## INDUCTION OF LABOUR GUIDELINE

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This guideline should be used for all women who require induction of labour whether for prolonged pregnancy or other clinical indications as specified by the NICE guideline Induction of Labour 2008. This guideline is predominantly for Induction of Labour using Dinoprostone vaginal gel (Prostin gel®) and Dinoprostone 10mg SR pessary (Propess®)

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1. Antenatal clinic

Midwives and obstetricians should explain and document the following points to women being offered induction of labour (IOL):

- The reasons induction is being offered
- When, where and how IOL will be carried out and how long it can take
- The arrangements for support and pain relief
- The alternative options if the woman chooses not to have IOL
- The risks and benefits of IOL in specific circumstances and proposed IOL methods
- That induction may not be successful and what the woman's options would be.
- Please refer to Patient Information Leaflet: Information about your induction of labour

1.1 Induction of labour (timing)

- Prior to booking the Induction confirm expected date of delivery. This should have been already agreed by the time of the anomaly scan. Dates are calculated by the earliest (ideally first trimester) scan. (If necessary use head circumference on anomaly scan at 18-20 weeks.)
- Due consideration should be given to maternal preferences and priorities prior to commencement of induction.

1.2 Risk assessment prior to making a decision for induction of labour

Are there any pregnancy related complications
(Click here to view Quick Guide to Obstetric Risk Factors)

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**NO**

Review at 40-41 weeks gestation

Offer:
- A Membrane sweep
- IOL – at 40+7 – 14 days

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**YES**

Consideration of the woman's Clinical Condition

Offer:
- Medical Review
- IOL at an appropriate gestation
1.3 Recommendations for women with a prolonged pregnancy

Definition of prolonged pregnancy is a pregnancy that continues beyond 42 weeks gestation. The most frequent indication for induction of labour is to avoid the risk of late stillbirth which occurs in 2-3 in 1000 pregnancies (NICE 2008) at 42 weeks, gestational age having been established from the first trimester ultrasound scan. Induction of labour may be booked after 41 weeks, thereby reducing the perinatal mortality rate without increasing the caesarean section rate (NICE 2008).

Women should be informed that most women will go into labour spontaneously before 42 weeks. All women over 38 weeks should be offered information about the risks associated with pregnancies that last longer than 42 weeks, and their options. The information should cover:

- Membrane sweep:
  - That a membrane sweep makes spontaneous labour more likely, and so reduces the need for formal IOL to prevent prolonged pregnancy.
  - What a membrane sweep is
    - That discomfort and vaginal bleeding are possible from the procedure
- IOL between 40+7 – 14 days
- Expectant management.

A membrane sweep should be offered to all women

1.4 Women who decline induction of labour for prolonged pregnancy at 42 weeks

- A Supervisor of Midwives appointment should be arranged for all women who decline induction of labour at 42 weeks
- Women need to be reviewed by a Consultant as soon as possible
- Propose induction of labour
- Initiate serial antenatal monitoring from 42+1 weeks to include
  - Measurement of single deepest pool of liquor
  - Twice weekly cardiotocography (CTG)
- If not in labour women need to be reviewed by a Consultant after 1 week.

1.5 Booking of type of induction

- The indication for induction must be documented in the notes
- Induction of labour should not routinely be offered on maternal request alone. However, NICE guidelines (2008) advise under exceptional circumstances, induction may be considered at or after 40 weeks.
- All inductions except those for post maturity (>40+7 weeks) must be discussed with a senior registrar or consultant.
- Abdominal palpation, confirmation of cephalic presentation and engagement recorded.
- Placenta site must be documented.
- Inform women that induction of labour may be delayed or interrupted due to the level of workload on the maternity unit (to ensure safety).
- Low risk post maturity inductions should be booked through Josephine Barnes Ward.
- Low risk nulliparous women who are post-dates should be induced using Dinoprostone 10mg SR pessary (Propess®) see section 3.1.
- Low risk Multiparous women who are post dates should be induced using Dinoprostone vaginal gel (Prostin gel®) see section 9 or Artificial Rupture of Membranes (ARM) if favourable.
- High risk induction of labour and women who are assessed as able to have an artificial rupture of their membranes should be booked through Labour ward.

1.6 Assessment of cervix in antenatal/community clinics (prior to admission)
- Prior to booking the induction the cervix should be assessed using the modified Bishops Score (see Modified Bishop Score on Page 5 of this document).
- If a woman declines an assessment this should be documented in the notes.
- One of the 3 protocols should be followed if using Dinoprostone vaginal Gel (Prostin gel®) (see section 9), depending on the Bishops score and parity.
- If the woman is a Low risk post dates pregnancy please refer to the Dinoprostone 10mg SR pessary (Propess®) protocol see section 3.1.

2. Admission
- **Low risk** – admit to Josephine Barnes ward at allocated date and time.
- **High risk** – admit to Labour ward or triage at allocated date and time.
- On admission the admitting midwife or doctor should discuss the induction process with the woman answering any concerns she may have.

2.1 Pre induction assessment of maternal and fetal well being on admission

A full antenatal check should be completed and documented on the admission for induction of labour form or in the notes and this should be continuously carried out throughout labour.

The information to be documented is:
- Reason for induction
- Induction of labour has been explained including:
  o Discomfort of the procedure
  o Risk of bleeding
  o Contractions
  o Pre-labour rupture of membranes
  o The need for close monitoring of the fetal heart rate
  o Risks of failed induction of labour
- Ensure that she has read the Patient Information leaflet. Click here to view [Patient Information Leaflet: Information about your induction of labour](#).
- Check Ultrasound for placental site
- A base line set of observations should be performed on admission prior to IOL and continued to the establishment of labour– BP, Temp and Pulse.
- Abdominal Palpation – documenting presentation, lie, position and engagement.
- Fetal heart MUST be auscultated (with pinard stethoscope or sonicaid) pre procedure and initial CTG.
• CTG prior to induction for at least 30 minutes prior to induction process, if non-reassuring a medical review must be undertaken and plan documented in the notes.

2.2 Fetal monitoring and induction of labour

• If Dinoprostone vaginal gel (Prostin gel®) or Dinoprostone 10mg SR pessary (Propess®) is given the CTG must be continued for at least 30 minutes post administration and be normal prior to being discontinued.

• Following ARM the CTG must be continued for at least 30 minutes and be normal prior to being discontinued.

• If neither Dinoprostone vaginal gel or Dinoprostone 10mg SR pessary is administered nor ARM is conducted, the fetal heart should be listened into immediately post examination, if non-reassuring a CTG should be commenced with a medical review.

• If the woman starts contracting fetal wellbeing should be assessed with continuous electronic fetal monitoring. Once the cardiotocogram is confirmed as normal, intermittent auscultation should be used unless there are clear indications for continuous electronic fetal monitoring. Click here to view the guideline for Care of Women in Labour and Fetal Monitoring Guideline

• Document all findings and discussions with the women in her maternity notes and on the Induction of labour proforma.

3. Low risk, post dates, nulliparous women being induced using Dinoprostone 10mg SR pessary (Propess®)

3.1 Propess® pessary for low risk induction of labour

Propess® is a slow release vaginal pessary containing 10mg Dinoprostone. At Chelsea and Westminster Propess® will be initially used for postdates induction of labour in low risk primigravida women only. Propess® releases prostaglandin at a steady rate of 0.3 mg/hr for up to 24 hours, and has a half life of 1-3 minutes. Studies have shown that Propess® is as effective as existing methods of induction of labour using prostaglandin preparations (Kelly et al 2003, NICE 2008). Whilst using Propess®, women may require fewer vaginal examinations, have no delay in administration of subsequent prostaglandins, have a reduction in IOL – delivery time and less time spent in the antenatal ward awaiting IOL.

3.2 Criteria for use of Propess® pessary

• Low risk primigravida women
• Post dates (40 weeks + 7 days)
• Singleton pregnancy
• Cephalic presentation
• Placenta clear of the cervical os on ultrasound
• Normal pre and post administration CTG’s
• Bishop’s Score (BS) < 6
• IOL with Propess® will be initiated on the antenatal ward (Josephine Barnes Ward)
3.3 Prior to administration of Propess® pessary

- Remove Propess® pessary from freezer 5 – 10 minutes before use
- Assess Bishop Score using the Bishop Score table on page:9
- If Bishop’s Score is 6 or greater, regular painful contractions, bleeding or spontaneous rupture of membranes (SROM) – do not insert Propess® pessary.
- If Bishop’s Score < 6 – insert Propess® pessary

4. Guidance on how to use Propess® pessary

4.1 Insertion of Propess® pessary

4.1.1 The recommended Propess® pessary administration technique

1. Insertion
   Holding the Propess® insert between the index and middle fingers of the examining hand, insert it high into the vagina towards the posterior vaginal fornix using only small amounts of water soluble lubricants.

2. Positioning
   The index and middle fingers should now be twisted a quarter turn clockwise, pushing the Propess insert higher up, behind the posterior fornix and turning it through 90º so that it lies transversely in the posterior fornix.

3. After positioning
   Carefully withdraw the fingers leaving the Propess® insert in the position shown in this diagram where it should remain in situ. After insertion ensure that the patient remains recumbent for 20-30 minutes to allow time for the Propess® insert to swell. Again, this will help it to remain in place for the duration of the treatment. Allow sufficient tape to remain outside the vagina to permit easy retrieval.

4. Removal
   To stop prostaglandin E2 release, gently pull the retrieval tape and remove the Propess insert.

A Propess® pessary should be inserted into the posterior fornix and rotated into a transverse position behind the cervix.

Fingers should be carefully removed so that the tape unravels to hang outside the vulva (similar to tampon)

4.2 After Propess® pessary insertion

- Women should remain in bed, in a semi-recumbent position for approximately 1 hour post insertion.
- Following CTG monitoring, women may mobilise after 1 hour, as they wish.
- Women should be reminded to take care when going to the toilet, not to pull on the tape and detach the pessary.
- 4 hourly observations and auscultation of the fetal heart should be carried out.
- Women should inform the midwife at the onset of painful regular contractions.
- Further vaginal examinations are unnecessary unless regular contractions are established or SROM occurs. Perform CTG at this time.
• Propess® should be unaffected by bathing and showering although women should be advised against excessive use of soap

4.3 When to remove Propess® pessary

A Propess® pessary is designed to remain in the vagina for up to 24 hours; however it should be removed immediately in the following instances:

• Regular contractions are established and the cervix is dilated greater than 3 cm
• Vaginal bleeding.
• Fetal compromise – CTG becomes pathological.
• If rupture of membranes occurs subsequent to administration of Propess®
• Uterine hyperstimulation (rare, but can occur) (refer to management of hyperstimulation section of this guideline – (see page 8)
  o More than 5 contractions in 10 minutes
  o Painful contractions lasting 90 seconds or more.
• At least 30 minutes prior to starting an intravenous infusion of oxytocin.
• Adverse maternal systemic reaction – severe nausea or vomiting (rare side effect).

To remove Propess®, apply gentle traction on the retrieval tape (the insert will have swollen to 2-3 times its original size and be pliable). Document in the maternal notes time of removal.

If after removal for a suspected indication above proves inappropriate and the pessary has been kept post removal on a clean field for less than 30 minutes, the pessary may be reinserted and induction of labour resumed.

4.4 After 24 hours

• Remove Propess® after 24 hours and perform vaginal examination
• Transfer to Labour ward if artificial rupture of membranes (ARM) is possible, or if in active labour
• If not possible to perform ARM, review by Consultant and/or SpR
• Oxytocin should not be commenced within 30 minutes of removing the pessary (following ARM)
• If ARM not possible, follow recommendations for failed induction (see page 8).

4.5 Definition of failed induction with Propess® pessary

The definition used by NICE for failed induction with prostaglandin is “the failure to induce progressive labour after one cycle of treatment”. In practice this means following the insertion of one Propess® for 24 hours. Please refer to Section 7 on page:8

4.6 Spontaneous rupture of membranes

If rupture of membranes occurs subsequent to Propess® administration, Propess® should be removed and an Oxytocin infusion commenced 30 minutes later. However, if the woman is contracting regularly at this point, in may be appropriate to delay augmentation for 2 hours to see if labour establishes spontaneously.
4.7 Group B Streptococcus positive (GBS)

Propess® can be used on women known to be GBS +ve and the antibiotic regime must be followed as per GBS guideline.

5. High risk women

All women who are outside of that category of prolonged pregnancy (41 weeks) are classed as high risk and at this time should be induced using Dinoprostone gel vaginal Gel (Prostin gel®) or ARM.

This includes:

- Women with Pre-term prelabour rupture of membranes. Click here to view the Preterm Prelabour Rupture of Membranes (PPROM) Guideline
- Women with previous LSCS. Click here to view the Vaginal Birth after Caesarean Section (VBAC) guideline
- Fetal growth restriction – NICE (2008) recommend if there is severe fetal growth restriction with confirmed fetal compromise, IOL is not recommended. Click here to view guideline for the Management of Suspected or Proven Fetal Growth Restriction (FGR).
- Maternal diabetes. Click here to view guideline for Pre-Existing Diabetes in Pregnancy.
- Intrauterine death or therapeutic termination of fetal abnormality.
- Pre-eclampsia or pregnancy induced hypertension.

Any induction for a high risk woman must be booked by a registrar or a consultant with a full management plan documented in the notes prior to admission or transfer.

All high risk women should be admitted to triage or Labour ward for their initial assessment and monitoring. If unit activity does not allow this then the registrar on call should be informed and women admitted to the antenatal ward to await transfer.

Women who have had a previous caesarean section must not be induced using Dinoprostone vaginal gel (See Vaginal Birth after Caesarean Section (VBAC) guideline).

Women with pre-labour rupture of membranes at term. Click here to view guideline for the Management of Pre-Labour Rupture of Membranes at Term (PROM).

6. Management of uterine hyperstimulation

The definition of hyperstimulation is a woman contracting more than 5 contractions in 10 minutes and this warrants a rapid review by a senior obstetrician.

Hyperstimulation- Propess®:

- If hyperstimulation is suspected, call the obstetric SpR.
- Commence continuous CTG.
- If fetal heart rate is non-reassuring, remove Propess® immediately.
- Review by SpR – if there is evidence of palpable uterine activity of >5:10 minutes or prolonged painful contractions > 90 seconds, and then remove Propess® pessary.
- Consider tocolysis - 250mcg terbutaline subcutaneously. However, due to the short half life of Propess® and slow dose release per hour, the hyperstimulation should resolve spontaneously within 15 – 20 minutes.
Hyperstimulation – Dinoprostone Vaginal Gel:

If contractions > 5:10 a CTG should be commenced immediately and a request for an urgent medical review should be made.

Tocolysis should be considered – 250mcg terbutaline subcutaneously

7. Recommendation if induction of labour fails

The decisions regarding the management of a failed induction must be made in accordance with the woman’s wishes and with regard to the clinical circumstances. A full assessment of the pregnancy in general, the woman’s condition and fetal wellbeing using electronic fetal monitoring (EFM), should be made. A management plan should be finalised after discussion with the Obstetric Consultant on call for Labour ward.

If induction fails, the management options are:

- A further attempt to induce the labour with Dinoprostone vaginal gel after consultation with the woman
- A further cycle of vaginal prostaglandins in the form of Dinoprostone gel may be commenced 24 hours after removal of a Propess® pessary.
- Caesarean Section. Click here to view the Caesarean Section Guidelines.

8. Modified Bishops Score

The modified Bishop scoring system (Calder score) NICE 2008 is presented below:

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<tr>
<td>Cervical feature</td>
<td>&lt;1cm</td>
<td>1-2cm</td>
<td>3-4cm</td>
<td>5 – 6cm</td>
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<tr>
<td>Dilation of cervix</td>
<td>&lt;1cm</td>
<td>1-2cm</td>
<td>3-4cm</td>
<td>5 – 6cm</td>
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<tr>
<td>Length of cervix</td>
<td>4cm</td>
<td>2-4cm</td>
<td>1-2cm</td>
<td>&lt;1cm</td>
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<tr>
<td>Station of presenting part (relative to the ischial spines)</td>
<td>-3cm</td>
<td>-2cm</td>
<td>-1/0cm</td>
<td>+1/+2cm</td>
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<tr>
<td>Consistency of cervix</td>
<td>Firm</td>
<td>Average</td>
<td>Soft</td>
<td>-</td>
</tr>
<tr>
<td>Position of cervix</td>
<td>Posterior</td>
<td>Mid/anterior</td>
<td>-</td>
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9. Protocols for women induced using Dinoprostone Vaginal Gel or who have a favourable cervix for ARM

A. Nulliparous Women (Bishop Score 4 or less) – see Protocol A (p9).

B. Multiparous Women (Bishop Score 4 or less) or Nulliparous women with Bishop score 5 or greater but unfavourable for ARM – see Protocol B (p10).

C. All women (Bishop Score 5 – 9) and favourable Cervix for ARM - see Protocol C (p11).
9.1 Protocol A: Nulliparous Women (Bishop Score 4 or less)

After assessment and normal CTG - 2mg Dinoprostone gel inserted into posterior fornix of vagina

CTG 30 minutes post Dinoprostone Gel

Reassess Cervix (Cx) 6 hours post Dinoprostone Gel

ARM: A/ Protocol C

Bishop Score 5 to 9 and Cx favourable for ARM on Labour ward. CTG Post ARM – 30mins

Oxytocin infusion within 2 hrs if not contracting (See related guideline on Use of Oxytocin)

If NO contractions or Bishop Score <5 for Registrar or Consultant Review

After review, if Bishop Score <5 administer 1mg Dinoprostone gel into posterior fornix if authorised by Registrar or Consultant- CTG

Reassess CX after 6 hours

If Bishop Score <5
Leave to rest
Consider LSCS
Plan documented in notes

ARM: B

Bishop Score < 5 – 1mg Dinoprostone gel inserted posterior fornix - CTG

Reassess Cx – After 6 hours

If Bishop Score 5 or more – Go to ARM A

If Bishop Score 5 to 9 and Cx favourable for ARM on Labour ward. CTG Post ARM – 30mins

Oxytocin infusion within 2 hrs if not contracting (See related guideline on Use of Oxytocin)

If NO contractions or Bishop Score <5 for Registrar or Consultant Review

After review, if Bishop Score <5 administer 1mg Dinoprostone gel into posterior fornix if authorised by Registrar or Consultant- CTG

Reassess CX after 6 hours

If Bishop Score <5
Leave to rest
Consider LSCS
Plan documented in notes

If Bishop Score 5 or more – Go to ARM A
9.2 Protocol B Multiparous Women (Bishop Score 4 or less) or Nulliparous women with Bishop score 5 or more but unfavourable for ARM

After assessment and Normal CTG – Max 1mg Dinoprostone gel inserted into posterior fornix.

CTG 30 minutes post Dinoprostone Gel

Reassess Cervix (Cx) (min) 6 hours post Dinoprostone Gel
Or sooner if tightening regularly

Bishop Score 5 to 9 and Cx favourable for ARM on Labour ward.
CTG Post ARM – 30mins

Bishop Score <5 and minimal response/ no contractions –
1 mg Dinoprostone gel inserted posterior fornix – CTG – 40mins

Oxytocin infusion within 2 hrs if not contracting
(See related guideline on Use of Oxytocin)

If NO contractions or cervical change– for Registrar or consultant review
Further 1mg authorised by Reg/ consultant.

Reassess Cx after minimum 6 hrs

Bishop Score <5 + unfavourable for ARM:
Leave to rest
Consider LSCS
Plan documented in notes
9.3 Protocol C: All women (Bishop Score 5 to 9) and favourable Cervix for ARM

Artificial Rupture of membranes (ARM) on labour ward

CTG post ARM for 30 minutes

Oxytocin infusion within 2 hours if not contracting
(Hyperlink to the guideline for the use of Oxytocin for IOL and augmentation)

10. Audit and Guideline

Compliance with this guideline will be audited annually as specified by CNST (see below). Results will be presented in a multidisciplinary forum and actions arising from audit will be monitored through Maternity Clinical Effectiveness Group and Labour Ward Forum. This guideline should be updated every 3 years.

Audit Standards:

1. Induction of labour in specific circumstances:
   a. Prolonged pregnancy
   b. Previous LSCS
2. Maternal observation that should be carried out prior to the onset of labour
3. Fetal observation that should be carried out prior to the onset of labour
4. Process for dealing with maternal request for induction of labour
11. References

1. NHSLA (2011)
2. CNST Maternity Clinical Risk Management Standards (2011-2012)
4. Prostin® Gel SPC. Electronic medicines compendium. Last updated 5.2.08
5. Propess® SPC. Electronic medicines compendium. Last updated 1.4.08