WOMEN'S HEALTH AND PAEDIATRICS
MATERNITY UNIT

INDUCTION OF LABOUR

Amendments			
Date	Page(s)	Comments	Approved by
August 2012	Document replacement	Introduction of the use of Propess for IOL. Planned launch date for change in practice 07/01/13	Women's Health guideline group
13/02/13		Updated Bishop Score guidance	Women's Health guideline group
Dec 2013	Whole document review	Clarification of IOL procedure	Women's Health guideline group
Feb 2018		No Changes	Head of Midwifery
Sep 2018	4,8,11-13	Addition of Balloon Induction	Women's Health guideline group

Compiled by: Mr James Thomas Consultant Obstetrician

In Consultation with: Women's Health Guideline Group,

Ratified by: Women's Health Guideline Group
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Impact Assessment Carried Women's Health guideline group

Comments on this document to: James Thomas
Addition Balloon Induction : Dr Matthew Erritty, Miss Ngozi Izuwah-Njoku

INDUCTION OF LABOUR GUIDELINE

Contents

See also:

- Oxytocin (Syntocinon) to induce/augment labour guideline
- Care in Labour guideline
- VBAC Guideline
- Fetal Monitoring guideline

Induction of labour (IOL) summary

Women should be informed that most women will go into labour spontaneously by 42 weeks. They should be offered information about the risks associated with pregnancies that last longer than 42 weeks, and their options.
Healthy pregnant women should be offered a vaginal examination for membrane sweeping at the 41 week antenatal visit. An additional membrane sweep can be offered if labour does not the start spontaneously (NICE 2017).

Women with uncomplicated pregnancies should be offered induction of labour (IOL) beyond 41 weeks. The reasons for IOL should have been discussed with the woman when the decision to induce was made, whether this was in the clinic or on the ward. At this time the woman should have been given an information leaflet about induction of labour and relevant Prostaglandin prescribed.

Maternal request for Induction of labour

Women that request induction of labour prior to 41 weeks must be referred to the consultant.

Declined Induction of labour

Women who decline induction of labour must be reviewed by a consultant and offered increased antenatal monitoring. A specific plan of care individualised to the clinical circumstances must be clearly documented, which must include:

- Frequency of monitoring
- Scan for liquor volume
- Membrane sweeping
- Assessment of any maternal medical conditions
- Discussion of risks including increased risk of IUD or maternal morbidity
- It must be clearly documented that the woman can change her mind at any time and can contact the labour ward

The majority of inductions will be carried out on Joan Booker ward (JBW). Whilst the woman is on JBW, her partner may stay until 10pm. Once labour becomes established he may return and the woman will be transferred to the labour ward.
Most inductions of labour will follow this guideline. In some circumstances management may deviate from it. In these cases the management must be discussed with the Consultant Obstetrician on call.

Methods of Induction

Two types of prostaglandins (Dinoprostone) are available at Ashford & St. Peter's NHS Trust:

a. **Propess** controlled release vaginal pessary (10mg). This is routinely used for IOL in the following circumstances:

- Prolonged pregnancy (40 weeks +12 – 14 days)
- Fetal growth restriction
- Maternal diabetes
- Third trimester IUD

- Poor Obstetric history
- Twins
- Hypertension/PET requiring IOL
- Other medical, social or emotional conditions, including maternal request (Agreed by consultant only)
- Previous Caesarean section (Agreed by consultant only)

b. **Prostin** vaginal gel (1mg, 2mg): this may be used at the discretion of the consultant in special circumstances:

- Failed Propess induction
- Multip with BS>6 at first assessment
- Previous Caesarean section
- Prelabour SROM at term
- Preterm prelabour rupture of membranes

c. **Mechanical Induction of Labour (Balloon Induction)** is an alternative method of induction used for women unsuitable for vaginal prostaglandins. NICE IPG 528. Please see page 10 for further details.

- Previous Caesarean Section – preferred induction agent as reduced risk of uterine rupture Failed Prostaglandin induction of labour
- Consider if previous history of hyperstimulation secondary to prostagladin induction
- Consider if fetal growth restriction (reduced incidence of hyperstimulation)
- Women who decline Prostaglandin induction

Exclusion criteria

- More than one previous CS, J or inverted T incision
- Classical Caesarean section or previous uterine rupture
- Ruptured membranes prior to balloon induction, previous myomectomy with cavity breeched

On admission for IOL the following must be confirmed (whether using propess, prostin or balloon):

- Indication for IOL
- Gestational age (by early ultrasound scan)
- Parity
- Placental position
- Presentation and 5ths palpable in the abdomen
- Maternal observations and a general assessment of wellbeing should be carried out prior to IOL including blood pressure, pulse & temperature.

Modified Bishops Score (BS):

	0	1	2	3
Dilatation (cm)	<1cm	1-2cm	2-4cm	>4cm
Length of cervix (cm)	>4cm	2-4cm	1-2cm	<1cm
Station of presenting part	-3	-2	-1/0	+1/+2
Consistency	Firm	Average	Soft	-
Position of cervix	Posterior	Mid/anterior	-	-

- Prior to administration of prostaglandin a 30 minute CTG must be performed.
- Provided the CTG is normal, the midwife should perform a vaginal examination, record the findings and modified Bishops score and give Propess /Prostin.
- If the CTG is abnormal DO NOT continue with the induction process. Document a plan of care and request urgent obstetric review.
- If the Bishops score is greater than or equal to 10, do not give Propess/Prostin and transfer the woman to Labour ward for artificial rupture of membranes (ARM).
- All women with BS<10 at the first assessment should be given prostaglandin prior to ARM. Primips should be given Propess, multips with BS>6 should be given 1mg Prostin gel with a plan for ARM 6 hours after this single dose.

Guidance for use of Propess and Prostin will be given in separate sections below.

Care management using Propess

Unless there are clinical indications for the induction to be performed on the labour ward, these women will be admitted to Joan Booker ward at 08:30, aim to administer Propess before 10:00. Women will remain on Joan Booker ward until they require analgesia or ARM, or are in established labour.

Primagravida & multipara with a BS<7 are managed in the same way.

Propess is presented as a thin, flat semi-opaque polymeric vaginal delivery system within a knitted polyester retrieval system. Each Propess vaginal insert contains 10mg of dinoprostone (Prostaglandin E2) and provides a controlled and constant release of approximately 0.3mg of prostaglandin per hour over 24 hours in women with intact membranes. Propess should be stored in a freezer in the original container in order to protect from moisture. It can be removed from the freezer immediately before use, or up to 20 minutes before insertion.

Use of Propess

- 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.

- 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.

- After positioning

Carefully withdraw the fingers leaving the Propess insert where it should remain *in situ*. After insertion ensure that the woman 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.

- Removal

Apply gentle traction on the retrieval tape (the insert will have swollen to 2-3 times its original size and be pliable). **Document the time of removal in the woman's notes.**

If the Propess insert falls out and has remained clean, e.g. dropped onto clean bed sheets and not dropped on to the floor or into the toilet, it may be reinserted and used to the 24 hour limit.
It is recommended that a new Propess should be inserted if there is any doubt of possible contamination and this could be used up to 24 hours after the insertion of the first Propess.
The excess tape outside the vagina may be cut and removed or taped to the woman's thigh to prevent accidental removal of the Propess insert e.g. when the woman removes underwear to go to the toilet.
Sufficient tape should be left to allow for easy removal when required. The woman should be advised to take extra care not to pull the insert out accidentally when going to the toilet or bathing.
Experience from clinical trials suggest that dinoprostone release from the Propess insert is unaffected by bathing or showering.
The manufacturer advises against excessive use of soap and care should be taken not to pull the retrieval tape.

Fetal Observations

- Prior to insertion of a prostaglandin a 30 minute CTG must be performed
- A CTG should be continued for at least 60 minutes following Propess insertion to establish fetal well-being.
- CTG monitoring should be continuous if there is abdominal pain or suspicion of fetal compromise.

In the absence of other risk factors such as meconium stained liquor or vaginal bleeding:

- A CTG should be carried out every 8 hours.
- Once contractions start, the fetal heart rate should be recorded hourly in the notes.
- For Spontaneous Rupture of Membranes (SROM) see SROM section below.

All findings should be recorded in the notes.

Maternal Observations

Maternal observations of temperature, pulse and blood pressure are routinely completed on admission. In uncomplicated pregnancies if the findings are within normal parameters, 4 hourly as documented in Care in Labour guideline.
The woman should be instructed to inform the midwife if:

- Her contractions become regular (every 5 minutes or more frequent)
- She becomes uncomfortable with contractions
- She has vaginal bleeding
- Her membranes have ruptured
- Propess falls out or drops lower in the vagina
- For Spontaneous Rupture of Membranes (SRM) see SRM section below

When to remove Propess

Propess should only be removed in the following instances:

- When labour is established (regular painful uterine contractions >3:10, **with associated cervical change**)

- Uterine hyperstimulation & hypertonic uterine contractions (*see management of hyperstimulation,below*)
- PV bleeding
- Evidence of fetal compromise
- Evidence of maternal adverse dinoprostone effects
- Following 24 hours, even if labour is not established

SROM with Propess in situ
Commence CTG and assess contractions. If there is regular uterine activity, perform a vaginal examination (VE) to assess if labour is established. If there is no regular uterine activity or labour is not established, Propess can be left in situ as per plan. Maternal observations of temperature, pulse and blood pressure should be recorded 4 hourly. Alternatively, after discussion with the on-call Registrar, the Propess can be removed and an oxytocin infusion commenced 30 minutes later.

22 hours after Propess insertion:

Multips: Transfer to Labour Ward for CTG followed by removal of Propess at 24 hours and ARM attempt by MW regardless of BS. If the MW is unable to perform the ARM, the woman must be examined by a Registrar or Consultant (possibly in lithotomy) for a further attempt at ARM. If ARM is not possible, an individual plan of management must be made and documented **after** discussion with the Consultant.

Primips: Assess contractions, if any. Perform 30 minute CTG no later than 23 hours after insertion of Propess.

At 24 hours, remove Propess and perform a VE to assess BS. This should be performed on Joan Booker Ward.

If BS≥6, transfer to Labour Ward for ARM. This should be performed by the MW within 30 minutes of arrival on Labour Ward. If the MW is unable to perform the ARM, the woman must be examined by a Registrar or Shift Leader (possibly in lithotomy) for a further attempt at ARM. If transfer to Labour Ward is not possible, consider performing ARM on Joan Booker Ward. In general, oxytocin should be commenced within 2 hours of ARM unless the woman is contracting regularly.
Before and after the ARM is performed there must be confirmation of the fetal heartbeat. The fetal heart beat must be audible to the parents and the rate documented in the Pregnancy and Birth notes.

If BS is 0-5, insert 2mg Prostin gel straight away. Reassess BS 6 hours after Prostin gel. If BS≥6, follow plan above. If BS remains 0-5, the woman must be examined by a Registrar or Consultant before an individual plan of management is made, this must be discussed with a Consultant and stopping the IOL and planning a further attempt may need to be considered (this will depend on the indication for IOL and current gestation). This plan must be clearly documented in the woman's notes.

Management of Hyperstimulation

Tachysystole: ≥ 5 contractions in 10 minutes with normal CTG
Hypertonus: painful contractions lasting ≥ 90 seconds with normal CTG
Hyperstimulation: Tachysystole or hypertonus with abnormal CTG

If tachysystole or hypertonus are suspected, CTG monitoring should be commenced immediately, if the CTG shows any abnormalities the woman should be transferred to Labour Ward where obstetric review should be sought. In general, Propess should be promptly removed if the CTG shows significant abnormalities; this may need to be considered before transfer to Labour Ward (keep Propess clean as reinsertion may be considered). If CTG abnormalities persist despite removal of Propess, Terbutaline 0.25mg s/c should be considered, however due to the short half-life of dinoprostone and the low dose released per hour, the hyperstimulation should resolve spontaneously in 15 – 20 minutes.

If no fetal heart rate abnormalities are noted then further management should be decided after discussion with a band 7 MW or a Registrar.

Failed Induction (including following one dose of Propess)

The definition used by NICE for failed IOL 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, or the insertion of two vaginal prostaglandin gel doses at 6 hourly intervals.

The decisions regarding the management of a ‘failed IOL” must be made in accordance with the woman’s wishes and with regard to the clinical circumstances and urgency of IOL. A full assessment should be made of the pregnancy in general, the woman’s condition and fetal wellbeing using electronic fetal monitoring (EFM).

Initial management as above.

If ARM is not possible after a single Propess in multips, or Propess plus one 2mg dose of Prostin gel in a primip, the woman must be examined by a Registrar or Consultant before an individual plan of management is made. This plan could be to delay the IOL, give further prostaglandin, consider balloon induction or consider caesarean section. **The plan must be discussed with the woman and a Consultant. All discussions must be clearly documented in the woman’s notes.**

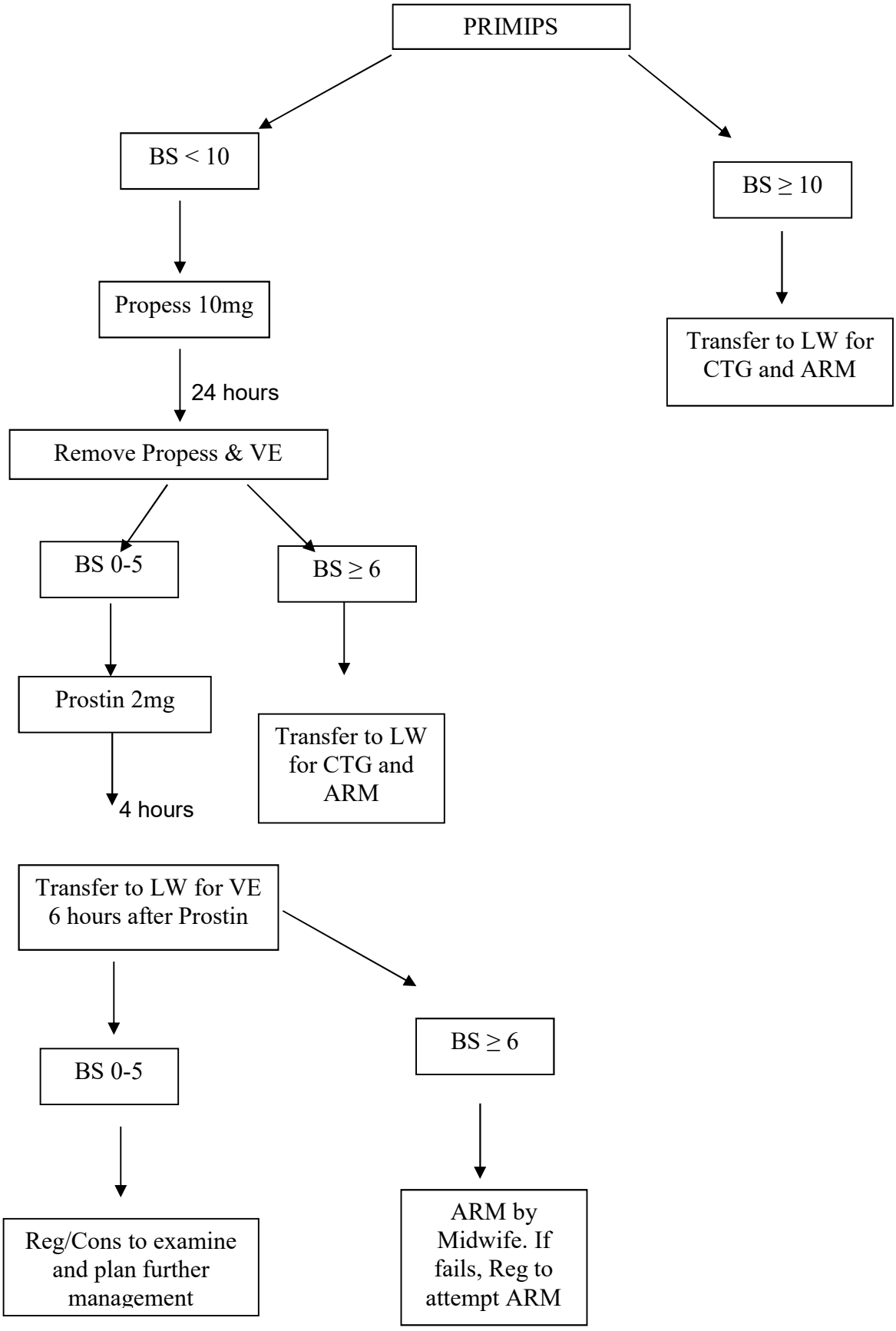
Use of Prostin gel

Most IOLs undertaken in ASPH will use Propess. Prostin gel may be used in certain circumstances with consultant approval. These may include:

- IOL for SROM at term
- IOL in multips with a favourable cervix
- IOL in grand multiparae
- Failed propess IOL
- IOL in woman with previous Caesarean delivery

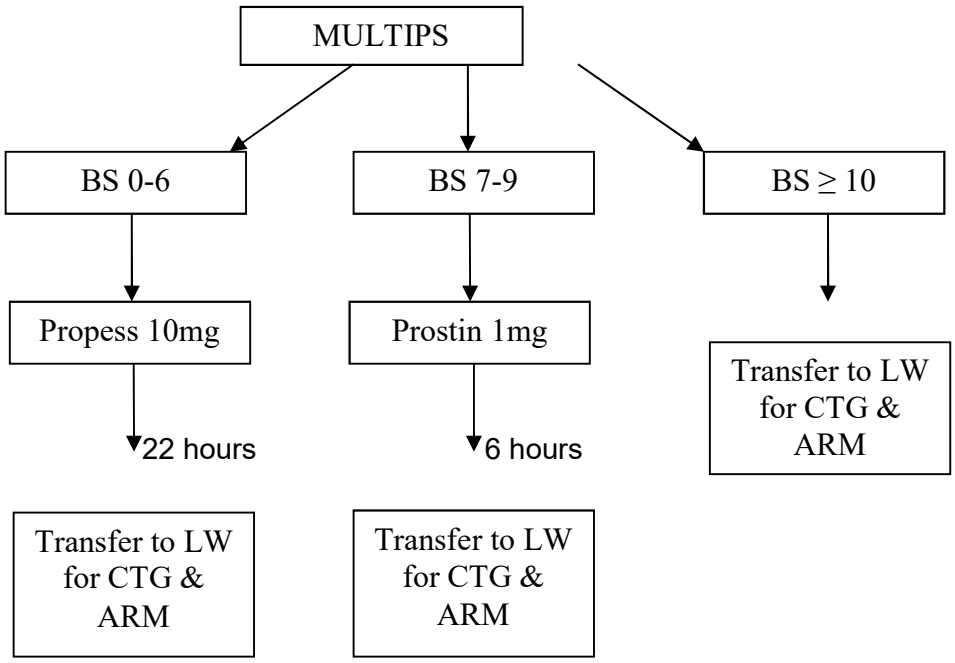
In these circumstances a specific plan for Prostin administration should be agreed with the Consultant and documented in the maternal records. This should include guidance as to number & strength of doses to be given and a plan for appropriate review.

IOL in Primips flow chart



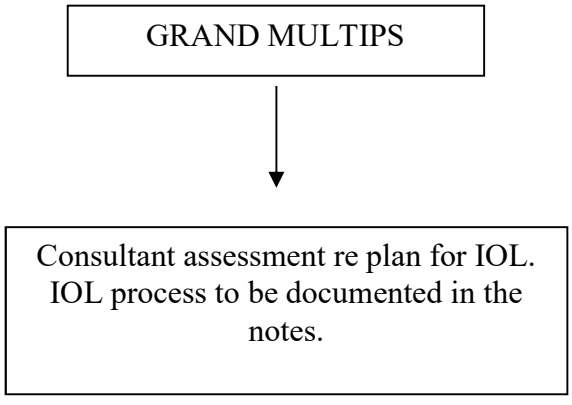
If transfer to Labour Ward for ARM is delayed, consider ARM on Joan Booker Ward.

IOL in Multips flow chart



If transfer to Labour Ward for ARM is delayed, consider ARM on Joan Booker Ward.

IOL in Grand Multips



Mechanical Induction of Labour (Balloon Induction)

A balloon induction of labour may be considered where the use of vaginal prostaglandins is contraindicated e.g. in the presence of a uterine scar, or where vaginal prostaglandins have been unsuccessful or declined.

The use of a balloon is supported by NICE and has similar outcomes to prostaglandin induction with a lower risk of hyper stimulation with no increased risk of caesarean section. NICE Interventional Procedures Guidance (IPG) 528 supports its use in women without previous Caesarean Section. Women must be given this information. The incidence of tachysystole is less with mechanical IOL when compared to Prostaglandins.

The type of balloon used may vary but may include a Foley's catheter with a 30-50ml reservoir or a Cook Cervical Ripening Balloon. (Note – Cooks balloon is licenced for induction of labour, whilst foleys catheters are not, however, neither are licenced for use in VBAC's)

As the use of a balloon for induction in women with a uterine scar is unlicensed, the decision to use the balloon must have been discussed with a consultant. Verbal consent must be gained from the woman and documented in the notes prior to insertion.

Insertion will be performed on the labour ward by the on-call registrar or consultant who will have been trained in balloon insertion.

Benefits and Risks - NICE Intervention Procedures Guideline (IPG528)

Benefits:

- Available evidence demonstrates;
- Softening of the cervix in 96% of women
- No increase in caesarean section risk
- Spontaneous vaginal delivery within 24 hours in 69% of women
- A positive birth experience in 90% of women

Risks

- Hyperstimulation in 5% in comparison to 17% of women requiring prostaglandins.
- CTG abnormalities in 2% in comparison to 15% with prostaglandins.
- Malpresentation - 2 women out of 293, one of whom required a caesarean section.
- Cord prolapse in 1/302.
- Post-partum Endometritis 1:59 women.

Process for Balloon IOL

1. The decision to use balloon for IOL has to be made at consultant level.
2. Ensure patient eligible, that she consents to the procedure and that this is fully documented (not more than 1 caesarean section (CS), no uterine rupture, J incision, inverted T incision or myomectomy with cavity breeched).
3. Add patients name to induction diary and state balloon IOL on LW. Give leaflet.
4. If the woman is a VBAC, then she should be booked for balloon IOL and also LSCS the following day.

5. Patient to present to Labour Ward reception at 0800 on day of IOL and transfer to LW for insertion of balloon once room and staff available.
6. Please perform the same admission procedure as in Prostaglandin induction.
7. Verbal consent to be obtained prior to insertion of balloon.
8. 30 minutes pre-insertion CTG.
9. Balloon to be inserted either by consultant or registrar trained in balloon induction.
10. 30 minutes post insertion CTG.
11. Transfer to JBW and ensure that pre-meds are prescribed.
12. Document patient's name on LW board under women for IOL.
13. VBAC's to be NBM from midnight and pre-meds given at 2200 and 0600.
14. After 12-24 hours, the balloon must be removed on JBW (this can be performed by MW) and then transfer the patient to LW for assessment re suitability ARM.
15. Mobilise for two hours after the balloon is removed to allow head descent prior to ARM.
16. If ARM is not possible after removal of balloon, consultant to make individualised care plan.
17. Inform medical staff if the patient complains of severe abdominal pain, vaginal bleeding, abnormal CTG or any concerns. Remove balloon immediately

Monitoring pre and post-insertion

If vaginal prostaglandins have been used prior to the insertion of the balloon then monitoring should continue as per protocol.

If no vaginal prostglandins have been inserted, then a 30 minute pre insertion CTG. If the CTG is normal, then proceed to insert the cervical ripening balloon. A 30 minute post insertion CTG should be performed and then repeated 8 hourly, prior to and after removal, or when the woman starts to contract

Balloon insertion

With a sterile speculum, clean the cervix with sterile water or saline. If using a foleys catheter, this is passed through the cervical canal with the balloon inflated in the extra-amniotic space. If using a Cook Cervical ripening balloon, this is also passed through the cervical canal with the first balloon inflated in the extra-amniotic space and a second vaginal balloon then inflated to increase cervical ripening. The catheter could to be secured with a tape to the thigh of the woman..

If the woman feels faint or unwell, then the balloon should be removed and the woman reviewed by a senior obstetrician.

Simple analgesics may be needed for discomfort post insertion.

Balloon removal

The balloon should be removed after 12-24 hours on JBW by deflating both balloons and applying gentle traction if using Cook's balloon. If foley's catheter is used, then deflate the single balloon and remove catheter.

The balloon should be removed under the following conditions:

1. spontaneous rupture of membranes

2. spontaneous labour
3. CTG abnormalities
4. scar tenderness
5. heavy vaginal bleeding.

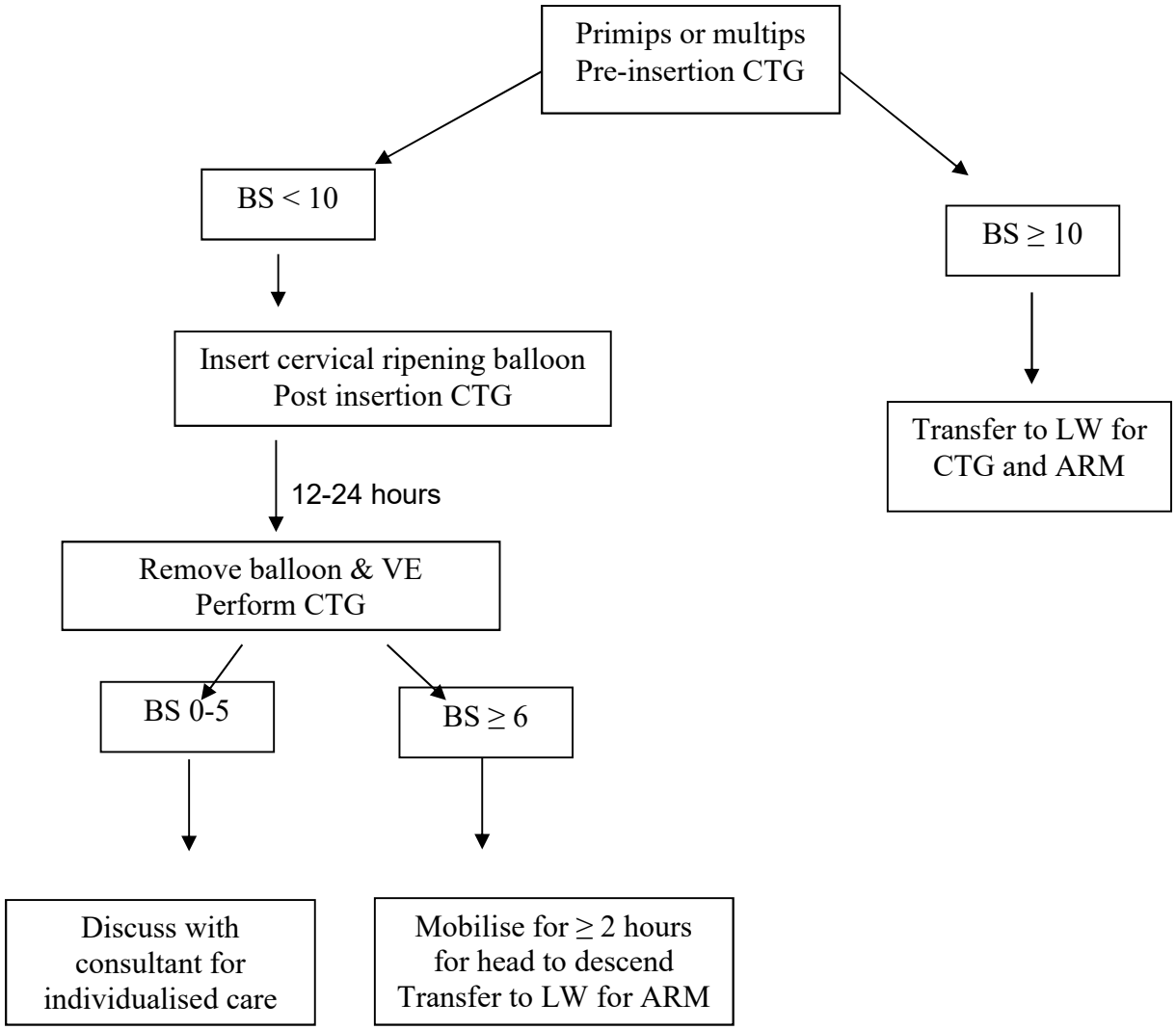
If the balloon falls out this will normally indicate that the cervix has dilated and a VE should be performed and Bishops score documented. Please manage the woman as you usually would for Prostagladin induction based on the Bishop's score.

Management of Hyperstimulation
This is extremely rare with balloon IOL. Please deflate and remove balloon catheter and give terbutaline as per protocol.

Analgesia for balloon induction:

Please prescribe oral analgesia as you would for Prostagladin induction.

Flow chart for IOL with cervical ripening balloon (e.g. CCRB)



*** If the Cervical balloon is inserted after failed Prostaglandin IOL, CTG is to be performed as per protocol.**

Monitoring:

Compliance with this guideline will be monitored as detailed in the table below. Where monitoring has identified deficiencies, recommendations and an action plan will be developed.

Element to be monitored	Lead	Tool	Frequency	Reporting arrangement	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
a. when membrane sweeping should occur b. gestation at which induction of labour should take place c. ***induction of labour in specific circumstances, which as a minimum must include*:** i. **prolonged pregnancy** ii. preterm prelabour rupture of membranes iii. prelabour rupture of membranes at term iv. **previous caesarean section** v. fetal growth restriction vi. maternal diabetes vii. intrauterine death d. methods of induction e. **maternal observations that should be carried out during induction prior to the**	**Criterion Lead** James Thomas - Obstetric Consultant	Audit tool attached (appendix 1). 1% of delivered women	Annually	Labour Ward Forum	**Standard Lead** Faris Zakaria- Obstetric Consultant Labour ward manager	1. Educational half days/annual perinatal audit day 2. Unit meetings if necessary 3. Communication bulletin as appropriate 4. Individual support if required One or all of the above

establishment of labour f. **fetal observations that should be carried out during induction prior to the establishment of labour** g. development of an individual management plan when induction of labour fails h. **process for dealing with maternal requests for induction of labour** i. development of an individual management plan when induction of labour is declined						

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Appendix 1 Procedure for Insertion and removal of Cervical Ripening balloon

Ensure woman is suitable for balloon insertion

Obtain verbal consent and document in notes

Perform pre-insertion CTG (30 mins)

Equipment

- Syringes 60ml
- Vaginal examination pack
- Sponge holder x1
- Normal saline bags 100ml x2 or 500ml sterile water bottle
- Cooks cervical ripening balloon or Foleys catheter with 30-50ml balloon
- Disposable speculum
- Suitable antiseptic solution

- **Insertion of balloon**
  Woman should first empty her bladder.
- Adopt lithotomy or left lateral position.
- Insert Cusco's speculum. Clean the cervix with sterile water solution.
- Cervix should be visualised and the balloon should be advanced through the cervix until both balloons are within the endocervical canal.
- The uterine balloon should be inflated with 40mls of saline and then pulled back until the balloon abuts the internal Os.
- The vaginal balloon should then be visible and should be inflated with 20mls of saline.
- Remove Cusco's speculum.
- Once both balloons are on either side of the cervix, saline should be added up to a total of 80mls in each balloon.
- Vaginal exam should be done to confirm that both balloons are in place.
- End of balloon catheter could be taped to the woman's thigh.
  30 minute CTG should be performed and the woman should be admitted to JBW.
- Consider IV cannula if VBAC and take blood for FBC and Group and Save.
  Encourage woman to mobilise.

Removal of balloon

CTG should be repeated 8 hourly post insertion and then for 30 minutes pre and post removal. Both balloons should be completely deflated and the catheter removed. ARM must be performed on the labour ward. If ARM isn't possible, discuss with the consultant for individualised care.

Foley's catheter: The procedure is similar but there is only a single balloon. Insert the catheter through the cervical canal and into the extra amniotic space and inflate with 30-50mls of saline.

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NHS Trust

Appendix 2 IOL Audit Tool

Induction of Labour – Audit Tool

1, Gestation ☐ 2, Parity ☐

3, Previous Caesarean Section ☐ Yes ☐ No

4, Reason for induction:

- Prolonged pregnancy ☐ Yes ☐ No
- Preterm prelabour rupture of membranes ☐ Yes ☐ No
- Prelabour rupture of membranes at term ☐ Yes ☐ No
- Previous caesarean section ☐ Yes ☐ No
- Fetal growth restriction ☐ Yes ☐ No
- Maternal diabetes ☐ Yes ☐ No
- Intrauterine death ☐ Yes ☐ No
- Maternal request* ☐ Yes ☐ No
- Other, please specify _____

*If Maternal Request – was an individual management plan recorded in the Antenatal notes ☐ Yes ☐ No

5, Method of induction:

- Membrane sweep ☐ Yes ☐ No
- Propess ☐ Yes ☐ No

- Prostin gel ☐ Yes ☐ No
- ARM ☐ Yes ☐ No
- N/A induction declined ☐ Yes ☐ No

If induction declined was there an individual care plan ☐ Yes ☐ No

6, Were the following recorded prior to induction

- Maternal base line observations ☐ Yes ☐ No
- Vaginal examination ☐ Yes ☐ No
- Bishops score ☐ Yes ☐ No

7, Were maternal observations done prior to labour ☐ Yes ☐ No

8, Were they recorded on the MOEWS chart ☐ Yes ☐ No

>>>PTO>>>

9, Was abdominal palpation done prior to induction ☐ Yes ☐ No

10, Was 30 min base line CTG completed prior to induction ☐ Yes ☐ No

11, Was 60 min CTG completed following insertion of Propess / Prostin ☐ Yes ☐ No

12, Was CTG carried out every 6-8 hourly prior to established labour ☐ Yes ☐ No

13, Was fetal heart recorded hourly once contracting ☐ Yes ☐ No

14, If Propess used, was it removed ☐ Yes ☐ No

15, If YES, what was the reason _____

16, Was it replaced ☐ Yes ☐ No

17, If Prostin used, how many doses were given ☐ 1 ☐ 2 ☐ 3

18, Was induction successful ☐ Yes ☐ No

19, If not was an individual management plan developed	☐ Yes	☐ No

Equality Impact Assessment Tool

Name: Induction of labour

Policy/Service: Maternity Service

Background • Description of the aims of the policy • Context in which the policy operates • Who was involved in the Equality Impact Assessment
Provides evidence based guidance enabling staff to deliver consistent care with maternity services
Methodology • A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age) • The data sources and any other information used • The consultation that was carried out (who, why and how?)
Unlikely to have any negative impact as no procedure is carried out with full consent of the women involved and is based on clinical need
Key Findings • Describe the results of the assessment • Identify if there is adverse or a potentially adverse impacts for any equalities groups
No impact identified
Conclusion • Provide a summary of the overall conclusions
No impact identified
Recommendations • State recommended changes to the proposed policy as a result of the impact assessment • Where it has not been possible to amend the policy, provide the detail of any actions that have been identified • Describe the plans for reviewing the assessment

Reconsider at next guidance review

Guidance on Equalities Groups

Race and Ethnic origin (includes gypsies and travellers) (consider communication, access to information on services and employment, and ease of access to services and employment)	**Religion or belief** (include dress, individual care needs, family relationships, dietary requirements and spiritual needs for consideration)
Disability (consider communication issues, access to employment and services, whether individual care needs are being met and whether the policy promotes the involvement of disabled people)	**Sexual orientation including lesbian, gay and bisexual people** (consider whether the policy/service promotes a culture of openness and takes account of individual needs
Gender (consider care needs and employment issues, identify and remove or justify terms which are gender specific)	**Age** (consider any barriers to accessing services or employment, identify and remove or justify terms which could be ageist, for example, using titles of senior or junior)
Culture (consider dietary requirements, family relationships and individual care needs)	**Social class** (consider ability to access services and information, for example, is information provided in plain English?)

If further assessment is required please see the Integrated Single Equality Scheme.

For advice in respect of answering the above questions, please contact, HR Manager, on extension 2552.

PROFORMA FOR RATIFICATION OF POLICIES AND GUIDELINES BY RATIFYING COMMITTEE

Policy/Guidelines Name:	……Induction of labour……..
Name of Person completing form:	……Dianne Casey…….
Date:	……31/12/2013…….

Author(s)	James Thomas
Name of author or sponsor to attend ratifying committee when policy/guideline is discussed	James Thomas
Date of final draft	January 2014
Has this policy/guideline been thoroughly proof-read to check for errors in spelling, typing, grammar and consistency?	Yes
By whom:	Women's Health guidelines Group
Is this a new or revised policy/guideline?	Revised

Describe the development process used to generate this policy/guideline.
Maternity guidelines Group, labour ward forum, disseminated to all obstetric consultants for comment
Who is the policy/guideline primarily for?
Staff working in maternity services
Is this policy/guideline relevant across the Trust or in limited areas?
Maternity services
How will the information be disseminated and how will you ensure that relevant staff are aware of this policy/guideline?
Notice board, intranet, communication bulletin, newsletters
Describe the process by which adherence to this policy/guideline will be monitored.
See monitoring section
Is there a NICE or other national guideline relevant to this topic? If so, which one and how does it relate to this policy/guideline?
Yes Induction of labour guidance incorporated
What (other) information sources have been used to produce this policy/guideline?
See reference list
Has the policy/guideline been impact assessed with regard to disability, race, gender, age, religion, sexual orientation?
No impact identified
Other than the authors, which other groups or individuals have been given a draft for comment?
Women's Health guideline Group, Supervisors of Midwives, all obstetric consultants
Which groups or individuals submitted written or verbal comments on earlier drafts?
Comments received by email
Who considered those comments and to what extent have they been incorporated into the final draft?
All comments considered by Women's Health guideline group
Have financial implications been considered? yes