Induction of Labour (IOL) - Policy

Unique Identifier	NMP200/SSM/110 - v01.01
Document Type	Policy
Risk of non-compliance	may result in significant harm to the patient/Te Whatu Ora
Function	Administration, Management and Governance
User Group(s)	Te Toka Tumai Auckland only
• Organisation(s)	Te Whatu Ora | Te Toka Tumai Auckland
• Directorate(s)	Women's Health
• Department(s)	Maternity
• Used for which patients?	Maternity patients delivering at Auckland City Hospital
• Used by which staff?	All maternity staff and access holders
• Excluded	
Keywords	
Author	Service Clinical Director - Secondary Maternity Services
Authorisation	
• Owner	Service Clinical Director - Secondary Maternity Services
• Delegate / Issuer	Service Clinical Director - Secondary Maternity Services
Edited by	Document Control
First issued	25 July 2022
This version issued	19 August 2022 - minor change
Review frequency	3 yearly

Contents

1. Purpose of policy

- To describe the process of booking induction of labour (IOL) (planned and urgent), which is the same for all practitioners.
- To define the roles and responsibilities of practitioners looking after pregnant women undergoing IOL.
- To ensure safe provision of care in the facility.

2. Policy statements

- All Te Toka Tumai Auckland maternity staff and access holders must follow this policy when arranging induction of labour.
- This policy is intended to be used alongside the Te Toka Tumai Auckland guideline "Induction of Labour - Clinical Guidance" and it is a reasonable expectation that staff and access holders follow this guideline as well as other clinical guidance around timing of birth in other relevant Te Toka Tumai Auckland guidelines.

3. Definitions

Term	Definition
CCM	Clinical Charge Midwife
CM	Charge Midwife
CS	Caesarean section
CTG	Cardiotocography
DAU	Day Assessment Unit
FGR	Fetal growth restriction
IOL	Induction of Labour
LBS	Labour and Birthing Suite
LMC	Lead Maternity Carer
LMP	Last menstrual period
NICU	Neonatal Intensive Care Unit
Post - dates (post - term)	41 weeks or more
PROM	Premature rupture of membranes
PTVC pathway	Post Term Virtual Consultation pathway
SCD	Service Clinical Director
SGA	Small for gestational age
SMO	Senior Medical Officer
WAU	Women's Assessment Unit

4. Planning IOL

4.1 Ultrasound scan report

If IOL is for concerns regarding fetal growth, the referring obstetrician must include the most recent scan reports with the IOL request form.

4.2 Research

Please inform eligible women about any current research studies around induction of labour, information about these can be accessed via the Women's Health external website.

4.3 Number of IOLs per day

There are a total of four elective IOL slots per day, seven days a week. There is no limit to the number of each method of IOLs per day, as long as the total number of elective IOLs in both the Women's Assessment Unit (WAU) and Labour and Birthing Suite (LBS) together is no more than four. This includes IOLs that are on a bereavement or abortion pathway.

Acute IOLs are those that need to be commenced as soon as possible, even if there are already four booked. Acute IOLs are to be added in consultation with the LBS SMO, LMC and WAU CCM. There is no limit to the number of acute IOLs per day. However, the number of elective IOLs may need to be adjusted for the level of staffing or beds, if more than three acute IOLs are required.

By their nature, acute IOLs will need to be commenced within 24 – 48 hours, whereas elective IOLs will not usually be able to be scheduled in that time frame.

4.4 Clinical prioritisation by the LBS SMO

On occasion, an induction that is less clinically urgent may need to be deferred to make space for one that is more urgent. If possible, patients will be notified of any deferral before they come into the hospital. Inductions for term PROM, high risk SGA/FGR, hypertension, or at 41+0 weeks gestation or more should not be deferred. Inductions for other indications may need to be deferred at the discretion of the LBS SMO.

The LBS SMO is responsible for review and clinical prioritisation of IOLs, in consultation with the WAU CCM. This should take place daily, before the 5pm handover, for that day's IOL not yet started, and the following day's IOL, or as a required response to escalation regarding capacity issues. The SMO should take into account the total number of inductions (more than seven planned for that day or the next working day, regardless of method, LMC, reason, acute or planned), clinical complexity, previous deferrals, midwifery and obstetric staffing, postnatal bed state and NICU availability.

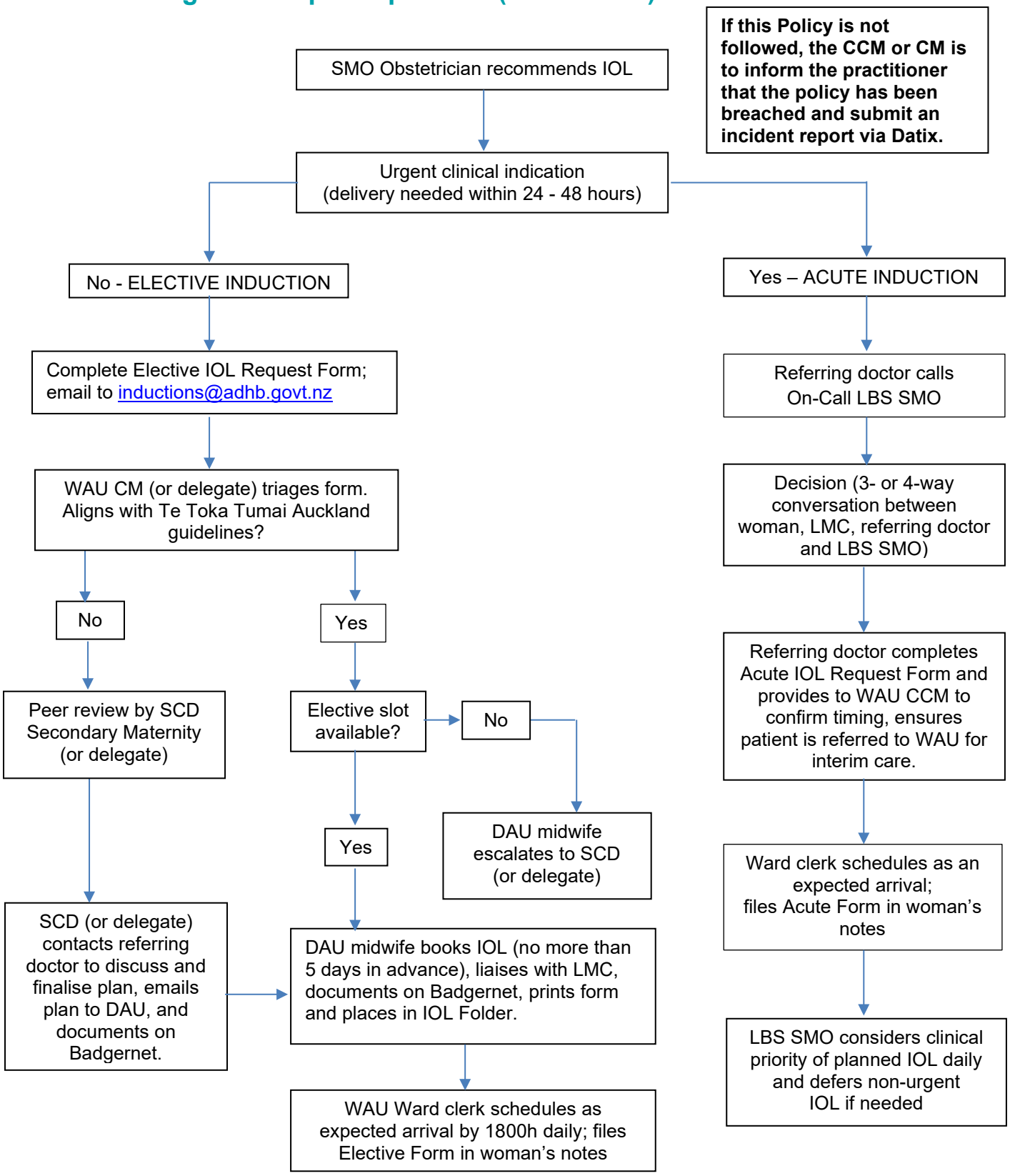
If deferral is contemplated, the LBS SMO should, if possible, discuss with the ward SMO of the team responsible for the decision for IOL (available on Medirota) and where appropriate, the woman's LMC, either the private obstetrician on call that day or the LMC midwife.

Note: this is consistent with requirements of local obstetric services under the Ministry of Health Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines) to enable a three way discussion including the woman, LMC and the local obstetric service.

The LBS SMO should document the decision in Badgernet (Maternity Clinical Information System). The LBS SMO or LMC should notify the woman of the new date/time, and if clinically appropriate offer an assessment in WAU or the Day Assessment Unit (DAU).

If agreement cannot be reached between the LBS SMO on call and the booking obstetrician, then the SCD - Secondary Maternity Services (or delegate) should be asked to mediate (during working hours). After hours or if the SCD is unavailable, the decision of the LBS SMO is final.

5. Booking IOL - required process (flowchart 1)



Back to Contents

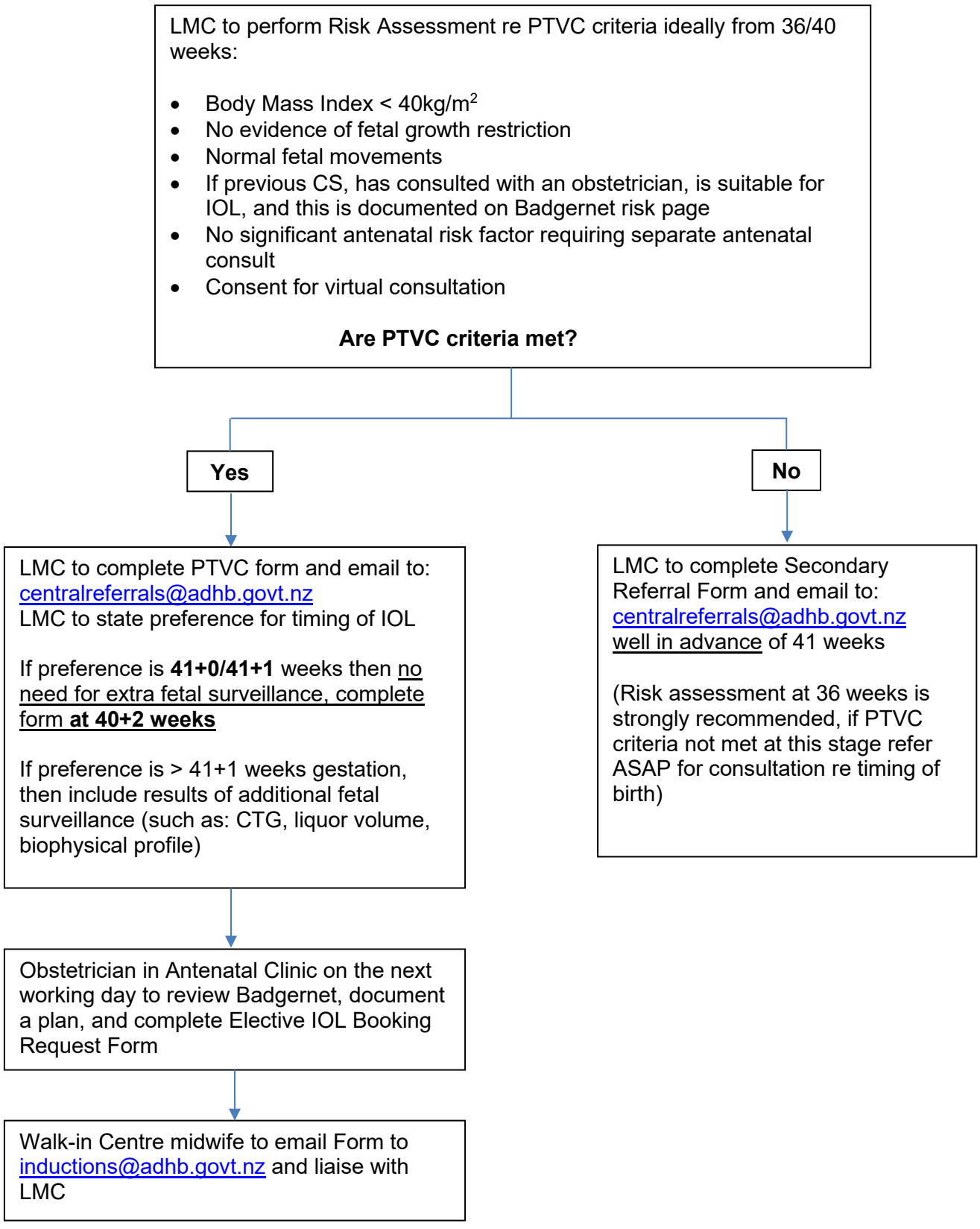
6. Booking of IOL for post-dates

Inform women of the benefits of IOL at 41+0/41+1 weeks based on high-quality research evidence. Provide women with the Te Toka Tumai Auckland patient information leaflet “Induction of Labour” (see Associated Documents).

- LMC Midwives to follow PTVC Pathway (see Flowchart 2)
  - Perform Risk Assessment from 36/40 weeks as to suitability for a virtual consultation, if not then refer to clinic for face-to-face assessment well in advance of 41/40 weeks.
  - If woman chooses to be induced at 41+0/41+1 weeks, then email PTVC Form to centralreferrals@adhb.govt.nz at 40+2 weeks and the IOL will be booked without need for any additional fetal surveillance.
  - If woman chooses to wait beyond 41+1 weeks, then encourage careful monitoring of fetal activity, recommending early discussion with LMC if any reduction noted, and offer additional fetal monitoring (such as cardiotocography (CTG), liquor volume, biophysical profile). Review decision for IOL if any concern for fetal well-being.

- LMC Obstetricians
  - If woman chooses to be induced at 41+0/41+1 weeks, then email IOL Request Form to inductions@adhb.govt.nz at 40+2 weeks and IOL will be booked without need for any additional fetal surveillance.
  - If woman chooses to wait beyond 41+1 weeks, then encourage careful monitoring of fetal activity recommending early discussion with LMC if any reduction noted, and offer additional fetal monitoring (such as cardiotocography (CTG), liquor volume, biophysical profile). Review decision for IOL if any concern for fetal well-being.

6.1 Post Term Virtual Consultation (PTVC) pathway for LMC midwives (flowchart 2)



7. Roles and responsibilities of practitioners

- The WAU Charge Midwife (or delegate) triages the request and if aligns with Te Toka Tumai Auckland guidelines will forward to the DAU midwife for booking. If not apparently aligned with Te Toka Tumai Auckland guidelines, the request is forwarded to SCD - Secondary Maternity Services (or delegate) for peer review. The review process includes looking at all clinical information available in the referral and clinical record, and contacting the referring doctor or team for further information and if necessary to discuss the plan. Agreement should be reached by consensus and in good faith.

- Once a decision is reached, the peer review doctor will forward the request to the DAU midwife for booking.

- The DAU midwife will book IOL according to the triage decisions. If appropriate booking is not possible (i.e. there are already four elective IOLs booked on the day another IOL is requested), escalation should occur to the SCD - Secondary Maternity Services, (or delegate). IOLs for high risk SGA, hypertension, or at 41+0 weeks gestation or more will be prioritised over other IOLs.

- The DAU midwife will prepare the induction schedule at the end of each working day (Monday to Friday) and place it in the induction folder.

- The WAU CCM creates an induction list for the day based on information in the folder, and brings the finalised induction list to the 0800 handover.

- The ward clerk starts the IOL tab in Badgernet on arrival of the woman.

- The LBS team on call (or LMC obstetrician) and where appropriate the LMC midwife (if they choose to be present) are responsible for the woman during the induction process. Roles and responsibilities of each of the clinicians providing care must be documented at the commencement of the induction and adjusted by negotiation if required.

- Consultation with an Obstetrician is always required prior to and in planning for IOL and in making the decision for IOL. According to the Referral Guidelines, consultation implies that the responsibility for maternity care remains with the LMC. Transfer of clinical responsibility occurs only after a three-way discussion between the LMC, the woman and the Obstetrician.

- There is no expectation that an LMC is present for the cervical ripening/induction care, but the LMC can choose to be present if they prefer.

- If the LMC chooses to be present and manage the IOL from the start, they will be supported to do so in consultation with the Obstetric team and with core midwifery staff. Core staff should provide care to support the LMC when in attendance or in their absence by negotiation.

- If the plan is for the core midwifery staff to manage the woman's induction of labour care until the woman requires the on-going care of her LMC; this will be supported and the LMC will be asked to attend by the core midwife or the woman when appropriate (when it is clear that the woman is labouring and requires one-to-one midwifery care), to provide on-going labour care.

- The plan for midwifery and LMC care during induction of labour must be documented in the woman's care plan. This should include a plan for communication on progress between the LMC and the core midwife.

8. Starting IOL in WAU or LBS

If IOL is not recorded on the Whiteboard as an expected arrival, then discussion between the LMC and LBS SMO on call, and between LBS team on call and LBS CCM, should occur prior to starting an IOL, regardless of indication, LMC type, location, method and acuity.

To start an IOL, the hospital midwife should:

- Confirm the IOL is on the Whiteboard as an expected arrival.
- Confirm the named obstetrician responsible for the IOL (can use Handover sticker).
- Confirm the primary indication for IOL.
- Identify other antenatal risk factors.
- Confirm estimated due date (by scan < 14 weeks if available, otherwise best estimate by LMP or later scan).
- Ensure most recent ultrasound does not show low lying placenta/placenta praevia or non-cephalic presentation.
- Confirm the woman's informed consent to have IOL (see points above for discussion regarding IOL).
- Offer the "Induction of Labour at Auckland City Hospital" information leaflet.
- Commence neonatal blue card.
- Perform assessment of:
  - Maternal well-being (observations; urinalysis and blood tests only if indicated)
  - Fetal lie, presentation and engagement (abdominal palpation)
  - Fetal well-being (CTG)
- Document all of the above in a proper "admission note" or ask the medical team to do so - it is expected that every woman undergoing IOL has a complete and comprehensive note.

If any concerns with any of the assessment, including if the primary indication stated on the Request Form does not match the clinical history and exam, consult with the LBS SMO on call. If there are no concerns, IOL can be started without further delay.

Please inform eligible women about any current research studies around induction of labour. Information about these can be accessed via the Women's Health external website.

Document the CTG at the start of the IOL in the woman's clinical record using the CTG sticker.

Document the Bishop Score (BS) at the start of the IOL in the woman's clinical record using the BS sticker.

SCORE	0	1	2
Position	Post	Mid	Ant
Consistency	Firm	Int	Soft
Length (cm)	3	1 - 2	< 1
Dilation	0	1 - 2	3
Station	-3	-2 -1	0

9. Management of IOL

At 0800 handover, review all women undergoing IOL, and all women with planned IOL.

It is expected that at all handovers, the LBS Registrar is knowledgeable about the primary indication for IOL and other antenatal risk factors, the progress and management plan.

It is expected that every woman undergoing IOL be reviewed daily by the LBS team on call. The LBS SMO should see women in person who are undergoing cervical ripening > 24 hours.

10. Audit standards

- Completeness of booking forms
- Adherence to booking process

11. Supporting evidence

- Wise, M. R., Marriott, J., Battin, M., Thompson, J. M., Stitely, M., & Sadler, L. (2020). Outpatient balloon catheter vs inpatient prostaglandin for induction of labour (OBLIGE): a randomised controlled trial. *Trials, 21*(1), 1-11.

12. Legislation

- Section 88 of the New Zealand Public Health and Disability Act (2000)
- Primary Maternity Services Notice (2007) issued pursuant to Section 88 of the New Zealand Public Health and Disability Act (2000)

13. Associated documents

National guidelines
- Ministry of Health. 2012. Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines). Wellington: Ministry of Health

Te Toka Tumai Auckland policies and guidelines
- Induction of Labour (IOL) - Clinical Guidance
- Access Holders in Women's Health (NWH)

Patient Information Leaflet
- Induction of Labour (https://www.nationalwomenshealth.adhb.govt.nz/assets/Womens-health/Documents/Pregnancy/Induction-of-labour.pdf

14. Disclaimer

No guideline can cover all variations required for specific circumstances. It is the responsibility of the health care practitioners using this Te Toka Tumai Auckland guideline to adapt it for safe use within their own institution, recognise the need for specialist help, and call for it without delay, when an individual patient falls outside of the boundaries of this guideline.

15. Corrections and amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed ***before*** the scheduled date, they should contact the owner or Document Control without delay.