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NHS Foundation Trust for Induction of Labour

<b>A Clinical Guideline For use in:</b>	Maternity Departments of JPUH, NNUH and QEH
<b>By:</b>	Midwifery and Medical Staff
<b>For:</b>	Women undergoing induction of labour
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**The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust Guideline for the Management of *(Condition or Procedure)* in Adults and / or Children *(title needed on every page)***

<b>the recommendations of NICE? If so why?</b>	
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## Version and Document Control:

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10	June 2022	Forming original joint LMNS guideline	Mollie Haskey (LMNS PDM) Emma Wiskin (Better Births Midwife)

### This is a Controlled Document

Printed copies of this document may not be up to date. Please check the hospital intranet for the latest version and destroy all previous versions.

### Language Use

Please note, within this guideline when discussing 'women' we are referring to all birthing people inclusively of their pronouns or gender identity.

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## 1. Quick Reference Guide to IOL Timings

This table summarises broad recommendations from other documents: please consult the relevant guidance.

<b>Reason for IOL</b>	<b>Suggested timing</b>
Prolonged pregnancy	Offer IOL from 41 weeks
PROM	Offer immediate IOL or within 24 hours
PPROM	IOL from 37 weeks onwards. Offer IOL from 34 weeks onwards if GBS +ve.
Previous LSCS	Based on individual discussion on timing. Only to be induced with balloon catheter method/ARM and +/- oxytocin.
Fetal growth restriction	<3 <sup>rd</sup> centile with no concerning features initiate IOL at 37+0. Consider less than 37 weeks if additional concerning features. 3 <sup>rd</sup> – 10 <sup>th</sup> centile with no high-risk features, initiate IOL at 39+0.
Maternal diabetes	Type 1 or type 2 diabetes: IOL between 37+0 – 38+6 weeks  GDM on diet: No later than T+6 GDM on medication or any other complications: from 38 weeks as per consultant recommendation
Intrauterine death	As per guideline
Maternal request	IOL for maternal request would not generally be recommended prior 39 weeks. IOL for maternal request requires discussion and decision with a consultant
Obstetric Cholestasis	Bile acids <40: IOL at 39 weeks  Bile acids >40: IOL at 37 weeks
Multiple pregnancy	Uncomplicated DCDA twins: IOL at 37 weeks  MCDA: 36 weeks
Polyhydramnios	Consider the clinical picture, abdominal examination and descent of fetal head when timing induction for

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	polyhydramnios.
Fetal Macrosomia	Discuss IOL with women whose babies are plotting over the 90 <sup>th</sup> centile at 36 weeks. IOL should be timed for when the baby is predicted to plot at 4kg on their customised growth chart. If the EFW is above 5kg (or 4.5kg for diabetics) discuss MOD.
Altered/reduced FM's	IOL for reduced FM's (if only risk factor) not before 39+0
Pelvic girdle pain	IOL for this reason before 40 weeks would not generally be recommended, however the full clinical picture should be taken into account. Use of crutches or a wheelchair may prompt discussion to consider this from 39 weeks.
Maternal age	Maternal age more than or equal to 40 years: Offer IOL from 39 weeks
Precipitate Labour	Do not routinely offer induction of labour to women with a history of precipitate labour to avoid a birth unattended by healthcare professionals. Ensure adequate antenatal information is provided on signs of labour and appropriate attendance to the maternity unit.
Pre-eclampsia	Mild- moderate PET: recommend IOL after 37 weeks.  Severe PET: Before 34 weeks delivery may be indicated with severe refractory hypertension. Recommend between 34 – 36+6 if PET with severe hypertension.
Gestational hypertension	Offer IOL after 37 weeks, timing to be agreed by woman and consultant
Mental health	Individualised based on discussion with consultant. In cases where IOL is needed for mental health reasons, aim for 39 weeks if maternal health is stable enough to do so.
Maternal Medicine cases	Individualised plan based on discussion with consultant.

For any combined reasons an individualised plan will be made with consultant discussion.

## 2. Objective/s

This guideline has been created in line with current evidence available on induction of labour (IOL) with the aim of providing guidance for the three trusts of Norfolk and Waveney LMNS on the following:

- Clinical indications for induction of labour
- Appropriate place and timings for induction of labour
- Care pathways offered to women undergoing induction of labour, including methods used for induction
- Management for if induction of labour is declined
- Management of complications of induction of labour

## 3. Rationale

The requirement for induction of labour arises from circumstances in which it is believed that the outcome of the pregnancy will be better if it is artificially interrupted rather than being left to follow its natural course.

A joint guideline across the LMNS should standardise the care women receive across Norfolk and Waveney, including those women who are transferred between trusts during the process of IOL.

The indication for induction and gestation should be documented at the time the decision for induction is made, by the decision maker.

Induction of labour is dramatically increasing in the UK with 34% of women being induced in the period 2020-21 (NHS Digital, 2021). The National Institute of Clinical Excellence (NICE) recommends a women centred approach, with every woman having the opportunity to make informed decisions about their care and follow department of health advice on consent.

The National Maternity and Perinatal Audit (NMPA) which investigated the association between rates of induction of labour and emergency caesarean section in each hospital

in England with the risks of stillbirth, admission to a neonatal unit and use of mechanical ventilation in babies born at term. Findings showed that hospitals that had a higher induction of labour rate had a lower risk of stillbirth and mechanical ventilation of babies born after 37 completed weeks of gestation. For each 5%-point increase in induction there was a decrease in the risk of term stillbirth by 9% and mechanical ventilation by 14%. There was no evidence of an association between the hospitals' emergency caesarean section rate and risk of adverse perinatal outcome (Gurol-Urganci et al 2022).

#### 4. Broad Recommendations

##### 4.1 Venue for IOL

4.1.1 All inductions of labour should be commenced on each trust's appropriate antenatal ward/ delivery suite.

4.1.2 Low risk women being induced with 10mg Propess should be offered outpatient induction of labour if they meet the criteria outlined below (see 4.2 Methods and processes of IOL for guidance) where following their post procedure CTG they are discharged home until readmission for the next review. Discuss with the woman the benefits and risks of returning home and respect her decision.

##### **Criteria for Outpatient IOL**

No significant maternal or fetal risk factors – if in doubt please discuss with Consultant on call

Gestation greater than 37 weeks

Singleton pregnancy

Cephalic presentation

Chooses to have outpatient induction of labour

Independent transport available and lives within an acceptable journey time for the woman and with agreement to return by car

Adult > 18 years old to accompany woman home and to stay at home with woman until labour occurs or until up to 24 hrs after Propess/Balloon Catheter insertion with planned return to trust

Has a home or mobile telephone – but not a shared line

No safeguarding concerns

No verbal communication concerns



#### 4.1.3 Ask the women to contact the maternity unit or triage:

- when contractions begin, or
- if her membranes rupture, or
- if she develops bleeding, or
- if she has any other concerns, such as reduced or altered fetal movements, excessive pain or uterine contractions, side effects or loss of the pessary/ balloon.

### 4.2 Methods and processes of IOL

The following will discuss the recommended process of induction of labour in different circumstances.

#### 4.2.1 Membrane Sweeping

Offer membrane sweeps at antenatal visits after 39 weeks. Offer additional membrane sweeps if first does not work.

Explain to women:

- what a membrane sweep is
- that membrane sweeping might make it more likely that labour will start without the need for additional pharmacological or mechanical methods of induction
- that pain, discomfort, and vaginal bleeding are possible from the procedure.

#### 4.2.2 Bishops Score

All women should have a Modified Bishop score (or Calder Score) calculated at the commencement of IOL. The Bishop score is a numerical value obtained by doing a vaginal examination, and is based on the dilation, effacement (or length), position and consistency of the cervix and the station of the head with respect to the ischial spines of the pelvis. A score of 7 or more generally indicates that the cervix is ready to dilate, (previously the terms 'ripe' or 'favourable' were widely used) and when there is a high chance of spontaneous labour, or response to interventions made to induce labour. For the purposes of this guideline, a Bishop score of less than or equal to 7, or a score

greater than 7, was used to help determine choice of pharmacological or mechanical methods to induce labour.

#### 4.2.3 Methods of IOL

The available evidence does not support the following non- pharmacological methods for induction of labour:

- Herbal supplements
- Acupuncture
- Castor oil
- Hot baths
- Sexual Intercourse
- Enemas
- Homeopathy\*

\*There is a postdates complimentary therapy clinic at the QEH which local audit has shown to be of benefit to women.

#### **Method of IOL for Primiparous (intact membranes) [appendix 1]**

- Following vaginal examination, if the bishops score is <7 then 10mg Propess should be inserted into the posterior fornix for 24 hours. This should be removed after 24 hours or if the woman establishes in labour or shows any signs of IOL complications.
- In cases of SROM whilst the Propess is insitu:
  - If the Propess falls out with SROM, it should not be reinserted
  - A CTG should be commenced to ascertain fetal wellbeing
  - If the Propess remains insitu and there is no uterine activity the Propess can remain insitu up to the 24 hours whilst awaiting Oxytocin on Delivery suite
  - If the Propess remains insitu and there is regular uterine activity, a vaginal examination using an aseptic technique should be carried out with consent to ascertain if in active labour. The Propess should be removed if BS>7.
- If following 24 hours of Propess the bishops score remains <7, 3mg prostin should be administered into the posterior fornix for 6 hours. It is appropriate for up to 2 prostin administrations to be administered before registrar review.

- If the bishops score remains <7 following 2 prostin, a 3<sup>rd</sup> or 4<sup>th</sup> prostin may be considered with registrar input. Consideration of a 12-hour break may be appropriate at this stage.

### **Method of IOL for Primiparous (ruptured membranes) [appendix 2]**

- Women should be offered expectant management for up to 24 hours or immediate IOL. (See 4.3 Prelabour rupture of membranes at term)
- Upon commencing induction, if the cervix is found to have a bishops score of <7 then 3mg Prostin should be administered into the posterior fornix.
- After 6 hours of Prostin the women will be suitable for +/- forewater ARM and +/- oxytocin infusion on delivery suite.
- Generally, a second prostin would not be recommended in this circumstance.

### **Method of IOL Multiparous (no uterine scar, intact membranes) [appendix 3]**

- Following vaginal examination, if the bishops score is <7 the women should be offered induction with 10mg Propess for 24 hours. The women may have an outpatient IOL with Propess insitu if clinically suitable.
- If the woman prefers a non-pharmacological method, then mechanical induction via foleys balloon catheter should be attempted for 24 hours (or until the catheter falls out).
- If the bishops score remains <7 after 24 hours of Propess or 24 hours of balloon catheter insertion, then the women should receive a registrar review. The prostin induction regime can be commenced (2x 3mg prostin, 6 hours apart before further registrar review).
- If the bishops score remains <7 following 2 prostin, a 3<sup>rd</sup> or 4<sup>th</sup> prostin may be considered with registrar input. Consideration of a 12-hour break may be appropriate at this stage.

### **Method of IOL Multiparous (no uterine scar, rupture membranes) [appendix 4]**

- Women should be offered expectant management for up to 24 hours or immediate IOL. (See 4.3 Prelabour rupture of membranes at term)
- Once commencing induction, the woman should be offered +/- forewater ARM and +/- oxytocin infusion on delivery suite.

### **Method of IOL Multiparous (uterine scar, ruptured membranes) [appendix 4]**

- Women should be offered expectant management for up to 24 hours or immediate IOL. (See 4.3 Prelabour rupture of membranes at term)
- Once commencing induction, the woman should be offered +/- forewater ARM and +/- oxytocin infusion on delivery suite.

### **Method of IOL Multiparous (uterine scar, intact membranes) [appendix 5]**

- Following vaginal examination, if the bishops score is <7 the women should be offered induction with a non-pharmacological method of a mechanical induction via foleys balloon catheter. The catheter should be left insitu for up to 24 hours or until the catheter falls out.
- If the bishops score remains <7 after falling out or 24 hours of balloon catheter insertion, then a registrar examination should be requested to determine if a forewater ARM is possible.
- If an ARM is possible this should be conducted on delivery suite with appropriate CTG monitoring available. Following 4 hours of mobilisation if labour has not established oxytocin infusion should be offered as per trust protocol for a scarred uterus.

### **N.B**

- **Oxytocin can be commenced within 30 minutes of Propess being removed**
- **Oxytocin must not be commenced within 6 hours of Prostin administration**
- **Women should be advised that if they have an ARM, they can choose whether to have an oxytocin infusion, or delay starting this, but it may mean labour takes longer and there may be an increased risk of neonatal infection.**

## **4.3 Monitoring the Fetus**

4.2.1 Prior to commencing induction all women should undergo an abdominal palpation to confirm position, presenting part and engagement of the fetus. (n.b at NNUH all women s should receive a V-scan to confirm presentation). If there are any concerns about malpresentation or a high presenting part this should be escalated to the obstetric team for review and USS prior to induction commencement.

4.3.2 All women undergoing induction should have an admission CTG for 30 minutes or more prior to commencement of IOL, unless a computerised CTG is available in which case the CTG should be discontinued once the criteria have been met. Abnormal Antenatal CTG's should be escalated for an obstetric review prior to IOL assessment,

4.3.3 Following insertion of any prostaglandin or mechanical method of IOL a CTG should be recorded for 30 minutes or more to ensure fetal wellbeing (not computerised). Abnormal CTG's should be escalated for an obstetric review.

4.3.4 A CTG should be conducted prior to any further reviews during the IOL process, and always before insertion of any further prostaglandin. A minimum of 2 CTG's a day should be carried out for each woman (unless outpatient IOL).

4.3.5 Women will only require further CTG's if it has been requested by the Consultant or if they experience:

- Abdominal pain
- Painful uterine activity
- PV bleeding
- Reduced fetal movements
- Spontaneous rupture of membranes

#### **4.4 Monitoring of Maternal Condition**

4.4.1 Women undergoing induction should have admission observations including:

- Maternal pulse
- Respirations
- Blood pressure (MAP where necessary)
- Temperature
- Oxygen saturations
- Urinalysis

4.4.2 Women who do not have any maternal risk factors require twice daily observations prior to established labour. All maternal observations should be appropriately documented onto a MEOWs chart. Any deviations should be escalated appropriately.

4.4.3 Women with complications such as hypertension, diabetes, SROM etc will have a minimum of 4 hourly observations during the induction of labour process.

4.4.4 All women must be VTE assessed.

4.4.5 All women respond differently to the process of induction. Clinicians should be aware of this and be responsive to what women are reporting.

## **5 Management of Specific Clinical Circumstances related to IOL**

### **5.1 Prolonged Pregnancy:**

5.1.1 Give women with uncomplicated pregnancies every opportunity to go into spontaneous labour.

5.1.2 Explain to women that labour usually starts naturally before 42+0 weeks, based on the gestational age estimated by their dating scan (see table 1)

5.1.3 Using the information in below table, explain to women that some risks associated with a pregnancy continuing beyond 41+0 weeks may increase over time and these include:

- increased likelihood of caesarean birth
- increased likelihood of the baby needing admission to a neonatal intensive care unit
- increased likelihood of stillbirth and neonatal death.

5.1.4 Following this discussion offer IOL from 41+0 based on the woman's choice.

Gestational (weeks)	Proportion of spontaneous labours that started at this gestational age	Cumulative proportion of spontaneous labours that started by this gestational age
weeks under	2.4%	2.4%
0 to 6 weeks	5.3%	7.7%
0 to 6 weeks	5.1%	12.8%
0 to 6 weeks	12.1%	24.9%
0 to 6 weeks	25.4%	50.3%
0 to 6 weeks	32.5%	82.8%
0 to 6 weeks	16.2%	99.0%
0 weeks over	0.9%	100%

## 5.2 Preterm Ruptured Membranes at Term

5.2.1 If a woman has preterm prelabour rupture of membranes, do not carry out induction of labour before 34+0 weeks unless there are additional obstetric indications (for example, infection or fetal compromise).

5.2.2 Offer expectant management until 37+0 weeks

5.2.3 If a woman has preterm prelabour rupture of membranes after 34+0 weeks, but before 37+0 weeks, discuss the options of expectant management until 37+0 weeks or induction of labour with her. When making a shared decision, take into consideration the following factors:

- risks to the woman (for example, sepsis, possible need for caesarean birth)
- risks to the baby (for example, sepsis, problems relating to preterm birth)
- local availability of neonatal intensive care facilities
- the woman 's individual circumstances and her preferences

5.2.4 If a woman has preterm prelabour rupture of membranes after 34+0 weeks (but before 37+0 weeks) and has had a positive group B streptococcus test at any time in their current pregnancy, offer immediate induction of labour or caesarean birth.

### **5.3 Pre-labour Ruptured Membranes at Term**

5.3.1 Offer women with PROM at term (at or after 37+0) a choice of:

- expectant management for up to 24 hours, or
- induction of labour as soon as possible.

5.3.2 Discuss the benefits and risks of these options with the woman and consider their individual circumstances and preferences. Discussion should also inform the woman that immediate induction will only happen when clinical priority allows, and this may not always be within 24 hours.

5.3.3 For women who choose expectant management after prelabour rupture of the membranes at term (at or after 37+0 weeks), offer induction of labour if labour has not started naturally after approximately 24 hours.

5.3.4 Respect the woman's decision if they choose to wait for spontaneous onset of labour for over 24 hours after prelabour rupture of membranes at term. Discuss the woman's options for birth from this point onwards with them.

5.3.5 If a woman has prelabour rupture of membranes at term (at or after 37+0 weeks) and has had a positive group B streptococcus test at any time in their current pregnancy, offer immediate induction of labour or caesarean birth.

### **5.4 Previous LSCS/ Uterine Scar**

5.4.1 Advise women who have had a previous caesarean birth that:

- induction of labour could lead to an increased risk of emergency caesarean birth
- induction of labour could lead to an increased risk of uterine rupture
- the methods used for induction of labour will be guided by the need to reduce these risks (for example, by using mechanical methods).



- some methods used for induction of labour may not be suitable (for example, both dinoprostone and misoprostol are contraindicated in women with a uterine scar).

-

5.4.2 If birth needs to be expedited, offer women who have had a previous caesarean birth a choice of:

- induction of labour, or
- planned caesarean birth.

5.4.3 Consider the woman's circumstances and preferences and record the discussions and plan in the woman's notes.

5.4.4 Advise women that they can choose not to have induction of labour or caesarean birth, even when it may benefit their or their baby's health.

5.4.5 Evidence shows there is no increased risk of hyperstimulation when using mechanical methods for induction of labour (including osmotic cervical dilators and balloon catheters). Balloon catheters were also effective at promoting vaginal birth within 24 hours and did not appear to markedly increase the risk of other adverse outcomes.

5.4.6 If women request induction of labour this should be offered via foleys balloon catheter induction for up to 24 hours.

## 5.5 Pre-eclampsia

5.5.1 Consider IOL:

- Mild- moderate: recommend after 37 weeks.
- Severe: Before 34 weeks delivery may be indicated with severe refractory hypertension. Recommended between 34 – 36+6 if PET with severe hypertension with appropriate monitoring.

(n.b Severe pre-eclampsia defined as severe hypertension that does not respond to treatment or is associated with ongoing or recurring severe headaches, visual scotomata, nausea or vomiting, epigastric pain, oliguria, as well as progressive deterioration in laboratory blood tests such as rising creatinine or liver transaminases or falling platelet count, or failure of fetal growth or abnormal Doppler findings)

## **5.6 Maternal Request/ Pelvic Girdle Pain**

5.6.1 IOL for maternal request should not be routinely offered. Requests should be considered only after discussing the benefits and risks with the woman, considering the individuals' circumstances and preferences.

5.6.2 IOL for pelvic girdle pain before 40 weeks would not generally be recommended, however the full clinical picture should be taken into account. Use of crutches or a wheelchair may prompt discussion to consider this from 39 weeks.

## **5.7 Suspected Fetal Macrosomia**

5.7.5 Discuss IOL with women whose babies are plotting over the 90<sup>th</sup> centile at 36 weeks. IOL should be timed for when the baby is predicted to plot at 4kg on their customised growth chart.

5.7.2 Discuss the options with the woman and consider their preferences.

5.7.3 Discuss the following risks when having discussions:

- IOL reduces risk of shoulder dystocia compared with expectant management
- IOL increases risk of third- and fourth-degree tears compared with expectant management
- The risk of perinatal death, brachial plexus injury or need for emergency caesarean section is the same between IOL and spontaneous labour

5.7.4 If the EFW is above 5kg (or 4.5kg for diabetics) discuss mode of delivery.

## **5.8 Breech Presentation**

5.8.1 Induction of labour is not generally recommended if a person's baby is in the breech position.

5.8.2 Consider induction of labour for babies in the breech position if:

- birth needs to be expedited, and
- external cephalic version is unsuccessful, declined, or contraindicated, and

- the woman chooses not to have a planned caesarean birth. Discuss the benefits and risks associated with induction of labour with the woman.

## **5.9 Fetal Growth Restriction**

5.9.1 Do not induce labour if there is fetal growth restriction with confirmed fetal compromise. Offer caesarean birth instead.

5.9.2 If measuring below the 3<sup>rd</sup> centile with no concerning features initiate IOL at 37+0. Consider less than 37 weeks if additional concerning features.

5.9.3 If measuring between 3<sup>rd</sup> – 10<sup>th</sup> centile with no high-risk features, initiate IOL at 39+0.

## **5.10 History of Precipitate Labour**

5.10.1 Do not routinely offer induction of labour to women with a history of precipitate labour to avoid a birth unattended by healthcare professionals. Ensure adequate antenatal information is provided on signs of labour and appropriate attendance to the maternity unit.

## **5.11 Diabetes**

5.11.1 See trust diabetes guideline

# **6 Management of complications of induction of labour**

## **5.1 Failed IOL**

5.1.1 If induction is unsuccessful, discuss this with the woman and provide support. Fully reassess the maternal condition

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and the pregnancy in general and assess fetal wellbeing using antenatal cardiotocography interpretation.

5.1.2 If induction is unsuccessful, discuss and agree a plan for further management with the woman, including whether they would like further attempts at induction, considering the clinical circumstances and their preferences.

5.1.3 If induction is unsuccessful, the subsequent management options include:

- offering a rest period if clinically appropriate and then re-assessing the woman
- expectant management
- further attempts to induce labour
- caesarean birth

## 5.2 Hyperstimulation

5.2.1 If uterine hyperstimulation occurs during induction of labour:

- carry out a fetal assessment, including CTG
- carry out maternal observations and document on a MEOWs chart
- do not administer any more doses of medicines to induce labour and remove any vaginal pessaries or delivery systems if possible
- escalate appropriately to the obstetric team
- consider tocolysis

## 5.3 Cord Prolapse

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

- before induction, abdominally assess the level and stability of the fetal head in the lower part of the uterus at or near the pelvic brim

- during the preliminary vaginal examination, obstetricians and midwives should palpate for umbilical cord presentation and avoid dislodging the baby's head
- Inducing labour
- Ensure to perform a CTG during induction after the membranes have ruptured if the presenting part is not stable and not well-applied to the cervix. In this situation, discuss the risks and benefits of induction of labour with the woman, and if necessary, consider caesarean birth.
- If the presenting part stabilises and the CTG is normal, use intermittent auscultation unless there are clear indications for a further CTG.

## 5.4 Uterine Rupture

5.4.1 All healthcare professionals should be aware of the signs of uterine rupture:

- fetal bradycardia,
- variable decelerations,
- evidence of hypovolemia,
- loss of fetal station (detected during cervical examination), and
- severe or constant abdominal pain

5.4.2 In case of suspected uterine rupture findings should be immediately escalated to the obstetric team, CTG commenced or continued, and intravenous access gained.

5.4.3 If uterine rupture is suspected carry out an immediate category 1 caesarean birth.

## 6 Management of Women Declining IOL

6.1 An individual management plan should be formed when induction of labour is declined. Healthcare professionals should respect the woman's decisions and discuss further care with them.

6.2 When a woman declines induction of labour the risks of not being induced should be discussed.

6.3 Women declining induction must have an individual management plan by the obstetric registrar/consultant regarding the pregnancy.

6.4 The individual management plan should be documented in the maternal records and when over 42 weeks gestation include CTG's and USS to assess Liquor volume and umbilical artery doppler.

6.5 The woman should be offered an appointment with a consultant obstetrician and birth choices clinic/consultant midwife.

## 7 Management of Delayed Induction of labour

7.1 A delay in induction of labour is defined as:

- Deferred start date (by maternity services)
- A delay of 6 hours or more of in the IOL procedure (Prostaglandin/ARM/Oxytocin)

If either of these delays are identified - follow flowchart Appendix 6 *Process for delay in induction of labour*

**NB: When communicating IOL delays with the DS coordinator/Manager of the day ensure updates for all IOL delays are discussed in one phone call (instead of multiple) at pre agreed times eg: 00:00/06:00/12:00/18:00**

## 8 Clinical Audit Standards

The Maternity Services are committed to the philosophy of clinical audit, as part of its Clinical Governance programme. The standards contained in this clinical guideline will be subject to continuous audit, with multidisciplinary review of the audit results at one of the monthly departmental Clinical Governance meetings. The results will also be summarised, and a list of recommendations formed into an action plan, with a commitment to re-audit within three years, resources permitting.

## 9 Summary of development and consultation process undertaken before registration and dissemination

Initially a GAP analysis was conducted with all 3 trusts Induction of Labour Guidelines against the NICE 2021 Inducing Labour Guideline.

In forming the joint guideline there has been a merger of all 3 trust guidelines to ensure compliance with NICE guidance.

Following this a working group with trust consultants was formed to develop and agree guidance before submitting the joint guideline to each trust governance.

## 10 Distribution list

Trust intranet

## 11 References

National Institute of Health and Care Excellence. (2021). *Inducing Labour: NG207*. NHS Digital. (2021). *NHS Maternity Statistics, England – 2020-21*. NHS England.

GuroI-Urgaci I, Jardine J, Carroll F, Muller P, Relph S, Lara L, Webster K, Oddie S, Hawdon J, Harris T, Khalil A, Van Der Meulen J. (2022). *Use of induction of Labour and emergency caesarean section and perinatal outcomes in English maternity services: a national hospital-level study*. British Journal of Obstetrics and Gynaecology. April 2022.

## 12 Appendices

### Appendix 1. Primiparous (intact membranes)

**BS= <7**

**BS= 7+**

**BS= 7 +**

**BS= <7**

**BS= 7+**

**BS= <7**

## **Appendix 2. Primiparous (ruptured membranes)**

Clinical Guideline: A Norfolk and Waveney LMNS Shared Clinical Guideline for Induction of Labour

Author/s: Mollie Haskey (LMNS PDM) & Emma Wiskin (Better Births Lead Midwife) Authors title: LMNS PDM, Better Births Lead Midwife

Approved by: MCG&NMCP

Date approved: 20/09/2022

Review date:26/08/2025

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**Immediately or after 24 hours SROM**

**BS=<7**

**BS= 7+**

### Appendix 3. Multiparous (intact membranes)

**BS= <7**

**BS= 7+**

**BS= 7+**

**BS= <7**

**BS= 7+**

**BS= <7**

## Appendix 4. Multiparous (ruptured membranes, with or without uterine scar)

Clinical Guideline: A Norfolk and Waveney LMNS Shared Clinical Guideline for Induction of Labour

Author/s: Mollie Haskey (LMNS PDM) & Emma Wiskin (Better Births Lead Midwife) Authors title: LMNS PDM, Better Births Lead Midwife

Approved by: MCG&NMCP

Date approved: 20/09/2022

Review date:26/08/2025

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## Appendix 5. Multiparous (scarred uterus, intact membranes)

BS= <7

BS= 7+

BS= <7

BS=7+

## **Appendix 6 – Process for delay in induction of labour**

*N.b. As a system consider liaising with other trusts as to capacity prior to delaying any IOL*

Clinical Guideline: A Norfolk and Waveney LMNS Shared Clinical Guideline for Induction of Labour

Author/s: Mollie Haskey (LMNS PDM) & Emma Wiskin (Better Births Lead Midwife) Authors title: LMNS PDM, Better Births Lead Midwife

Approved by: MCG&NMCP

Date approved: 20/09/2022

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Author/s: Mollie Haskey (LMNS PDM) & Emma Wiskin (Better Births Lead Midwife) Authors title: LMNS PDM, Better Births Lead Midwife

Approved by: MCG&NMCP

Date approved: 20/09/2022

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