Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

WOMEN'S HEALTH AND PAEDIATRICS
MATERNITY UNIT

OUTPATIENT INDUCTION OF LABOUR FOR LOW RISK PREGNANCY

Amendments			
Date	Page(s)	Comments	Approved by
June 16 May 2019	 6	Minor amendments Admission time changed to 08.30	Women's Health guideline group Women's Health Governance & Guideline Group

Compiled by: Mr Joyanto Choudhury, Consultant O&G;
Jill Hickman, Antenatal Team Leader/SOM

In Consultation with: Dr S Newbold, Women's Health Guideline Group, labour ward forum, Obstetric Consultants, Supervisors of Midwives

Ratified by: Women's Health Guideline Group
Date Ratified: 20th May 2016
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Target Audience: Staff working within the maternity unit
Impact Assessment Carried Out By: Women's Health guideline group

Comments on this document to: Joyanto Choudhury/Jill Hickman

Outpatient Induction of Labour for Low Risk Pregnancy

<u>This should be followed in conjunction with the 'Induction of Labour' guideline</u>.

Induction of labour (IOL) is a relatively common procedure with approximately 20-25 per cent of deliveries in the UK being induced.
The induction rate in England continues on an upward trend as more women undergo induction of labour on a yearly basis. As a result there is more strain on maternity resources with often deterioration in patient experience.

Outpatient Induction of Labour is the process of induction that starts in the hospital maternity unit for women who are then discharged to home and return to hospital for the birth of their baby.

It is essential that induction of labour in an outpatient setting is only carried out with safety and support procedures in place and in low risk pregnant women (NICE 2008).

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

- Reduction in length of antenatal stay in hospital
- Less strain on antenatal units and resources
- Potential reduced financial costs
- Higher maternal satisfaction
- Avoidance of unnecessary hospital admission

It is essential that there is a careful risk profiling of women eligible for outpatient induction of labour and it is offered to low risk women who meet the following criteria:

1. Uncomplicated singleton pregnancy requiring induction for prevention of prolonged pregnancy (between 41^{+3} and 42 weeks)
2. Number of previous births less than or equal to three
3. Booking BMI <35 with no mobility restriction
4. Women should have been offered a sweep prior to IOL (Multips 1, Primips 2)
5. No relevant obstetric problems:
    - Previous stillbirth/neonatal death
    - GBS+ve requiring IV antibiotics in labour
    - Gestational hypertension, PET
    - Oligohydramnios/polyhydramnios/Unstable lie/SROM
    - Fetal abnormality/Macrosomia (>4.5kg)/IUGR
    - ≥2 episodes of reduced fetal movements after 30/40
    - History of significant PPH (>1000mls)
    - Previous birth by caesarean section
6. No relevant medical problems
    - Diabetes
    - Hypertension, Cardiac disease, CVA
    - Haematological disorders

- Psychiatric disorders or social issues

7. No previous major uterine surgery (Myomectomy/Hysterotomy)
8. No significant vaginal bleeding after 24 weeks of pregnancy

She must also:

- Have transport available and live within 30 minutes of ASPH geographical area
- Have a functional telephone
- Have the ability to communicate with Birth Centre staff
- Have an adult as companion at all times
- Have reassuring pre and post prostaglandin fetal heart rate monitoring

Information given to patients

The community midwife will have a discussion with the woman about the Outpatient Induction of Labour (IOL) process and if she meets all of the above criteria, offer this method of induction to her.

Women should be given clear verbal and written information on outpatient induction containing:

- The reasons for induction being offered
- When, where and how induction could be carried out
- The arrangements for support and pain relief
- The risks and benefits of outpatient IOL in specific circumstances and the proposed induction process
- That induction may not be successful and what options are available to the woman

Method of Outpatient IOL - Offered Monday to Friday only as no Maternity Day Assessment Unit (MDAU) over weekend

We shall be using vaginal PGE2 controlled-release pessary (Propess) for outpatient induction of labour.

The induction will be started in the MDAU. The woman will attend MDAU at **07:30 hours** by arranged prior appointment.

On arrival to MDAU for IOL the following must be confirmed by the attending Midwife:

- Induction of labour is for low risk pregnancy only
- Gestational age between 41^{+3} and 42 weeks by early ultrasound scan
- Parity 3 or less
- Placenta praevia has been excluded by ultrasound scan
- Cephalic presentation and presenting part in the pelvis
- Maternal observations including blood pressure, pulse, temperature, respiration rate and urinalysis are within normal range as per MEOWS chart

The midwife will confirm that the woman is suitable for outpatient induction of labour (satisfies low risk criteria as above). She will also discuss the process of induction and answer any questions that the woman may have.

A **30 minute** CTG must be performed before administration of Propess. If there is any concern, the Midwife will contact the Labour Ward/MDAU Registrar on **Bleep 5059** for advice.

Provided all maternal observations and CTG are normal, the midwife will perform a vaginal examination with verbal consent, record the findings and modified Bishops score (BS).

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	-	-

BS <7 for both Primips and Multips - Propess 10mg inserted by the MDAU midwife into the posterior vaginal fornix (for 'Use of Propess' refer to **Induction of Labour** guideline)

BS 7-9 in Primips - Admit to JBW for Prostin gel 1mg PV and ARM after 6 hours

BS ≥7 in Multips and **BS >9** in Primips - Transfer to Labour Ward for ARM

The time of insertion and planned removal of Propess should be clearly documented in the woman's hand held notes.

After insertion the patient should be advised to lie in a lateral position for **30 minutes** to allow time for the Propess to absorb moisture from the vagina which helps it to swell slightly and settle into place for the duration of the treatment. During this period a CTG should be continued to establish fetal well-being.

If the post Propess 30 minute CTG is normal the woman will be transferred to the Abbey Birth Centre (ABC) sitting room for refreshments. The woman will remain there for a further 30 minutes.

If there are any concerns at any stage of this process, the Midwife will transfer the woman to LW or discuss with the LW/MDAU Registrar via bleep 5059 for advice.

If there are no concerns the woman is then allowed to go home with clear information regarding what to expect after the procedure, what to look for and when to return or contact the ward. The information should be given verbally and in writing.

A patient information leaflet should be provided with a clearly marked 24 hour contact number for **Abbey Birth Centre Triage 01932 723761** and advised about contacting the unit if any concerns, particularly if:

- She thinks her waters have broken
- Having regular and painful contractions or constant pain
- Requiring stronger pain relief for contractions other than Paracetamol
- Has any fresh bleeding
- Feels baby's movements are reduced
- The Propess falls out or drops lower in the vagina

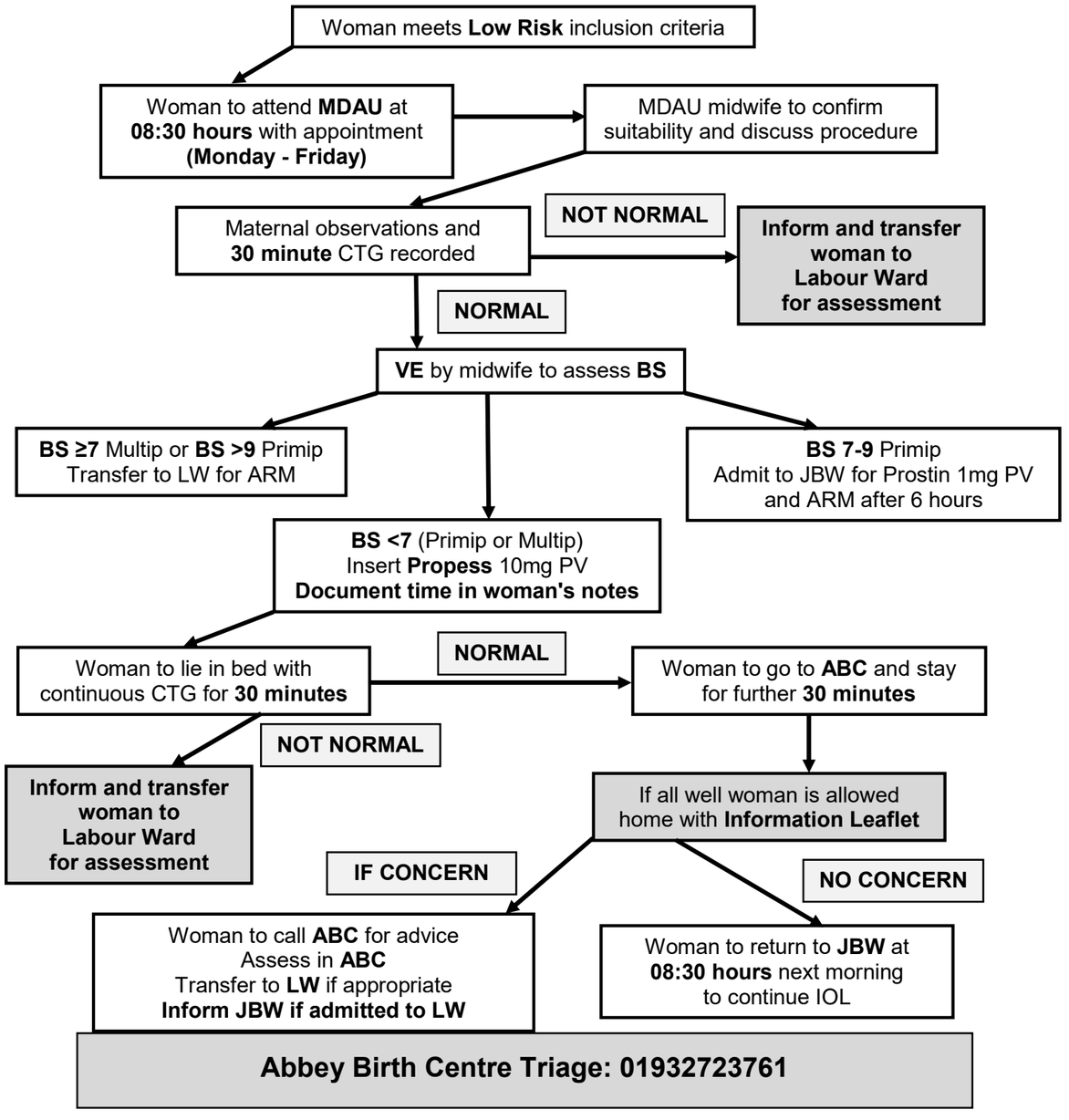
In the event of any of these concerns the woman must be advised to return to **the ABC** immediately for an assessment and possible transfer to Labour Ward as necessary. A CTG will be commenced on Labour Ward as a **priority** case.

The ABC midwife should inform the Joan Booker Ward (JBW) midwife if a women attends for assessment or is admitted to Labour Ward as they will be expecting her for admission the following day.

If no concerns, the woman will be advised to return to **Joan Booker Ward** between **08:30 to 09:00 hours** the following morning (**24 hours** after insertion of Propess as documented in her notes) for removal of Propess and to be assessed by midwife.

The rest of induction process will be as per routine guideline for 'Induction of Labour'.

PATHWAY FOR OUTPATIENT INDUCTION OF LABOUR



NB: If any concern Midwife to contact LW/MDAU Registrar via Bleep 5059

Other Useful Contact Numbers

Joan Booker Ward 01932 722291/ 2660/ 2378	**Maternity Triage** 01932722835

References:

1. National Institute for Health and Care Excellence. Clinical Guideline (CG70) **Inducing labour**. NICE, 2008. http://www.nice.org.uk/guidance/cg70

2. National Institute for Health and Care Excellence. Clinical Guideline (CG190) **Intrapartum care for healthy women and babies**. NICE, 2014. http://www.nice.org.uk/guidance/cg190

3. Dowswell T, Kelly AJ, Livio S, Norman JE, Alfirevic Z. **Different methods for the induction of labour in outpatient settings. Cochrane Database of Systematic Reviews.** 2010, Issue 8. Art. No.CD007701.DOI:10.1002/14651858.CD007701.pub2

4. Kelly AJ, Alfirevic Z, Dowswell T. **Outpatient versus inpatient induction of labour for improving birth outcomes. Cochrane Database of Systematic Reviews.** 2009, Issue 2. Art. No.: CD007372. DOI: 10.1002/14651858.CD007372.pub2

5. Biem SR, Turnell RW, Olatunbosun. **A randomized controlled trial of outpatient versus inpatient labour induction with vaginal controlled-release prostaglandin-E2: effectiveness and satisfaction.** Journal of Obstetrics and Gynaecology, Canada: JOGC. 2003;25(1):23–31

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. method(s) of induction e. **maternal observations that should be carried out during induction prior to the 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	**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

Appendix 1: Outpatient Induction of Labour – Audit Tool

Hospital Number:

1. Gestation **2.** Parity

3. Does the woman meet the inclusion criteria for guideline ☐ Yes ☐ No

If No, why

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4. Was outpatient induction declined by the woman ☐ Yes ☐ No

If Yes, why

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5. Offered membrane sweep ☐ 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. Was abdominal palpation done prior to induction ☐ Yes ☐ No

8. Was 30 min base line CTG completed prior to induction ☐ Yes ☐ No

9. Was 30 min CTG completed following insertion of Propess ☐ Yes ☐ No

10. Was the woman sent home with Information Leaflet ☐ Yes ☐ No

11. Did the woman call/attend Maternity Triage ☐ Yes ☐ No

If Yes, why

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12. Did the woman attend JBW 24 hours after Propess insertion ☐ Yes ☐ No

13. Was outpatient induction successful (ARM possible) ☐ Yes ☐ No

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

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 without full consent of the women involved and is based on clinical indication
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:	Outpatient Induction of labour
Name of Person completing form:	Dianne Casey
Date:	May 2016
Author(s)	Joyanto Choudhury/Jill Hickman
Name of author or sponsor to attend ratifying committee when policy/guideline is discussed	Joyanto Choudhury/Jill Hickman
Date of final draft	20 May 2016
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?	New

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