considered when the cervix is unfavourable. **Where Prostin is used, Oxytocin (Syntocinon) should be commenced after six hours**.

3.2.3 Pre-Labour Rupture of Membranes at Term

Over 37 weeks gestation, the woman may either be offered acceleration of labour with Oxytocin (Syntocinon) or expectant management.

- If membranes have been ruptured for 24 hours or more and expectant management is chosen, acceleration of labour should be offered due to increasing risk of infection (chorioamnionitis).
- In the absence of Chorioamnionitis, the use of one Prostin gel or tablet should be considered when the cervix is unfavourable. Where Prostin is used, Oxytocin (Syntocinon) should be commenced after six hours.
- Women who are known to be Group B Streptococcus (GBS) positive should have labour accelerated as soon as possible with Oxytocin (Syntocinon).

3.2.4 Previous Caesarean Section – (VBAC)

The decision to induce labour must be made by the Consultant Obstetrician and an individual management plan must be documented in the health record.

ARM should be considered as first line where possible before the use of Cervical Ripening balloon (CRB). Use of Propess is contraindicated

3.2.5 Fetal Growth Restriction / Reduced Fetal Movements

Induction of labour should be avoided if there is confirmed fetal compromise.

- The Obstetrician (ST3 or above) must document an individual management plan in the health record.
- Refer to 'Assessment of Foetal Growth' (CORP/GUID/421) and 'Reduced Fetal Movements – Triage Management' (OBS/GYNAE/GUID/006).

3.2.6 Maternal Diabetes

Induction of labour should be offered after 38 weeks gestation if there is no evidence of fetal growth restriction.

- The Diabetes team must document an individual management plan in the health record.

3.2.7 Intrauterine Death

Refer to Termination of Pregnancy and Delayed Miscarriage – Medical Management 13+ weeks Gestation by Scan OBS/GYNAE/PROC/041.

3.2.8 Other considerations

- Late booker: dating or earliest scan after **14^{+5}** weeks gestation.
- Maternal age **40 years** or more.

3.3 Methods of Induction

(Appendix 2)

- Artificial Rupture of Membrane (ARM) with or without Oxytocin (Syntocinon) infusion.
- Propess: slow release Pessary over 24 hours (Dinoprostone vaginal insert).
- Prostin-Dinoprostone gel or tablet.
- Cervical ripening balloon

3.4 Pre-Induction

The midwife will:

- Record and document the MEOWS score on the MEOWS chart.
- Perform an antenatal assessment and complete the Induction of Labour Record.

3.5 Maternal Observations that should be carried out during Induction Prior to the Establishment of Labour

As a minimum the midwife will record a daily inpatient MEOWS score until labour commences and document on the MEOWS chart.

3.6 Fetal Observations that should be carried out during Induction Prior to the Establishment of Labour

The midwife will perform electronic fetal monitoring immediately prior to the initiation of induction of labour for a minimum of twenty minutes. Once established as 'normal', the Electronic Fetal Monitoring (EFM) will be discontinued.
This does not need to be repeated until labour is established or induction of labour process is repeated. See Fetal Monitoring Protocol, OBS/GYNAE/PROC/041.

3.7 The development of an Individual Management Plan following Failed Induction of Labour

Ongoing assessment by the Obstetrician (ST3 or above) following one cycle of induction of labour

ONE CYCLE (= 24HOURS)	NULLIPARA	MULTIPARA
DINOPROSTONE (PROPESS) slow release pessary	**TOTAL = 10mg** One pessary STAT	**TOTAL = 10mg** One pessary STAT
DINOPROSTONE (PROSTIN) GEL Available in 2mg or 1mg	**TOTAL = 3mg** 2mg STAT, then 1mg after 6 hours if cervix not favourable	**TOTAL = 2mg** 1mg STAT, then 1mg after 6 hours if cervix not favourable
DINOPROSTONE (PROSTIN)TABLET Available as 3mg tabs	**TOTAL =6 mg** 3mg (one tablet) STAT, then 3mg(one tablet) after 6 hours if cervix not favourable	**TOTAL = 6mg** 3mg (one tablet) STAT, then 3mg (one tablet) after 6 hours if cervix not favourable

In women being induced in consideration for VBAC:

- ONLY Prostin gel (1mg) or Prostin tablet (3mg) is allowed in one induction cycle.

The following actions to be taken:

- The Obstetrician (ST3 or above) assesses the woman including a vaginal assessment.
- If the cervix is favourable (Bishop's Score of 6 or above – Appendix 3 Bishop's Score Sticker), the woman should be transferred to Delivery Suite and ARM (Artificial Rupture of Membranes) performed by the midwife or doctor.

- All actions taken to be documented in the birth record by the clinician (see Labour Care Guideline OBS/GYNAE/GUID/004).
- If the cervix is not favourable for ARM after one cycle of induction, the Obstetrician (ST3 or above) to discuss with the Consultant who must agree an individualised management plan.

3.8 Management of Suspected Hyper-Stimulation following Prostin

- Hyperstimulation occurs with the use of prostaglandin (Prostin or Propess) for induction of labour. There are frequent contractions (**tachysystole, 6 or more in 10 minutes**) which may be associated with fetal compromised (abnormal EFM)
- **Propess should be removed immediately and the patient transferred to delivery suite if occurring on MDU or WARD D**.
- The midwife should arrange an urgent clinical review by a senior obstetrician
- If the EFM is not improved 15- 20minutes after removal of Propess administer one dose of Terbutaline 250 micrograms subcutaneously.
- If EFM does not improve after one dose of terbutaline, the obstetrician should perform ARM (if intact membranes) and a fetal blood sampling (FBS) should be performed if feasible (3cm dilatation or more).
- Immediate delivery of the baby must be considered if hyperstimulation is unresolved with associated maternal or fetal compromise.

3.9 The Process for Dealing with Maternal Requests for Induction of Labour

Induction of labour for maternal request alone must only be carried out in exceptional circumstances at or after 40 weeks.

- Refer to Consultant Obstetrician for an individualised management plan, which must be documented in the health record.

3.10 The Development of an Individual Management Plan when Induction of Labour is Declined

The woman's decision should be respected and further care should be discussed with her.

- An individual management plan must be documented in the health record by the Obstetrician (ST3 or above) which as a minimum must include:

After 42 weeks gestation

- Perform electronic fetal monitoring (Cardiotocography (CTG)) twice weekly.
- Ultrasound estimation of maximum amniotic pool depth and umbilical artery Doppler at 42 weeks

4 ATTACHMENTS	
Appendix Number	**Title**
1	Planning Induction of Labour
2	Method of Induction of Labour Flow Chart
3	Bishop's Score Sticker
4	Removal of Propess Sticker
5	Syntocinon (Oxytocin) Sticker
6	Process for Monitoring Compliance
7	Equality Impact Assessment Tool

5 PROCEDURAL DOCUMENT STORAGE (HARD AND ELECTRONIC COPIES)
Electronic Database for Procedural Documents
Held by Procedural Document and Leaflet Coordinator

6 LOCATIONS THIS DOCUMENT ISSUED TO		
Copy No	**Location**	**Date Issued**
1	Intranet	20/04/2017
2	Wards, Departments and Service	20/04/2017

7 OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	**Title and web links from the document library**
CORP/GUID/421	Assessment of Foetal Growth http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/CORP-GUID-421.docx
OBS/GYNAE/GUID/004	Labour Care http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/OBS-GYNAE-GUID-004.docx
OBS/GYNAE/GUID/006	Reduced Fetal Movements – Triage Management http://fcsp.xfyldecoast.nhs.uk/trustdocuments/OBS-GYNAE-GUID-006.docx
OBS/GYNAE/PROC/041	Termination of Pregnancy (TOP) http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/OBS-GYNAE-PROC-041.docx
OBS/GYNAE/PROT/003	Fetal Monitoring and Fetal Blood Sampling http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/OBS-GYNAE-PROT-003.docx
OBS/GYNAE/PROT/027	Outpatient Induction of Labour http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/OBS-GYNAE-PROT-027.docx

8 SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS
References In Full
National Institute for Health and Care Excellence. (July 2008). Inducing labour - CG70. Available: https://www.nice.org.uk/guidance/cg70 . Last accessed 15/01/2016.
National Institute for Health and Care Excellence. (April 2014). Inducing labour - QS60. Available: https://www.nice.org.uk/guidance/qs60 . Last accessed 15/01/2016.

8 SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS
References In Full
Royal College of Obstetricians and Gynaecologists. (01/02/2013). Induction of Labour at Term in Older Mothers (Scientific Impact Paper No. 34). Available: https://www.rcog.org.uk/en/guidelines-research-services/guidelines/sip34/ . Last accessed 15/01/2016.

9 CONSULTATION / ACKNOWLEDGEMENTS WITH STAFF, PEERS, PATIENTS AND THE PUBLIC		
Name	**Designation**	**Date Response Received**
	Obstetrics and Gynaecology Policy Group	
	Womens Health Department Meeting	
	Obstetric consultants	
Janet Danson –Smith	Patient Experience Manager	
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10 DEFINITIONS / GLOSSARY OF TERMS	
ARM	Artificial Rupture of Membranes
CTG	Cardiotocography
EFM	Electronic Fetal Monitoring
GBS	Group B Streptococcus
IOL	Induction of Labour
MOEWS	Modified Obstetric Early Warning Score
SPC	Summary of Product Characteristics
VBAC	Previous Caesarean Section

11 AUTHOR / DIVISIONAL / DIRECTORATE MANAGER APPROVAL			
Issued By	Dr Linton	**Checked By**	Mr Amu
Job Title	ST6	**Job Title**	Head of Department
Date	January 2017	**Date**	January 2017

APPENDIX 1: PLANNING INDUCTION OF LABOUR

PLANNING INDUCTION OF LABOUR

Blackpool Teaching Hospitals NHS
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Abbreviations used in this document to be listed here with the full description:
IOL - Induction of labour
Cx - Cervix

Write patient details or affix Identification label
Hospital Number:
Name:
Address:

Date of Birth:
NHS Number:

Antenatal examination completed Yes ☐ No ☐
Expected date of delivery checked Yes ☐ No ☐
Reason for induction of labour .....
Membrane sweep offered, information given Yes ☐ No ☐
declined (state reason) .....
Accepted Consent given Yes ☐ No ☐

Bishops score	0	1	2	3	score
Cx Position	Post	Cent	Ant		
Consistency	Firm	Med	Soft		
Length (cm)	3	2	1	0	
Dilatation (cm)	0	1-2	3-4	5-6	
Station to spines	-3	-2	-1	0	
TOTAL SCORE					

Comments

IOL Date given for ..... gestation .....

The following issues have been discussed

- the risk of failure is 1:4 for primigravida, 1:20 for multigravida Yes ☐ No ☐
- Leaflet given re induction of labour and woman advised that leaflet clearly explains procedure risks and benefits, including possibility of emergency Caesarean Section if induction fails Yes ☐ No ☐
- There may be a delay with starting or proceeding with the induction process. This is forthe safety of mother and baby and will have been discussed with a consultant before she is contacted Yes ☐ No ☐
- One Birth Partner is welcome on the maternity ward between 9am and 8pm, but not overnight Yes ☐ No ☐
- To attend the maternity ward at ..... on the date given Yes ☐ No ☐

Name ..... Signature..... Print..... Date.....

VS982 Approved by the Health Records Committee 18/03/08 **17A**

APPENDIX 2: METHOD OF INDUCTION OF LABOUR FLOW CHART (4 PAGES)

Method of induction of labour

Intact membranes

Ruptured membranes

ARM followed by Oxytocin (Syntocinon)

Bishops Score >6
Cervix 3cm or more
Para 5 or more

CERVICAL RIPENING BALLOON (CRB)
Indications for CRB are on page 3 of appendix 2

I.V Oxytocin (Syntocinon)

24 hours following ruptured membranes at term or preterm

If cervix unfavourable and no evidence of chorioamnionitis: *Offer single dose of Prostin gel followed by I.V Oxytocin (Syntocinon) 6hours later*

PROPESS PESSARY (10mg)

-Term (37weeks or more)
-Post maturity
-Para 3 or less
-IUGR (normal Doppler)
-Maternal medical conditions (e.g. Diabetes, PET, PIH, **cardiac)
-Obstetric cholestasis
-Polyhydramnios
-Multiple pregnancies
**Consultant decision

CONTRAINDICATIONS to Propess

- **Previous C/S (classical)**
- Para 4 or more
- Fetal Malpresentation
- Cephalopelvic disproportion
- Previous uterine surgeries, e.g., myomectomy, rupture of cervix
- Placenta Praevia or unexplained vaginal bleeding in current pregnancy
- Current PID
- Hypersensitivity to Dinoprostone
- Severe Asthma (also applies to Prostin)

PROSTIN GEL/TABLETS

HIGH RISK PREGNANCY
-**IUGR
-**Complicated maternal medical condition (PET, Diabetes, cardiac conditions)
-*Prematurity (<37weeks)
-*Para 5 or more

**Consultant decision

Propess Pessary
Midwife to perform an antenatal assessment and document in the woman's health record
Following the first Bishop's Score, the Midwife / Doctor will administer the Propess Pessary.
The Midwife / Doctor will document on the Bishop's score sticker (Appendix 3) and affix in the Induction of Labour Record

Management of Hyperstimulation with Propess
Commence EFM monitoring
Remove Propess (if in situ) and observe EFM
Administer subcut Terbutaline 250 micrograms if EFM abnormal
Consider ARM and/or FBS if EFM not improving
Consider immediate delivery if maternal or fetal compromise worsens or persist

Induction with Propess Pessary:

- The Propess Pessary will be inserted into posterior fornix of the vagina
- The woman must lie down for at least 30 mins. following insertion
- If spontaneous rupture of membranes, Propess Pessary does not need removing until the cervix is 4 cm dilated, i.e., established labour.
- Propess Pessary must be removed when
  - There is evidence of Hyperstimulation
  - Fetal or maternal abnormalities
  - The woman is in established labour
  - After 24 hours of insertion without labour

Removal of Propess Sticker must be used (Appendix 4)

- If induction fails (ARM not possible or Bishop's Score less than 6):
  - Consider a single dose of Prostin Gel 1mg inserted into the posterior fornix at least 30 minutes after removal of Propess

The midwife must document the date and time Propess was removed using the 'Propess sticker' (Appendix 4)

Prostin E2 vaginal Tablets

1st assessment: One 3mg tablet to be given if required according to the parity and/or Bishop's score

2nd assessment 6 hours later: One 3mg tablet to be given if required according to the Bishop's score

PGE2 gel

1st assessment and initial dose.

- Nulliparous women with a modified Bishop's score <6, give 2 milligrams.
- All other women give 1 milligram

Repeat dose of 1 milligram after 6 hours if required according to the parity and/or **Bishop's score**

The midwife will document on the Bishop's score sticker (Appendix 3) and affix in the Induction of Labour Record

APPENDIX 2: METHOD OF INDUCTION OF LABOUR FLOW CHART (4 PAGES)

Induction with Oxytocin (Syntocinon)

- Oxytocin (Syntocinon) can be started, if needed, 30 minutes after removal of Propess Pessary or 6 hours following insertion of Prostin gel/E2 tablets.

Continuous fetal monitoring must be started prior to commencement of Oxytocin (Syntocinon) (See Fetal Monitoring Protocol OBS/GYNAE/PROC/041)

- Oxytocin (Syntocinon)must be prescribed by the obstetrician
- Amniotomy must be performed prior to the commencement of Oxytocin (Syntocinon)
- Oxytocin (Syntocinon) may be commenced after 1 hour up to a maximum 2 hours following the amniotomy

High risk women

- The decision to use Oxytocin (Syntocinon) must be made by a senior Obstetrician (ST3 or above) and administration will be according to the individualised management plan.
- The decision to commence Oxytocin (Syntocinon) for women having vaginal birth after caesarean section must be discussed with the consultant obstetrician.

Oxytocin (Syntocinon) stickers

- **Oxytocin (Syntocinon) stickers (Appendix 5) must be used to document initial clinical assessment, indication and management plan**
- **Oxytocin (Syntocinon) review sticker (Appendix 5) should be considered when there is a change in the initial management plan**

When to Stop Oxytocin (Syntocinon)

- • Persistent Hyperstimulation (after reduction in titration regime)
- Prior to Caesarean Section.
- Pathological EFM.

See Appendix 3 in Labour Care Guideline (Obs/Gynae/Guid/004)

Infusion regime

- Standard dilution – 10 units Oxytocin (Syntocinon) in 500 mls 0.9% Sodium Chloride
- A higher concentration 30 units Oxytocin (Syntocinon) in 500 mls 0.9% Sodium Chloride may be appropriate in women with fluid restriction – the decision to use this regime must be made at Consultant level
- The dose is increased at intervals of 30 mins or more
- Administered using a Infusion pump
- The minimum possible dose should be used with the aim of 4-5 contractions in every 10 mins
- Slower incremental doses may be used at the discretion of the midwife/doctor responsible for care

Time After Starting	Dose delivery 10 Units / 500mls	CONCENTRATED Dose delivery 30units/500mls	**The dose and rate must be documented on the Partogram by the midwife.**
Mins	ml/hr	ml/hr	
0	3	1	
30	6	2	
60	12	4	
90	24	8	
120	36	12	
150	48	16	
180	60	20	
210	72	24	
240	84	28	
270	96	32	

APPENDIX 2: INDUCTION OF LABOUR WITH CERVICAL RIPENING BALLOON (PAGE 3 OF 4)

The cervical ripening balloon (CRB) is a silicone double balloon catheter (see pictures)

Eligibility for use

- Not in labour
- Singleton pregnancy
- Term
- Longitudinal lie
- Cephalic presentation
- Intact membranes
- No active genital infection e.g herpes
- No genital cancer
- No cardiac disease or severe hypertension
- No contraindication

Indications for CRB

- One previous caesarean section
- Multiparous (Para 5 or more need **consultant decision**)
- Two or more caesarean sections
- Failed IOL after Propess +/- Prostin gel
- FDIU after failed IOL with Prostin gel

Contraindications to CRB

- Abnormal CTG
- Ruptured membrane
- IUGR
- Polyhydramnious
- Placenta praevia or low lying placenta at 20weeks
- Vasa praevia
- Previous classical CS, cervical tear
- Previous myomectomy or hysterotomy
- Abnormal Pelvic structure

Process of IOL with cervical ripening balloon (CRB)

Admission

- Patient is admitted to delivery suite from 1800hrs
- Midwife should check maternal vital signs (BP, pulse) and perform CTG monitoring for at least 30minutes

Insertion of CRB

- After a normal CTG , the patient is reviewed by the obstetrician (ST3 and above)
    - Abdominal palpation should be performed to ensure fetus is cephalic and head is engaged
    - VE should be performed to determine if ARM is possible.
    - If ARM not possible, a CRB should be inserted with up to 80mls of normal saline inserted into both cervical and vaginal balloons incrementallyand amount documented (see appendix 2 for instructions)
- Midwife to perform post procedure CTG monitoring for 40minutes
- The patient should be encouraged to mobilise after a normal post procedure CTG and then transferred to Ward D.

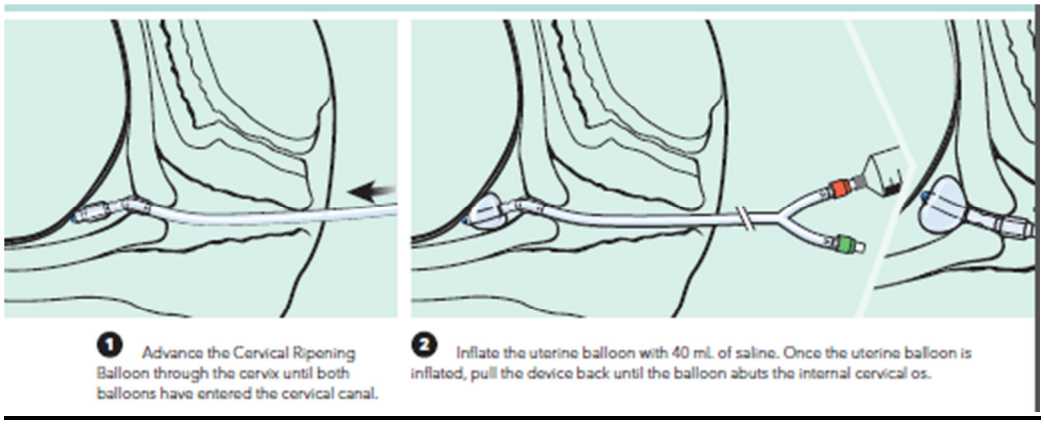
Removal of CRB

- After 11.5hours following insertion of CRB, the midwife to recommence CTG monitoring

After 12hrs post insertion of CRB, the midwife (ward D) should deflate the balloon removing the exact amount of normal saline inserted (check obstetricians procedure documentation)

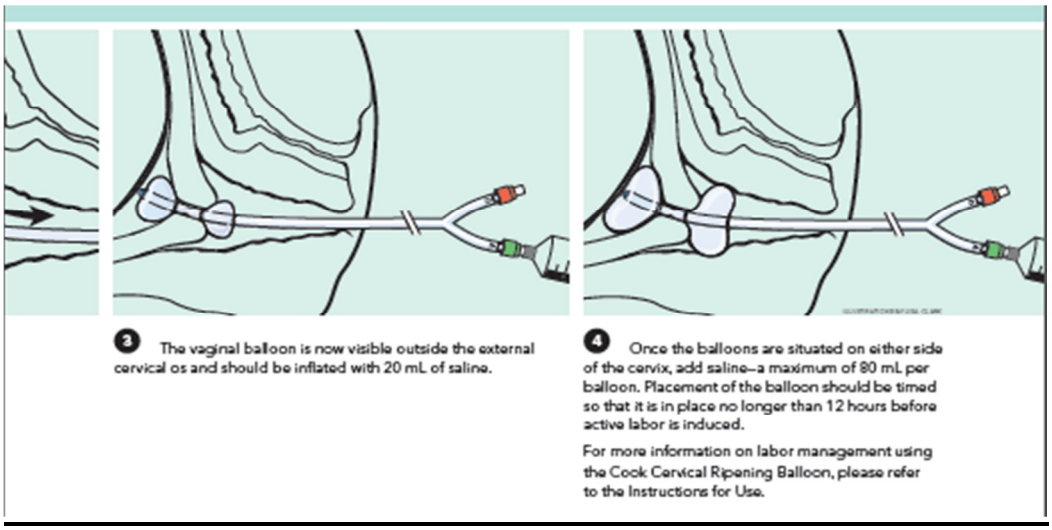
- After removal of CRB, the midwife should perform a VE to assess if ARM is possible
- If ARM is possible the midwife should arrange transfer to delivery suite
- If ARM not possible, the patient should be reviewed by the obstetrician (ST3 and above).
    - Further management should be discussed with the consultant

APPENDIX 2: INSERTION OF CRB INSTRUCTIONS (PAGE 4 OF 4)



1 Advance the Cervical Ripening Balloon through the cervix until both balloons have entered the cervical canal.

2 Inflate the uterine balloon with 40 mL of saline. Once the uterine balloon is inflated, pull the device back until the balloon abuts the internal cervical os.



3 The vaginal balloon is now visible outside the external cervical os and should be inflated with 20 mL of saline.

4 Once the balloons are situated on either side of the cervix, add saline--a maximum of 80 mL per balloon. Placement of the balloon should be timed so that it is in place no longer than 12 hours before active labor is induced.

For more information on labor management using the Cook Cervical Ripening Balloon, please refer to the Instructions for Use.

Issues following insertion of CRB

- **If insertion of CRB is not possible,**
  - An individualised management plan following discussion with the consultant should be documented in the patient record.
- **If ARM is not possible following CRB insertion**
  - An individualised management plan following discussion with the consultant should be documented in the patient record
- **If balloon falls out**, this would imply cervix is dilated.
  - the midwife should perform a VE to confirm ARM is possible , and transfer to delivery suite when possible
- **if there is significant discomfort without contractions after insertion of CRB,** the patient should be reviewed by the obstetrician (ST3 and above)
  - consider deflating the balloons slightly and document amount of fluid removed
- **If SROM occurs**, deflate both the balloons and remove the CRB catheter.
  - the midwife should perform a VE to assess the cervix
  - If in labour transfer to delivery suite
  - If not in labour, transfer to delivery suite 6hours after for syntocinon
- **If bleeding occurs,** the patient should be reviewed by the obstetrician (ST3 and above
  - The midwife should commence CTG monitoring
  - The obstetrician should review the patient and consider deflating both the balloons and removing the catheter

APPENDIX 3: BISHOP'S SCORE STICKER

Assessment No Consent Y

Abdominal Palpation

Fetal Heart before VE

Contractions Y N

Signature:
PRINT NAME:
Date……Time……

Bishop's Score	0	1	2	3	Score
Cx Position	post	centre.	Ant.	-	
Consistency	firm	med	soft	-	
Length (cm)	3	2	1	0	
Dilatation (cm)	0	1-2	3-4	5-6	
Station to Spines	-3	-2	-1	0+	
				Total	

Show	Membranes
External genitalia	**F H R after VE**

Prostaglandin given: YES NO
Dose given:

APPENDIX 4: REMOVAL OF PROPESS STICKER

Removal of Propess

Date and time of removal……..……..

Reason for removal……..…….

Propess Fell out? Date and time…….

Confirmed by ……

Name……..Signature……

APPENDIX 5: SYNTOCINON (OXYTOCIN) STICKER

SYNTOCINON

Date..... Time.....
Reason for Syntocinon: IOL ☐ Acceleration ☐
Risk : Low ☐ High ☐
Aim for: ..... Contractions in 10
Decision for Syntocinon made by .....
Maximum dose before review by Consultant Dose – mls/hr ☐
When to stop Syntocinon:
Plan .....
Name ..... Grade..... Signature.....

Syntocinon Review Sticker

Reason for Review:

Plan:

Name …….. Grade ……..

Signature: ……

APPENDIX 6: PROCESS FOR MONITORING COMPLIANCE

Minimum requirement to be monitored		Process for monitoring e.g. audit	Responsible individual/ group/ committee	Frequency of monitoring	Responsible individual/ group/ committee for review of results	Responsible individual/ group/ committee for development of action plan	Responsible individual/group/ committee for monitoring of action plan and Implementation
a)	When membrane sweeping should occur	Audit 0.5% of health records of all woman who have had their labour induced	Divisional Risk Governance Group	Annual	Divisional Risk Governance Group	Divisional Risk Governance Group	Divisional Risk Governance Group
b)	Gestation at which induction of labour should take place	Audit 0.5% of health records of all woman who have had their labour induced	Divisional Risk Governance Group	Annual	Divisional Risk Governance Group	Divisional Risk Governance Group	Divisional Risk Governance Group
c)	Induction of labour in specific circumstances which as a minimum must include: • Prolonged pregnancy • Preterm prelabour rupture of membranes • Prelabour rupture of membranes at term • Previous caesarean section • Fetal growth restriction • Maternal diabetes • Intrauterine death	Audit 0.5% of health records of all woman who have had their labour induced	Divisional Risk Governance Group	Annual	Divisional Risk Governance Group	Divisional Risk Governance Group	Divisional Risk Governance Group
d)	Methods of induction	Audit 0.5% of health records of all woman who have had their labour induced	Divisional Risk Governance Group	Annual	Divisional Risk Governance Group	Divisional Risk Governance Group	Divisional Risk Governance Group
e)	Maternal observations that should be carried out during induction prior to the onset of labour	Audit 0.5% of health records of all woman who have had their labour induced	Divisional Risk Governance Group	Annual	Divisional Risk Governance Group	Divisional Risk Governance Group	Divisional Risk Governance Group
f)	Fetal observations that should be carried out during induction prior to the	Audit 0.5% of health records of all woman	Divisional Risk Governance	Annual	Divisional Risk Governance	Divisional Risk Governance	Divisional Risk Governance

APPENDIX 6: PROCESS FOR MONITORING COMPLIANCE							
Minimum requirement to be monitored		**Process for monitoring e.g. audit**	**Responsible individual/ group/ committee**	**Frequency of monitoring**	**Responsible individual/ group/ committee for review of results**	**Responsible individual/ group/ committee for development of action plan**	**Responsible individual/group/ committee for monitoring of action plan and Implementation**
	onset of labour	who have had their labour induced	Group		Group	Group	Group
g)	The development of an individual management plan when induction of labour fails	Audit 0.5% of health records of all woman who have had their labour induced	Divisional Risk Governance Group	Annual	Divisional Risk Governance Group	Divisional Risk Governance Group	Divisional Risk Governance Group
h)	The process for dealing with maternal requests for induction of labour	Audit 0.5% of health records of all woman who have had their labour induced	Divisional Risk Governance Group	Annual	Divisional Risk Governance Group	Divisional Risk Governance Group	Divisional Risk Governance Group
i)	The development of an individual management plan when induction of labour is declined	Audit 0.5% of health records of all woman who have had their labour induced	Divisional Risk Governance Group	Annual	Divisional Risk Governance Group	Divisional Risk Governance Group	Divisional Risk Governance Group

APPENDIX 7: EQUALITY IMPACT ASSESSMENT FORM

Department	Departmental Wide	**Service or Policy**	Protocol	**Date Completed:**	November 2015

GROUPS TO BE CONSIDERED

Deprived communities, homeless, substance misusers, people who have a disability, learning disability, older people, children and families, young people, Lesbian Gay Bi-sexual or Transgender, minority ethnic communities, Gypsy/Roma/Travellers, women/men, parents, carers, staff, wider community, offenders.

EQUALITY PROTECTED CHARACTERISTICS TO BE CONSIDERED

Age, gender, disability, race, sexual orientation, gender identity (or reassignment), religion and belief, carers, Human Rights and social economic / deprivation.

QUESTION	**RESPONSE**		**IMPACT**	
	Issue	Action	Positive	Negative
What is the service, leaflet or policy development? What are its aims, who are the target audience?	The Procedural Document is to ensure that all members of staff have clear guidance on processes to be followed. The target audience is all staff across the Organisation who undertakes this process.	Raise awareness of the Organisations format and processes involved in relation to the procedural document.	Yes – Clear processes identified	
Does the service, leaflet or policy/ development impact on community safety • Crime • Community cohesion	Not applicable to community safety or crime	N/A	N/A	
Is there any evidence that groups who should benefit do not? i.e. equal opportunity monitoring of service users and/or staff. If none/insufficient local or national data available consider what information you need.	No	N/A	N/A	
Does the service, leaflet or development/ policy have a negative impact on any geographical or sub group of the population?	No	N/A	N/A	
How does the service, leaflet or policy/ development promote equality and diversity?	Ensures a cohesive approach across the Organisation in relation to the procedural document.	All policies and procedural documents include an EA to identify any positive or negative impacts.		
Does the service, leaflet or policy/ development explicitly include a commitment to equality and diversity and meeting needs? How does it demonstrate its impact?	The Procedure includes a completed EA which provides the opportunity to highlight any potential for a negative / adverse impact.			
Does the Organisation or service workforce reflect the local population? Do we employ people from disadvantaged groups	Our workforce is reflective of the local population.			
Will the service, leaflet or policy/ development i. Improve economic social conditions in deprived areas ii. Use brown field sites iii. Improve public spaces including creation of green spaces?	N/A			
Does the service, leaflet or policy/ development promote equity of lifelong learning?	N/A			
Does the service, leaflet or policy/ development encourage healthy lifestyles and reduce risks to health?	N/A			
Does the service, leaflet or policy/ development impact on transport? What are the implications of this?	N/A			
Does the service, leaflet or policy/development impact on housing, housing needs, homelessness, or a person's ability to remain at home?	N/A			
Are there any groups for whom this policy/ service/leaflet would have an impact? Is it an adverse/negative impact? Does it or could it (or is the perception that it could exclude disadvantaged or marginalised groups?	None identified			
Does the policy/development promote access to services and facilities for any group in particular?	No			

APPENDIX 7: EQUALITY IMPACT ASSESSMENT FORM

Does the service, leaflet or policy/development impact on the environment • During development • At implementation?	No			

ACTION:			
Please identify if you are now required to carry out a Full Equality Analysis	~~**Yes**~~	**No**	**(Please delete as appropriate)**

Name of Author: **Signature of Author:**	**Mr Johnson Amu**	**Date Signed:**	**November 2015**
Name of Lead Person: **Signature of Lead Person:**		**Date Signed:**	
Name of Manager: **Signature of Manager**	Miss E J Davies	**Date Signed:**	November 2015