East Sussex Healthcare
NHS Trust

FOI REF: 24/901

Eastbourne District General Hospital
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Eastbourne
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BN21 2UD

Tel: 0300 131 4500
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14th January 2025

FREEDOM OF INFORMATION ACT

I am responding to your request for information under the Freedom of Information Act. The answers to your specific questions are as follows:

I am writing to request the following information:

1) Copy of any maternity/midwifery/obstetric care guidelines or policies specifically relating to the care of obese women/women with a raised BMI (>30kg/m²).

Please see attached East Sussex Healthcare NHS Trust's 'Clinical Guideline for the Management of the Obese Pregnant Woman'.

2) Copy of any maternity/midwifery/obstetric induction of labour guidelines.

Please see attached the Trust's 'Clinical Guideline for Induction and Augmentation of Labour'.

Please note that it is the Trust's FOI policy to only provide the names of staff that are grade 8a or above, therefore staff that are below that grade have been redacted from the attached guidelines. We have also redacted the names of staff that have now left the Trust.

I can confirm that we hold this information, but it is exempt under section 40(2) of the Freedom of Information Act 2000 – Personal Information of third parties. This is because this information may allow the identification of individuals and disclosure would breach the principles of the Data Protection Act.

If I can be of any further assistance, please do not hesitate to contact me.

Should you be dissatisfied with the Trust's response to your request, you have the right to request an internal review. Please write to the Freedom of Information Department (esh-tr.foi@nhs.net), quoting the above reference, within 40 working days. The Trust is not obliged to accept an internal review after this date.

Cont…/

Should you still be dissatisfied with your FOI request, you have the right of complaint to the Information Commissioner at the following address:

The Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire SK9 5AF

Telephone: 0303 123 1113

Yours sincerely

Freedom of Information Department
esh-tr.foi@nhs.net

East Sussex Healthcare NHS Trust

Clinical Guideline for the Management of the Obese Pregnant Woman

Document ID Number:	988
Version:	V3
Ratified by:	Women and Children's Governance and accountability members
Date ratified:	November 2021
Name of author and title:	Catherine O'Callaghan, Named Midwife for Safeguarding and Public Health Smoking Cessation Dr Nicky Roberts, Consultant Obstetrician
Date Originally Written:	November 2008
Date of current version was completed:	September 2021
Name of responsible committee/individual:	Chair of the Guideline Implementation Group for Maternity Services
Date issued:	24 December 2021
Review date:	November 2024
Target audience:	All staff caring for women / pregnant people within ESHT maternity services
Compliance with CQC outcome:	Person Centred Care Dignity and Respect
Compliance with any other external requirements (e.g. Information Governance):	NICE, RCOG
Associated Documents:	N/A

Did you print this yourself?
Please be advised the Trust discourages retention of hard copies of procedural documents and can only guarantee that the procedural document on the Trust website is the most up to date version

Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V1 2008283	November 2008	Gayle Clarke	New document	
V2 2009297	December 2009	Gayle Clarke		
V1.0 2013054	January 2013	Catherine O'Callaghan		
V2.0	December 2014	Catherine O'Callaghan et al	Practice Changes	Implementing 3rd trimester assessments
V2.0 2018326	December 2017	Catherine O'Callaghan	Review and update	
V2.1	February 2020	Gayle Clarke	Clinical Update	Replacing Syntocinon with Oxytocin
V3	September 2021	[redacted] Gayle Clarke	Clinical Update	Replacing Syntocinon with Oxytocin Updating NICE guidance

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
Guideline Implementation Group	Obstetrics and Gynaecology	Oct 2008 Oct 2009
Women and children's Clinical Directorate Team	Obstetrics and Gynaecology	Oct 2008
Strategic Business Unit Women's Health Operational Meeting		Oct 2009
Guideline Implementation Group		October 2012
Clinical Unit – Integrated Division	Obstetrics and Gynaecology	December 2012
WRASH	Obstetrics and Gynaecology	April 2014
Women and Children's Guideline Implementation Group		March 2018
Women and Children's Governance and Accountability meeting		May 2018
Women and Children's Guideline Implementation group		September 2021
Raisa Buss (previously Rampersad) Lead Pharmacist for Women's, Children and Sexual Health		September 2021
Women and Children's Governance and Accountability		October 2021
Medicines Optimisation Group		November 2021

This information may be made available in alternative languages and formats, such as large print, upon request. Please contact the document author to discuss

Table of Contents

1. Introduction

Obesity in pregnancy is usually defined as a Body Mass Index (BMI) of 30kg/m² or more at the first antenatal consultation. Maternal obesity has become one of the most commonly occurring risk factors in obstetric practice. Obesity in pregnancy is associated with an increased risk of a number of serious adverse outcomes, including miscarriage, fetal congenital anomaly, thromboembolism, gestational diabetes, pre-eclampsia, dysfunctional labour, postpartum haemorrhage, wound infections, stillbirth, and neonatal death.

There is also a higher caesarean section rate in this group of women **/ pregnant people**. Maternity services must develop and implement robust processes to manage the risks associated with obesity and consistently provide sensitive, comprehensive and appropriate multidisciplinary care. Obesity in women **/ pregnant people** can cause serious pregnancy complications, but it is a risk factor that can be modified to improve birth outcomes.

2. Rationale

This guideline is intended to inform the practice of all clinical maternity staff and medical staff involved in providing care to the pregnant woman with a raised BMI.

3. Scope

This guideline is of reference to all midwives, medical staff and support workers with involvement in providing care to the pregnant woman with a raised BMI in the outpatient, community and acute hospital setting.

4. Definitions

Obesity - Defined epidemiologically using the Body Mass Index (BMI), calculated as weight (in kg) divided by the square of height (in metres squared)

- BMI = weight/height^2

Clarification - The standard measure for determining obesity is the classification by the World Health Organisation, as shown in the following table

OYES – OneYou East Sussex

Classification	BMI (kg/m2)	Risk of obstetric/anaesthetic complications
Normal range	18.5-24.9	No increased obstetric or maternal risk
Overweight	25-29.9	No increased obstetric or maternal risk
Obese 1	30-34.9	Mildly increased obstetric and maternal risk
Obese 2	35-39.9	Moderately increased obstetric and maternal risk
Obese 3 (previously known as morbidly obese)	Greater than or equal to 40	Significantly increased obstetric and maternal risk

5. Accountabilities

5.1 Midwives , Obstetricians and Anaesthetics

- To access, read, understand and follow this guidance
- To use their professional judgement in application of this guideline

5.2 Management

- To ensure the guideline is reviewed as required in line with the Trust and National guidelines
- To ensure the guideline is accessible to all relevant staff
- To monitor the audit process

6. Process

4.1. Pre-Pregnancy Care

All women / pregnant people planning a pregnancy with a BMI ≥ 30 be advised of the risks of pregnancy associated with obesity and encouraged to loose weight.

Women **/ pregnant people** with a BMI ≥ 30 should be advised to take ***5mg folic acid*** supplementation daily starting at least one month before conception and continuing through the first trimester.

6.2 Antenatal Management

All women / pregnant people must have their BMI calculated at booking and the result recorded in the maternal clinical record Women **/ pregnant people** not consenting to be weighed must have all the risks identified to them and documented in their pregnancy record.

Direct woman to the following NHS Choices web-sites for information:

- Overweight and Pregnant
  https://www.nhs.uk/conditions/pregnancy-and-baby/overweight-pregnant/

- Exercise in pregnancy – Pregnancy and baby guide
  https://www.nhs.uk/conditions/pregnancy-and-baby/pregnancy-exercise/

- Have a healthy diet in pregnancy
  https://www.nhs.uk/conditions/pregnancy-and-baby/healthy-pregnancy-diet/

Consider referral from a lower BMI (e.g. ≥27.5kg/m2) for patients of black African, African-Caribbean and Asian family origin as they are at an increased risk of conditions, such as type 2 diabetes, at a lower BMI. (Let's Talk About Weight - step by step guide www.publishing.service.gov.uk

6.2.1 Women / pregnant people with a BMI>30

Advise that a healthy diet and being physically active will benefit both the woman and her unborn child during pregnancy and will also help her to achieve a healthy weight after giving birth. (NICE 2010)

Advise to take ***Vitamin D 10 micrograms (400units***) once a day as supplementation during pregnancy (NICE 2021)

Offered a GTT at 28 weeks

Blood pressure should be checked with an appropriately sized cuff at each visit

Assess for antenatal thromboprophylaxis

Have a documented antenatal consultation with an appropriately trained health professional

for assessment, to discuss possible intrapartum complications, personalised advice on healthy eating and how to be physically active

6.2.2 Women / pregnant people with a BMI>35

All of the above plus:

Must be booked for shared care with a consultant and to deliver in a consultant unit

In line with the NHS Fetal Anomaly Screening Programme (2015, updated 2021) two separate scan appointments can be offered to complete the anomaly scan. Where an adequate assessment of the fetal anatomy remains compromised after the second scan, all women **/ pregnant people** should be told that the screening is incomplete and this should be recorded in all formats.

No referral to the consultant specialist scan list is necessary under these circumstances unless there is a suspected fetal anomaly.

Blood pressure should be checked with an appropriately sized cuff at each visit

Women **/ pregnant people** with a BMI >35 plus one additional risk factor for hypertensive disease should be prescribed ***Aspirin 150mg/day*** *from 12 weeks* to 36 weeks and consider lower for patients with hepatic or renal disease.

Assess for antenatal thromboprophylaxis

BMI ≥35 with any co-existing medical conditions must be referred to an obstetric anaesthetist antenatally.

This must be:

- Documented in the maternal clinical record
- Plan made for labour and delivery

Ultrasound scan should be booked for women **/ pregnant people** at 34 and 38 weeks if BMI ≥35 however; additional scans and aspirin maybe required if any additional risk factors exist.

ADDITIONAL RISK FACTORS

Medical history

- Maternal medical conditions
- (chronic kidney disease, hypertension, autoimmune disease (SLE,APLS), Diabetes, cyanotic heart disease

Obstetric history

- Previous FGR (<3rd centile)
- Hypertensive disease in a previous pregnancy
- Previous SGA stillbirth

Current pregnancy

- PAPPA ≤ 0.4 MoM
- Echogenic bowel
- Significant bleeding (Consultant decision)
- EFW <10th centile

If any of the above risk factors exist please see the scanning algorithm in *Appendix C*

6.2.3 Women / pregnant people **with a BMI ≥40**

All of the above plus:

Women / pregnant people with a BMI ≥40 must be referred to an obstetric anaesthetist antenatally.

This must be:

- Documented in the maternal clinical record
- Plan made for labour and delivery

Women / pregnant people with a BMI ≥40 must have a risk assessment relating to antenatal, intrapartum and postnatal care carried out in the 3rd trimester.

This must be:

- Documented in the maternal clinical record include: Manual Handling assessment – follow Appendix E from the Moving and Handling Policy

- Tissue viability assessment – will be performed using the modified waterlow assessment tool which is found in the maternity booklets

- Re-measurement of maternal weight - Only weigh again if clinical management (i.e. medication) can be influenced or if nutrition is a concern (NICE)

- Ultrasound scan should be booked for women / pregnant people at 34 and 38 weeks if BMI ≥40 again if additional risk factors present see page 6 above for risk factors and ***Appendix C*** for the additional scans required.

For women / pregnant people presenting in labour with a BMI ≥40 who have not seen an anaesthetist antenatally, the anaesthetic middle grade should be contacted to organise an urgent anaesthetic consultation

Specific anaesthetic risks due to a raised BMI ≥ 40

- Increased maternal risk of morbidity and death for both mother and baby
- Difficult patient positioning (patient cannot lie flat)
- Regional anaesthesia for surgery is the preferred route but is more difficult to site with unpredictable spread of local anaesthetics
- Epidural more likely to dislodge or fail
- Increased risk of difficult and failed intubation and other methods of airway management
- Difficulty securing peripheral access
- Increased risk of regurgitating gastric contents during general anaesthesia
- Non-invasive BP cuffs may be unreliable
- High dependency and/or intensive care may be needed
- Need for extra resources (staffing and equipment)

Day Assessment Unit / Admission to hospital in the antenatal Period

Monitoring of the fetal heart in the antenatal period

- Pre term labour
    - Individualised plan of care
    - If unable to monitor fetal heart continuously due to BMI with a CTG escalate

to the Registrar
- Registrar to discuss with Obstetric Consultant and plan to be discussed and documented in the maternal clinical record

- Assessment in DAU and over 24 weeks
  - 24 – 27+7 Record fetal heart with pinnard/sonic-aid
  - If 28+ weeks and CTG is required and you are unable to do a CTG due to BMI escalate to the Registrar
  - Registrar to discuss with Obstetric Consultant and plan to be discussed and documented in the maternal clinical record

6.2.3 Antenatal risks due to raised BMI

- Gestational diabetes
- Hypertension, pre-eclampsia
- Macrosomia or IUGR
- Sleep apnoea
- Undiagnosed fetal anomaly due to difficult ultrasound examination

6.3 Intrapartum

Women / pregnant people with a raised BMI ≥30 in an otherwise uncomplicated pregnancy does not have to have continuous fetal monitoring
Women / pregnant people with a BMI ≥40:

- Are at significantly higher risk of operative delivery and such operative deliveries carry an increased obstetric and anaesthetic risk
- If in labour, an IV cannula should be inserted early in labour and a group and save and FBC taken
- There is no specific requirement for continuous electronic fetal monitoring in an otherwise uncomplicated pregnancy
- If there are indications for continuous monitoring a fetal scalp electrode should be considered
- Presentation of the fetus should be checked with the portable labour ward scanner
- There is an increased risk of shoulder dystocia
- Midcavity instrumental delivery should be discussed with the consultant before being attempted
- Waterbirth is contraindicated

If an obese woman is going to be induced, staff should aim for these women / pregnant people to deliver in normal working hours when a full complement of staff (including consultant anaesthetists) are present in the hospital.

Intrapartum risks due to raised BMI

- Failure to progress in labour
- Shoulder dystocia
- Difficulties monitoring the fetal heart
- Difficulties with labour analgesia
- Emergency caesarean section Technically difficult surgery with associated increased morbidity and mortality

6.4 Postpartum

Oxytocin infusion should be considered once the placenta is delivered for women / pregnant people with a BMI >35 to anticipate post-partum haemorrhage. The following should be prescribed and administered; Oxytocin infusion 40units Sodium Chloride 0.9% 500ml over 4 hours.

All women / pregnant people re-assess for postnatal thromboprophylaxis after the delivery

Offer referral to OYES adult weight management programme. Encourage breastfeeding and advise women **/ birth parent** that losing weight by eating healthily and taking regular exercise will not affect the quantity or quality of their milk. (NICE 2010)

Advise that 10 micrograms of vitamin D per day for pregnant and lactating women / pregnant people / birth parent and population groups at increased risk of vitamin D deficiency.

Postpartum risks due to raised BMI

- Wound infections post-operative delivery
- Thromboembolic events
- Postnatal depression

6.5 Occupational Health and Safety issues

- Safe working Load of equipment is stated on the equipment
- Elective caesarean section women **/ birth parent** are encouraged to walk to theatre wherever possible.
- Women **/ birth parent** with a BMI>30 should have a blue canvas slide sheet inserted on their labour ward bed on admission in labour or prior to any intervention
- Maximum weight equipment can tolerate:
    - Main theatre operating table 200kg
    - Labour ward bed 180kg
- A high weight tolerance critical care/bariatric bed should be requested for any woman weighing more than 160kg through the EME equipment library
- Large patient gowns should be made available to maintain the woman's dignity
- Large BP cuffs are available throughout the care the woman receives, to ensure accurate readings.
- Patient Lifting equipment is available: refer to the ***Moving and Handling Policy*** http://eshealthcare/guideline/361.pdf

6.6 Home Environment delivery

If the mother intends to deliver in the home environment a risk assessment should be carried out and documented in the maternal clinical record. Ensuring the risks to the mother and the attending midwives are reviewed.

The midwife continues to have a duty of care for women **/ birth parent** that decide to deliver at home even if hospital birth is advised.

The community midwife should develop an action plan which may need to involve other agencies.

The maternity service manager should be informed
The woman's named Consultant obstetrician should be informed of her intention to deliver at home.

6.7 Moving and handling

Refer to the ***Moving and Handling Policy***

6.8 Maternity Pressure Ulcer Risk Assessment

Refer to ***Guidelines for the Prevention of Pressure Ulcers***

The Modified from Plymouth Maternity Pressure Sore Risk Assessment Tool 2012 must be completed when in labour every 2 hours from the initial assessment (***Guideline for the Prevention of Pressures Ulcers*** appendix 3, page 32)

7 Special Considerations

When using this guideline refer to the following:

- ***Moving and Handling Policy***
- ***Guidelines for the Prevention of Pressure Ulcers***
- ***Clinical Guideline for Thromboprophylaxis and Treatment of Venous Thromboembolism in Maternity***

8 Evidence Base/References

'NHS Screening Programmes Service Specification No 16 NHS Fetal Anomaly Screening Programme - Screening for Down's, Edwards' and Patau's Syndromes (Trisomy 21, 18 and 13), Public Health England and NHS England Public Health Commissioning, April 2017.

National Institute for Health and Clinical Excellence (NICE). 2006. Updated 2015. *Obesity. Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children.* London: National Institute for Health and Clinical Excellence.

National Institute for Health and Clinical Excellence (NICE). 2021. *Antenatal care: Routine care for healthy pregnant women.* London: NICE

National Institute for Health and Clinical Excellence (NICE). 2015. *Nutrition: improving maternal and child nutrition.* London: NICE

National Institute for Health and Clinical Excellence (NICE). 2010. *PH27 Weight management before, during and after pregnancy.* London: NICE

Royal College of Obstetrics and Gynaecologists & Centre for Maternal and Child Enquires. 2010. *Management of Women with Obesity in Pregnancy*. London: RCOG

Royal College Obstetrician Gynaecologist (RCOG) 2015. *Guideline No. 37a Reducing the risk of Thrombosis and Embolism during Pregnancy and the Puerperium.* London: RCOG.

National Institute for Health and Clinical Excellence (NICE). 2014 *Vitamin D: supplement use in specific population groups Public health guideline*. London. www.nice.org.uk/guidance/ph56

9 Competencies and Training Requirements

Refer to the maternity training needs analysis.

10 Monitoring Arrangements

Document Monitoring Table

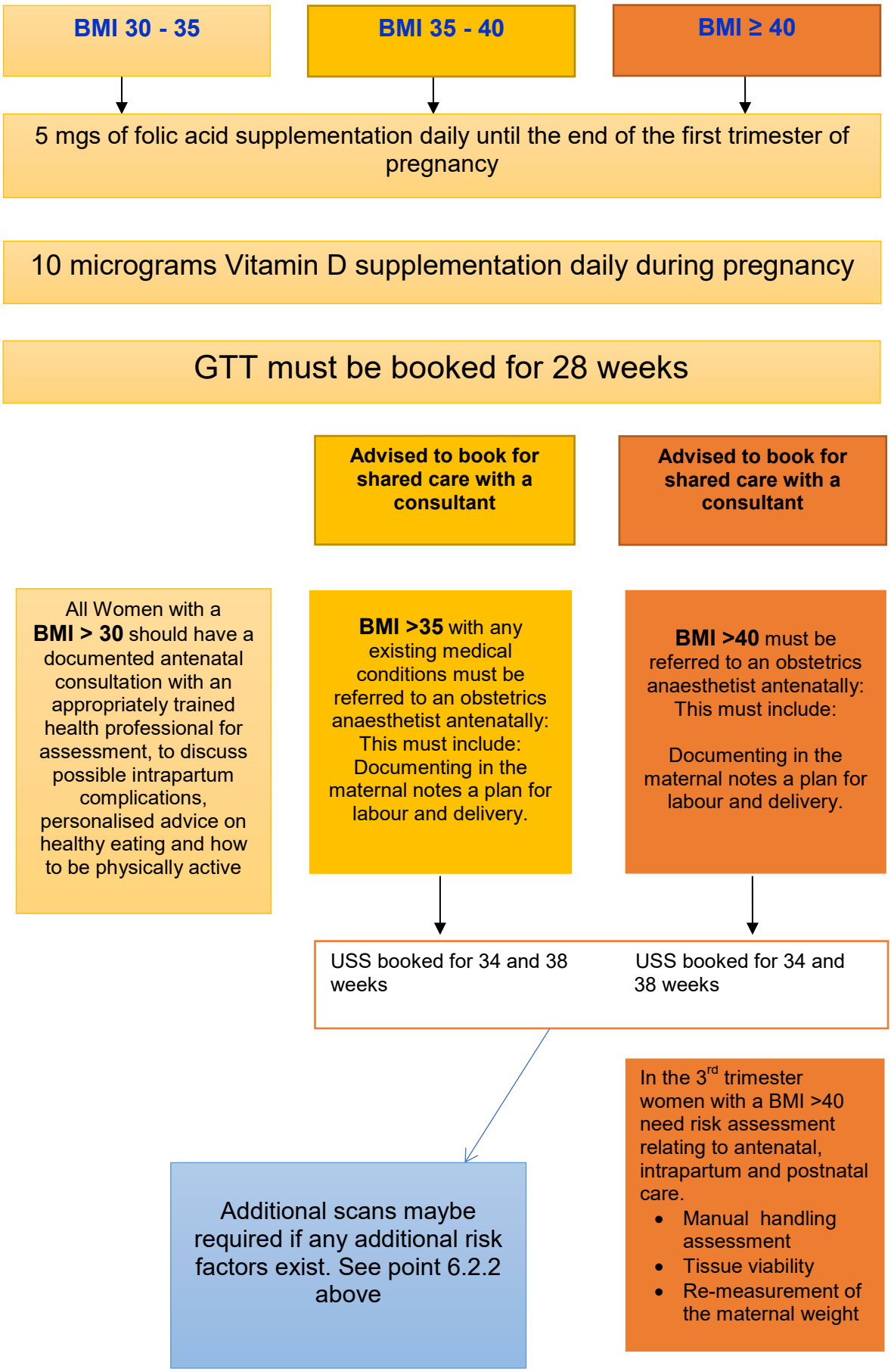
Element to be Monitored	Lead	Tool for Monitoring	Frequency	Responsible Individual/Group/ Committee for review of results/report	Responsible individual/ group/ committee for acting on recommendations/action plan	Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented
BMI has been calculated at booking and documented in the maternal clinical record	Consultant audit lead	Audit	Every 3 years Or 6-9 months after a practice change.	Obstetrics and Gynaecology audit meetings and any other appropriate meetings	Deputy Heads of Midwifery Midwifery matrons Clinical unit Obstetrics lead	Consultant Obstetrician Audit lead
Was the BMI recorded electronically	Consultant audit lead	Audit	Every 3 years Or 6-9 months after a practice change.	Obstetrics and Gynaecology audit meetings and any other appropriate meetings	Deputy Heads of Midwifery Midwifery matrons Clinical unit Obstetrics lead	Consultant Obstetrician Audit lead
Women with a BMI > 30 have been advised to take Folic Acid 5 mgs and vit D 10 mcg	Consultant audit lead	Audit	Every 3 years Or 6-9 months after a practice change.	Obstetrics and Gynaecology audit meetings and any other appropriate meetings	Deputy Heads of Midwifery Midwifery matrons Clinical unit Obstetrics lead	Consultant Obstetrician Audit lead
Women with a BMI > 35 have been referred for shared care	Consultant audit lead	Audit	Every 3 years Or 6-9 months after a practice change.	Obstetrics and Gynaecology audit meetings and any other appropriate meetings	Deputy Heads of Midwifery Midwifery matrons Clinical unit Obstetrics lead	Consultant Obstetrician Audit lead
Women with a BMI > 40 or BMI> 35 with	Consultant audit lead	Audit	Every 3 years Or 6-9 months	Obstetrics and Gynaecology audit meetings and any	Deputy Heads of Midwifery Midwifery matrons Clinical unit Obstetrics lead	Consultant Obstetrician Audit lead

co-existing medical conditions were referred to an obstetric anaesthetist antenatal			after a practice change.	other appropriate meetings		
Ultrasound scan at 34 and 38 weeks for BMI over 35	Consultant audit lead	Audit	Every 3 years Or 6-9 months after a practice change.	Obstetrics and Gynaecology audit meetings and any other appropriate meetings	Deputy Heads of Midwifery Midwifery matrons Clinical unit Obstetrics lead	Consultant Obstetrician Audit lead
Women with a BMI >40 had a risk assessment carried out in the 3rd trimester	Lead Consultant audit lead	Audit	Every 3 years Or 6-9 months after a practice change.	Obstetrics and Gynaecology audit meetings and any other appropriate meetings	Deputy Heads of Midwifery Midwifery matrons Clinical unit Obstetrics lead	Consultant Obstetrician Audit lead
Women with a BMI >40 had their weight recalculated in the 3rd trimester	Consultant audit lead	Audit	Every 3 years Or 6-9 months after a practice change.	Obstetrics and Gynaecology audit meetings and any other appropriate meetings	Deputy Heads of Midwifery Midwifery matrons Clinical unit Obstetrics lead	Consultant Obstetrician Audit lead
Women with a BMI over 40 are seen antenatally by an Anaesthetist	Consultant audit lead	Audit	Every 3 years Or 6-9 months after a practice change.	Obstetrics and Gynaecology audit meetings and any other appropriate meetings	Deputy Heads of Midwifery Midwifery matrons Clinical unit Obstetrics lead	Consultant Obstetrician Audit lead

11 Equality and Human Rights Statement

An Equality and Human Rights Analysis Form has been completed for this document.

Appendix A - BMI pathway



Appendix B – EIA Form

A Due Regard, Equality & Human Rights Analysis form must be completed for all procedural documents used by East Sussex Healthcare NHS Trust. Guidance for the form can be found here on the Equality and Diversity Extranet page.

Equality Impact Assessment Form

1. Cover Sheet

Please refer to the accompanying guidance document when completing this form.

Strategy, policy or service name	Clinical Guideline for the Management of the Obese Pregnant Woman
Date of completion	September 2021
Name of the person(s) completing this form	Click here to enter text.
Brief description of the aims of the Strategy/ Policy/ Service	This guideline is intended to inform the practice of all clinical maternity staff and medical staff involved in providing care to the pregnant woman with a raised BMI.
Which Department owns the strategy/ policy/ function	Women and Childrens
Version number	V3
Pre Equality analysis considerations	Click here to enter text.
Who will be affected by this work? **E.g. staff, patients, service users, partner organisations etc.**	Women requiring additional monitoring and care during pregnancy
Review date	Click here to enter text.
If negative impacts have been identified that you need support mitigating please escalate to the appropriate leader in your directorate and contact the EDHR team for further discussion.	To whom has this been escalated? Name: Click here to enter text. Date: Click here to enter a date.

Have you sent the final copy to the EDHR Team?	Choose an item.

2. EIA Analysis

<table>
<tr><td></td><td>☺ 😐 ☹</td><td>Evidence:</td></tr>
<tr><td>Will the proposal impact the safety of patients', carers' visitors and/or staff?

Safe: Protected from abuse and avoidable harm.</td><td>Choose:
Negative</td><td>Click here to enter text.</td></tr>
<tr><td>Equality Consideration
Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td>Choose:
Negative</td><td>
<table>
<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
<tr><td>Gender reassign ment</td><td>Marriage & Civil Partnership</td><td>Religion and faith</td><td>Maternity & Pregnancy</td><td>Social economic</td></tr>
<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
</table>
</td></tr>
<tr><td>Is the proposal of change effective?

Effective: Peoples care, treatment and support achieves good outcomes, That staff are enabled to work in an inclusive environment. That the changes are made on the best available evidence for all involved with due regards across all 9 protected Characteristics</td><td></td><td>Click here to enter text.</td></tr>
</table>

Equality Consideration *Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)*		**Race** ☐ **Gender** ☐ **Sexual orientation** ☐ **Age** ☐ **Disability & carers** ☐ **Gender reassignment** ☐ **Marriage & Civil Partnership** ☐ **Religion and faith** ☐ **Maternity & Pregnancy** ☐ **Social economic** ☐
What impact will this have on people receiving a positive experience of care?	Choose: Negative	Click here to enter text.
Equality Consideration *Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)*		**Race** ☐ **Gender** ☐ **Sexual orientation** ☐ **Age** ☐ **Disability & carers** ☐ **Gender reassignment** ☐ **Marriage & Civil Partnership** ☐ **Religion and faith** ☐ **Maternity & Pregnancy** ☐ **Social economic** ☐
Does the proposal impact on the responsiveness to people's needs?	Choose: Negative	
Equality Consideration *Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)*		**Race** ☐ **Gender** ☐ **Sexual orientation** ☐ **Age** ☐ **Disability & carers** ☐ **Gender reassignment** ☐ **Marriage & Civil Partnership** ☐ **Religion and faith** ☐ **Maternity & Pregnancy** ☐ **Social economic** ☐
What considerations have been put in place to consider the organisations approach on improving equality and diversity in the workforce and leadership?	Choose: Positive Neutral Negative	Click here to enter text.

Equality Consideration *Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)*		<table><tr><td>**Race**</td><td>**Gender**</td><td>**Sexual orientation**</td><td>**Age**</td><td>**Disability & carers**</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr><tr><td>**Gender reassign ment**</td><td>**Marriage & Civil Partnership**</td><td>**Religion and faith**</td><td>**Maternity & Pregnancy**</td><td>**Social economic**</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr></table>
Access Could the proposal impact positively or negatively on any of the following:		
• Patient Choice	Choose: Positive Neutral Negative	
• Access	Choose: Positive Neutral Negative	
• Integration	Choose: Positive Neutral Negative	
Equality Consideration *Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)*		<table><tr><td>**Race**</td><td>**Gender**</td><td>**Sexual orientation**</td><td>**Age**</td><td>**Disability & carers**</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr><tr><td>**Gender reassign ment**</td><td>**Marriage & Civil Partnership**</td><td>**Religion and faith**</td><td>**Maternity & Pregnancy**</td><td>**Social economic**</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr></table>

Engagement and Involvement How have you made sure that the views of stakeholders, including people likely to face exclusion have been influential in the development of the strategy / policy / service:	Choose: Positive Neutral Negative	
Equality Consideration *Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)*		**Race** ☐ **Gender** ☐ **Sexual orientation** ☐ **Age** ☐ **Disability & carers** ☐ **Gender reassignment** ☐ **Marriage & Civil Partnership** ☐ **Religion and faith** ☐ **Maternity & Pregnancy** ☐ **Social economic** ☐
Duty of Equality Use the space below to provide more detail where you have identified how your proposal of change will impact.	Choose: Positive Neutral Negative	
Characteristic	**Rating** ☺ ☹ 😐	**Description**
Race	Choose: Positive	
Age	Choose: Positive	
Disability and Carers	Choose: Positive	

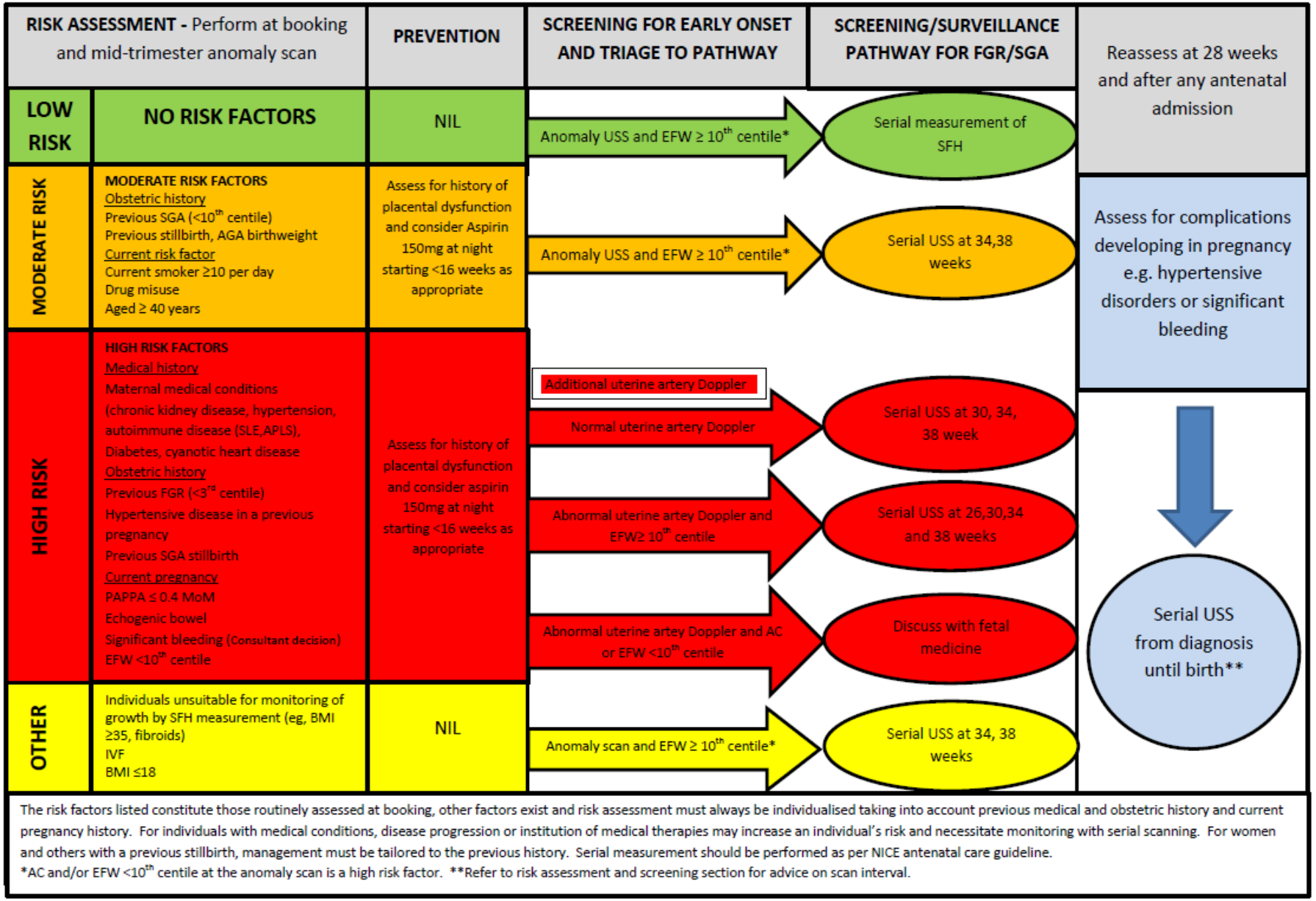
Religion or belief	Choose: Positive	
Sex	Choose: Positive	
Sexual orientation	Choose: Positive	
Gender re-assignment	Choose: Positive	
Pregnancy and maternity	Choose: Positive	
Marriage and civil partnership	Choose: Positive	

Human Rights

Please look at the table below to consider if your proposal of change may potentially conflict with the Human Right Act 1998

Articles		Y/N
A2	Right to life	**Y/N**
A3	Prohibition of torture, inhuman or degrading treatment	**Y/N**
A4	Prohibition of slavery and forced labour	**Y/N**
A5	Right to liberty and security	**Y/N**
A6 &7	Rights to a fair trial; and no punishment without law	**Y/N**
A8	Right to respect for private and family life, home and correspondence	**Y/N**
A9	Freedom of thought, conscience and religion	**Y/N**
A10	Freedom of expression	**Y/N**
A11	Freedom of assembly and association	**Y/N**
A12	Right to marry and found a family	**Y/N**
Protocols		
P1.A1	Protection of property	**Y/N**
P1.A2	Right to education	**Y/N**
P1.A3	Right to free elections	**Y/N**

Appendix C
Scanning Algorithm



The risk factors listed constitute those routinely assessed at booking, other factors exist and risk assessment must always be individualised taking into account previous medical and obstetric history and current pregnancy history. For individuals with medical conditions, disease progression or institution of medical therapies may increase an individual's risk and necessitate monitoring with serial scanning. For women and others with a previous stillbirth, management must be tailored to the previous history. Serial measurement should be performed as per NICE antenatal care guideline.
*AC and/or EFW <10th centile at the anomaly scan is a high risk factor. **Refer to risk assessment and screening section for advice on scan interval.

East Sussex Healthcare NHS Trust

Clinical Guideline for Induction and Augmentation of Labour

Document ID Number	395
Version:	V5.1
Ratified by:	Women and Children's Governance and Accountability
Date ratified:	November 2019
Name of author and title:	Jo Sinclair Locum Consultant Obstetrician Cathy O'Callaghan Specialist Midwife Practice Development Dexter Pascall Consultant Obstetrician Mini Nair Consultant Obstetrician
Date Originally Written:	January 2003
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Target audience:	All Staff
Compliance with CQC outcome	Regulation 9 Person centred Care Regulation 10 Dignity and Respect Regulation 11 Need for Consent Regulation 12 Safe Care and Treatment Regulation 15 Premises and Equipment Regulation 18 Staffing Regulation 19 Fit and Proper Persons Employed
Compliance with any other external requirements (e.g. Information Governance)	NICE

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Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V1 2003050 (Augmentation of Labour)	January 2003		New Guideline	
V2 2004107 (Augmentation of Labour)	October 2004	[redacted] & [redacted]		
V3 2005217 (Augmentation of Labour)	October 2005	[redacted] & [redacted]	Clinical Update	
V3 2008232	October 2008	Gayle Clarke	Clinical Update	
V4 2009205	October 2009	Gayle Clarke	Clinical Update	
V4.1 2012325	December 2012	Cathy O'Callaghan Dexter Pascall	Clinical Update	
V4.2 2014020	January 2014	Cathy O'Callaghan Dexter Pascall	Clinical Update	Small change to page 5, section 6.2
V4.3 2016038	September 2015	Jo Sinclair	Practice Changes	Inclusion of outpatient Induction of Labour
V5 2016182	August 2016	Jo Sinclair, Cathy O'Callaghan, Dexter Pascall	Review and update	
V5.1	September 2019	Mini Nair – [redacted]	Review and update	Some CTG use updates, who can administer the Cooks Balloon and IOL proforma added

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
Clinical Directorate Team		Jan 2003
Professional Midwifery Forum		Sept 2004
Obstetrics and Gynaecology Directorate		Oct 2004
Guideline Implementation Group.		2004 Oct 2008 Sept 2009
Strategic Business group Women's Health Operational meeting.		Sept 2009
Guideline Implementation Group	Obstetrics and Gynaecology	October 2012
Clinical Unit – Integrated Division	Obstetrics and Gynaecology	November 2012
Guideline Implementation Group	Obstetrics and Gynaecology	July 2014
Clinical Unit – Integrated Division	Obstetrics and Gynaecology	July 2014
Guideline Implementation Group	Obstetrics and Gynaecology	September 2015
Clinical Unit – Integrated Division	Obstetrics and Gynaecology	September 2015
Women and Children's Guideline Implementation group		November 2019
Women and Children's Governance and Accountability		November 2019

This information may be made available in alternative languages and formats, such as large print, upon request. Please contact the document author to discuss.

Table of Contents

1. Introduction

Induction of Labour (IOL) is an intervention to initiate the process of labour by artificial means. In the National Health Service (NHS) in England the IOL rate is 20%. It has been slowly rising since 1993 and has become an intervention that is common practice in maternity units within the NHS (DH 2006).

2. Rationale

To provide guidance for clinical staff on the management of Induction and augmentation of Labour
IOL constitutes an intervention in pregnancy and the decision for such an intervention must be made by a Consultant or experienced Middle Grade doctors, other than routine T+12 inductions.
IOL is only justified when there is greater benefit to the health of the mother and/or baby than if the pregnancy continues.

3. Scope

This document applies to all staff caring for women within the maternity services at East Sussex Healthcare Trust.

4. Definitions used in this guideline

Induction of Labour (IOL)

Intervention to stimulate uterine contractions and cervical dilatation before the onset of spontaneous labour.

Augmentation of Labour

Either:

1) Intervention to stimulate uterine contractions and cervical dilatation before the onset of spontaneous labour, when there is prelabour rupture of membranes (PROM)

or

2) the use of the hormone oxytocin to correct slow progress in labour

Bishop's Score

A scoring system, calculated during vaginal examination at the commencement of the IOL process, used to assess suitability of the cervix for IOL and to identify correct method of IOL. (***see Appendix A*** for guidance on calculation of Bishops score).

Membrane Sweep

Sweeping of the membranes by separating the membranes from their cervical attachment by introducing the examining fingers into the cervical os and passing them circumferentially around the cervix.

Artificial rupture of membranes (ARM)

Deliberate breaking of the membranes with an Amnihook. This may be performed as part of the IOL process prior to the use of Oxytocin, or as an intervention in the context of slow progress in labour.

Cardiotocography (CTG)

The continuous recording of the fetal heart rate and contractions by a machine, rather than by intermittent auscultation. The term CTG is synonymous with electronic fetal monitoring.

Uterine Hyperstimulation

Excessive uterine activity, which may present as more than 5 contractions in 10 minutes (tachysystole) or individual contractions lasting more than 2 minutes (hypertonus). Hyperstimulation may occur with or without fetal heart rate abnormalities on CTG (NICE 2008)

5. Accountabilities

5.1. Midwives & Obstetricians

- To access, read, understand and follow this guidance
- To use their professional judgement in application of this guideline

5.2. Management

- To ensure the guideline is reviewed as required in line with the Trust and National guidelines
- To ensure the guideline is accessible to all relevant staff
- To monitor the audit process

6. Process

6.1. Guidelines of care

Indications for IOL or augmentation:

- Prolonged pregnancy
- Pregnancy complications
- Prelabour rupture of membranes (augmentation)

Women should be able to make informed choices regarding their care or treatment using evidenced based information

An information leaflet for pregnant women and their partners is available either as a paper copy or on the maternity website and should be used and discussed with the woman to inform decision making and care planning.

Prior to IOL the expected date of delivery must be confirmed and the last ultra sound scan checked for any history of low lying placenta.

An induction of labour pro-forma should be commenced when the decision is made for induction of labour, including assessment of Bishops score, prescription for Propess and required analgesia.

The advantages and disadvantages of inducing labour with Prostaglandins or Oxytocin and/or augmentation should be discussed with the woman.

6.2. Authorisation of IOL

All IOLs should be authorised by a consultant, apart from those where the indication is for prolonged pregnancy at 41+5 weeks as defined below.

6.3. Prolonged Pregnancy

Women who are otherwise low risk and have no antenatal complications should be offered IOL if their pregnancy extends beyond 41 weeks (NICE 2008). This may be booked by the community midwife for a date at 41+5 weeks. If they are primigravid then these women should be offered the option of outpatient IOL (see section 6.11 below).

Prior to formal IOL women should be offered information about the risks associated with pregnancies that last longer than 42 weeks, and their options.

Midwives should discuss membrane sweeping with the woman:

Offer membrane sweeps:

- To nulliparous women at 40 week antenatal visit
- To all women at 41 week antenatal visit

The woman should be informed:

- What a membrane sweep is
- Discomfort and vaginal bleeding are possible from the procedure
- Membrane sweeping makes spontaneous labour more likely, therefore reduces the need for IOL
- That membrane sweeping is not associated with an increase in maternal or neonatal infection

Women over 42^{+0} weeks gestation, who choose not to be induced, should be offered the following:

- Increased antenatal monitoring consisting of a twice weekly CTG
- Ultrasound estimation of maximum amniotic pool depth
- On-going care to be discussed and planned with a Consultant

The indications, implications and method of IOL should be discussed with the woman. All women should be offered an IOL information leaflet at the time of booking IOL.

For all women, the indication for induction, the person authorising the induction and any specific management plan must be clearly documented in the woman's handheld maternity notes.

6.4. Pregnancy Complications

The clinical decision regarding timing and method of IOL should be taken at consultant level in conjunction with the woman.

Women with high risk pregnancies (for example small for gestational age fetus, previous Caesarean section or pre-eclampsia) should have an individual assessment by a consultant obstetrician. This assessment should include making a plan of care based on her wishes and the risks and benefits to her and her baby.

The consultant plan will indicate timing and location of the induction process.
IOL for these women may be offered prior to their estimated date for delivery.

6.5. Maternal request for IOL

This can only be decided by a consultant and a plan documented in the woman's handheld maternity notes.

Maternal request for IOL may be considered when there are compelling psychological or social reasons and the woman has a favourable cervix (modified Bishops score >8)

The woman must be advised of the risks of IOL.

6.6. Methods of IOL

- Prostaglandins (Propess) inserted into the posterior fornix of the vagina
- Insertion of the Cook's balloon
- ARM alone
- ARM plus Oxytocin infusion

The decision regarding the method of induction will depend upon the following:

- Gestation
- If the woman's pregnancy is high / low risk
- Modified Bishop's score (see Appendix A)
- The woman's preferences
- Contraindications to individual methods of induction

The methods of induction can be used individually or in combination.

For women with a Bishop's score ≥ 6 or a cervical dilatation of ≥ 2cm, the use of Propess or the balloon is not required and the woman can be transferred directly to the delivery suite for an ARM +/- commencement of Oxytocin after 2 hours. Occasionally it may be desirable to avoid waiting for 2 hours, for example in the presence of meconium, in which case the product literature advises that Oxytocin can be used after half hour of removal of Propess (see Appendix A for Oxytocin infusion regimen).

Oxytocin should never be used in the presence of intact membranes – all women with intact membranes should have an ARM prior to commencement of Oxytocin.

If there is pre-labour rupture of membranes > 37 weeks gestation, Propess may be inserted for 6 hours only prior to the use of Oxytocin (see section 6.8).

All women being induced must be reviewed by the middle grade or consultant obstetrician prior to IOL being commenced.

Consider location of IOL if the woman is high risk, or staffing constraints dictates that it is safer to care for the woman on labour ward. Discuss with labour ward co-ordinator and the middle grade/consultant.

6.7. Assessment of the cervix

Assess the cervix with the use of the modified Bishop's score.

6.8. Women with pre-labour rupture of membranes

The evidence suggests that the use of prostaglandins in this situation does not make a difference to outcome but may decrease patient satisfaction due to a longer perceived labour.

Either prostaglandins or Oxytocin may be used initially. After discussion with the middle grade or consultant obstetrician on call, a woman with prelabour rupture of membranes over 37 weeks gestation may receive a Propess pessary which can be removed 6 hours following insertion.. The woman can then be transferred to the delivery suite for commencement of Oxytocin after 2 hours. Occasionally it may be desirable to avoid waiting for 2 hours, for example in the presence of meconium, in which case the product literature advises that Oxytocin can be used half an hour after removal of Propess (see Appendix A for Oxytocin infusion regimen).

If Propess is used it should be inserted at the time of initial vaginal assessment in order to avoid repeated vaginal examinations and reduce the risk of infection.

A plan of management should be documented and in place by the middle grade or consultant prior to the Propess insertion.

6.9. IOL for the small-for-gestational-age fetus

If there is severe fetal growth restriction with confirmed fetal compromise, induction of labour is not recommended (NICE 2008). The decision to induce a small-for-gestational-age fetus should be a consultant only decision.

Confirmation of fetal wellbeing prior to and subsequent to insertion of the Propess or Balloon is required using CTG.

Continuous CTG is necessary as soon as contractions commence and for the duration of the labour process.

6.10 Propess for IOL

This product can be used for all indications for IOL. An advantage for high risk inductions is that it can be removed easily and quickly in cases where there is fetal or maternal compromise.

All high risk pregnancies being induced must be reviewed by middle grade or consultant obstetrician prior to IOL being commenced.

In the following situations Propess should only be used if authorised by a consultant:

- Uterine scar
- Cardiac, pulmonary, renal or hepatic disease
- Para 3 or greater.
- Multiple pregnancies
- Severe IUGR
- Severe asthma is a relative contraindication to prostaglandin administration and therefore the decision to use it must be made by the senior obstetrician

Prostaglandins are not licensed for use with uterine scar therefore informed consent needs to be from the woman and documented clearly before using Propess in this situation.

Propess is licensed for use in PROM.

6.11 Induction of labour with Cooks cervical ripening Balloon

Cooks cervical ripening Balloon is a double balloon transcervical catheter. It is inserted vaginally and the two balloons which are positioned above and below the cervix and filled with fluid. The aim of mechanical interventions is to ripen and dilate the cervix and promote onset of labour by applying pressure on the internal cervical os, by indirectly increasing local secretion of prostaglandin and oxytocin, or both. Also, mechanisms that involve neuroendocrine reflexes may promote the onset of uterine contractions.

6.11.1 Indications for use of the Cooks cervical ripening Balloon

The Cooks balloon can be used for induction of labour for pregnant women, primigravida as well as multip after being seen in the consultants clinic where a decision will be made with the woman on method of Induction and if she fits the criteria for the Cooks balloon, this includes situations of failed induction with propess (decision to be made on the ward with a consultant), except in the following situations-

• Women who have had previous LSCS or other uterine incision, unless with management plan documented by a Consultant Obstetrician.
• Membranes are ruptured
• All other indications where induction of labour, labour or vaginal delivery are contraindicated.

Consider use of the Balloon in induction of high risk pregnancies with SGA, pre-eclampsia, diabetes and in grandmultips.

6.11.2 Procedure

Balloon insertion can be performed at any time and women who are for cooks balloon IOL can also come in at the usual induction admission time.
Record baseline maternal observations on the MEOW's chart.
Examine patient to confirm longitudinal lie, cephalic presentation and perform pre-assessment CTG (30 minutes).

The Doctor will then perform a vaginal examination to assess that membranes are intact and to calculate Bishop Score.

If Bishop Score < 6, they will insert the Balloon. Observe with CTG for 30 minutes following procedure.

6.11.3 Process for insertion of cervical ripening balloon

This procedure is performed by Obstetricians and specifically trained midwives at the Consultant led unit in Hastings Only.

Take verbal consent for the procedure.
Use a catheter pack, to clean vulval area with water.
Perform a vaginal examination.
Introduce the catheter with the stylus into the vagina and locate the position of the cervix.
Place the tip of the catheter through the external os into the cervical canal and once in place remove stylus.
Advance the catheter through the cervix until both the balloons have entered the cervical canal and passed the internal os.

Alternatively insert a Cusco speculum to visualise the cervix. Using a Rampley's sponge holder advance the catheter through the cervix until both the balloons have entered the cervical canal and passed the internal os.
Inflate the uterine balloon with 40mls of 0.9%Sodium Chloride or sterile water, through the **red** Check-Flo valve (marked U) using a standard 20ml luer- lock syringe.

Once the uterine balloon is inflated, pull back until the balloon is against the internal os.
The vaginal balloon should now be felt outside the external cervical os.
Inflate the vaginal balloon with 20ml of 0.9% Sodium Chloride through the **green** Check-Flo valve (marked V).

Once the balloons are situated on each side of the cervix, add more 0.9% Normal Saline (slowly in 20mls increments) until each balloon contains 80mls maximum) – this is to ensure that the balloons are placed correctly and to ensure the woman's comfort.

6.11.4 Following insertion

Document the amount of fluid inserted in each balloon.

Advise the woman to inform the midwife if: SROM, Contractions, Vaginal Bleeding, or cervical balloon/catheter falls out.

6.11.5 Assessment on the following morning.

SROM:
If membranes rupture spontaneously whilst the balloon is in situ the device should be removed as below

- Check presentation,
- mobilise for two hours,
- then if not contracting start Oxytocin as per protocol.

Labour:
If labour commences following insertion - remove the balloon (as per page 9) and manage as per labour guideline

6.11.6 Spontaneous expulsion

If the balloon falls out spontaneously the cervix should be favourable for ARM
Assess the cervix to confirm it is favourable for ARM, check presentation and then contact labour ward to continue the induction process

6.11.7 Next day 9-11am

- Record maternal observations & CTG.
- Remove balloon (if not fallen out) by deflating both balloons through the corresponding valves marked **u** and **v**.
- Assess if favourable for ARM, check presentation, mobilise and for 2 hours,
- If favourable for ARM, inform labour ward. If not favourable, discuss management with senior medical staff & document in antenatal care plan.

6.11.8 Removal of cervical balloon:

- This should occur after a minimum duration of 12 hours, or a maximum of 24 hours). If the balloon is still in position.
- Perform a VE to assess suitability for ARM check presentation, mobilise for 2 hours, and then contact labour ward to continue the induction process
- If no spontaneous rupture of membranes ARM should be performed on labour ward at earliest opportunity, dependent on workload.

6.12 Location of IOL – inpatient vs outpatient

Low risk women requiring routine post-dates IOL who are primigravid should be offered outpatient IOL, where they will attend the Conquest unit to have Propess inserted and then go home for 24 hours to await events.

The initial assessment and insertion of Propess will only be performed in the Conquest Hospital, regardless of whether the woman lives in Eastbourne or Hastings. It should be explained to women who live in Eastbourne that once the outpatient IOL process is commenced, all further attendances and intra-partum care will be at the Conquest site. It should also be mentioned that the outpatient IOL process carries a risk of birth before arrival (BBA), particularly if the woman lives further away from the hospital.

In order to be suitable for outpatient IOL, the woman must meet the following criteria:

- under midwifery-led care during the pregnancy
- aged 18-39
- primigravid
- BMI 18-34
- gestational age of 41^{+0} – 41^{+6}

All other women will be required to have IOL as an inpatient.

If a woman who is suitable for outpatient IOL prefers to remain an inpatient after receiving Propess, she should be supported in her decision.

6.13 Admission arrangements for IOL

All women for IOL (inpatient or outpatient) should attend Murray ward (the antenatal ward) at the Conquest Hospital as appointed, with their handheld maternity notes

6.14 Insertion of Propess

When women attend Murray for routine IOL for example post-dates the propess and the plan should be prescribed and in place, then after a full examination by the midwife which should include a conscious check of the presentation and any newly identified risk factors then the midwife can progress to assessing the wellbeing of the woman and the fetus and proceed to giving the propess only if still appropriate and required.

If there are any concerns clinically or with the plan that is documented then the midwife should discuss the case with the Middle Grade / or consultant how to proceed and ensure any discussions have taken place with labour ward as to any high risk inductions and the place of induction if any concerns.

If the woman attends Murray for IOL with no plan or propess prescribed then they will need to be reviewed by the Middle Grade / or consultant prior to commencing the IOL.

In the case of outpatient IOL, the obstetrician will review the notes and the woman to ensure that the woman is suitable for the outpatient IOL process. This will help to avoid an unsuitable outpatient IOL taking place, for example a breech or small-for-gestational-age fetus,

The Midwife will perform a full antenatal examination. He/she should ensure that Propess is prescribed.

The midwife will record maternal observation of temperature, pulse, blood pressure and urinalysis, perform an antenatal assessment and perform a CTG for a minimum 30 minutes on a standard CTG monitor or if using the Dawes Redman the CTG can be stopped if it has met criteria and the midwife is happy with the CTG.

If the antenatal risk assessment has not identified any concerns and the CTG is NORMAL or Dawes Redman criteria is met, a vaginal examination should be performed and cervical assessment made prior to the insertion of the Propess pessary (***see Appendix A for guidance on calculation of Bishops score***).

If the CTG has any abnormal features the middle grade on call must review the CTG prior to proceeding with the Induction and inform the labour ward co-ordinator

Women should receive Propess if they have a Bishops score of < 6 and a cervical dilatation of < 2cm. For women with a Bishop's score ≥ 6 or a cervical dilatation of ≥ 2cm, the use of Propess is not required and the woman can be transferred directly to the delivery suite for an ARM and commencement of Oxytocin after 2 hours. Occasionally it may be desirable to avoid waiting for 2 hours, for example in the presence of meconium, in which case the product literature advises that Oxytocin can be used half an hour after removal of Propess (see Appendix A for Oxytocin infusion regimen).

The actual insertion of propess can be performed by either the obstetrician or the midwife, as long as the patient has been reviewed by the obstetrician.

Propess should be inserted into the posterior fornix of the vagina so that it lies transversely. The vaginal examination findings and time of insertion should be recorded in the notes.

6.15 Fetal and maternal surveillance immediately following insertion of Propess

Fetal wellbeing should be confirmed after insertion of Propess using continuous CTG for a minimum of 30 mins

If the CTG is NOT NORMAL, the findings must be escalated to the middle grade immediately at the same time as the labour ward co-ordinator, and an immediate plan of care devised and documented in the maternity handheld notes. NOTE: the expectation is that during this the CTG continues to monitor the fetal heart.

Maternal observations that should be carried out during the IOL process (prior to established labour) are:

- base line observations recorded on the Maternity Early Obstetric Warning Chart: temperature, blood pressure, pulse and respiration rate at time of commencement of IOL
- then daily observations unless clinical situation dictates more frequently
- daily urinalysis (recorded in pregnancy record)
- If high risk induction of labour or clinical situation dictates, refer to middle grade for an individualised plan for observations.

6.16 Care of the woman 0-24 hours following insertion of Propess

See Above for Fetal monitoring. If the CTG is normal, those women choosing outpatient IOL can go home and await events. They should arrange with Murray ward to attend for reassessment 24 hours after Propess insertion. The midwife providing care will ensure that prior to going home; all women have been given verbal and written information about outpatient IOL, with documentation of this in the handheld maternity notes. She should be sent home with four doses of co-codamol 30/500, or a suitable alternative if allergic to codeine. The woman should be asked to telephone the unit immediately if:

- SROM occurs
- the Propess falls out
- there is any vaginal bleeding
- she suspects there is hyperstimulation (based on the information provided to her)
- she has any concerns about fetal movements
- she thinks she is in established labour
- she is unable to cope at home

If a woman re-attends the unit for any of the above reasons prior to her booked 24 hour review, she should have a set of observations recorded (pulse, blood pressure, respiratory rate and urinalysis), a full antenatal assessment and a CTG commenced. She should then be discussed with the middle grade obstetrician.

Whether or not a woman is allowed to return home after assessment (if everything is found to be normal) will depend on the clinical situation. This will be decided by the obstetric middle grade or consultant on a case-by-case basis.

For inpatient IOL, the woman should be instructed to inform the midwife if:

- Contractions become regular (every 5 minutes or more frequent)
- She becomes uncomfortable with contractions

- She has bleeding
- Membranes rupture
- Propess falls out or drops lower in the vagina

Occasional undesirable effects of Propess include gastrointestinal effects such as nausea, vomiting and diarrhoea.

Maternal observations should be taken and a CTG recommenced if the woman reports any of the above symptoms. NOTE: Dawes Redman CTG is not suitable if you suspect the woman is in labour.

If contractions become strong and regular or if the woman requires further analgesia then a vaginal examination can be done with Propess in situ.

If the woman is not in labour do not remove the Propess. Commence CTG monitoring if identified risk factors

If labour is diagnosed i.e. the cervix is effaced, ≥ 4cm dilated and the woman is having strong and regular contractions then remove the Propess. The woman should be transferred to delivery suite for further management.

If the woman has no other risk factors and the indication for IOL is post-dates and enters established labour with the use of Propess alone then during active labour on the delivery suite the fetal heart can be intermittently auscultated as per NICE intrapartum care guidelines, provided that:

- The CTG remains normal for 30 mins post removal of Propess
  - The woman is not started on Oxytocin
- There are no fetal or maternal reasons requiring continuous CTG.

In all other situations continuous CTG monitoring is required.

If **SROM** occurs the Propess should be removed and preparation made for the woman to move to the delivery suite. If labour is not established 2 hours after SROM then Oxytocin should be commenced. Occasionally it may be desirable to avoid waiting for 2 hours, for example in the presence of meconium, in which case the product literature advises that Oxytocin can be used half an hour after removal of Propess (see Appendix A for Oxytocin infusion regimen).

In **high risk cases** at risk of fetal compromise e.g. small-for-gestational-age fetus, , oligohydramnios, pre-eclampsia and diabetes a VE may be performed 6 hourly, with the woman's consent, to assess if the membranes can be ruptured with a view to commencing Oxytocin 30 minutes after ARM. If regular contractions continue but ARM is not possible - leave the Propess in situ but continue with the continuous CTG.

If at any point the Propess pessary inadvertently **falls out**, provided it has remained clean (fallen into bed sheet), then the same Propess can be reinserted and used to the 24 hour limit.

If it is not possible to re-insert the Propess due to contamination, a new one may be inserted and used up to 24 hours after the insertion of the first Propess.

If the woman is having outpatient IOL, then once she has attended the unit and had a new Propess inserted, she can go home again and return as planned at the end of the 24 hours, as long as assessment indicates maternal and fetal wellbeing.

6.17 Management of Hyperstimulation

This has an incidence of 1-5% (NICE 2008).

Hyperstimulation is defined as excessive uterine activity, which may present as more than 5 contractions in 10 minutes (tachysystole) or individual contractions lasting more than 2 minutes (hypertonus). Hyperstimulation may occur with or without fetal heart rate abnormalities on CTG (NICE 2008).

If tachysystole or hypertonus is suspected, CTG monitoring should be commenced immediately. If the CTG is normal the middle grade obstetrician should be informed and the CTG should be continued until the hyperstimulation has resolved. Propess should not routinely be removed in the presence of uncomplicated tachysystole with a normal CTG.

If the CTG is suspicious/pathological the Propess should be removed and the middle grade obstetrician informed immediately. 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.

Subsequent management needs to be discussed with the consultant on call.

6.18 Removal of Propess

Propess is designed to remain in the vagina for up to 24 hours.
Propess should be removed immediately in the following instances:

- When labour is established (contractions at least 3 in10 minutes and cervical dilation of ≥4cm
- PV bleeding
- Uterine hyperstimulation with abnormal CTG (see section 6.16 for definition and management)
- Evidence of fetal compromise
- Evidence of maternal adverse prostaglandin effects
- At least 30 minutes prior to starting an intravenous infusion of oxytocin
- If rupture of membranes occurs subsequent to administration of Propess
- Following 24 hours, even if labour is not established

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

6.19 More than 24 hours following Propess insertion

After the first 24 hours, all women having outpatient IOL will be required to attend Murray ward in the Conquest Hospital and remain an inpatient for the rest of the IOL process. It is not appropriate for women to return home after insertion of a second Propess.

Remove the Propess 24 hours after insertion

Perform a CTG for at least 30 minutes

Perform a VE to assess suitability for ARM

If suitable for ARM, there should be a minimum of at least 30 minutes between Propess removal and commencement of Oxytocin; this is not dependent on parity. In most circumstances it is appropriate to wait for 2 hours after ARM before commencing Oxytocin, to give the woman a chance to enter active labour spontaneously.

If there is a delay in transferring the women to delivery suite, a senior obstetrician must be informed of the reasons and should try to facilitate transfer. The senior obstetrician should review activity on delivery suite with the co-ordinator and try and facilitate transfer by transferring women off delivery suite if possible.

If unsuitable for ARM, a further management plan should be discussed with the middle grade or consultant obstetrician and documented in the handheld maternity notes. The insertion of a second Propess is outside of the product licence, but experience suggests that this is acceptable. In the case of routine post-dates IOL it is appropriate for the middle grade obstetrician to make the decision about use of a second Propess. In the case of high-risk IOL, the use of any further prostaglandins beyond the first Propess should be a consultant only decision. Due to the short half-life of the active product a rest day is not required between administration of first and second Propess.

If ARM is still not possible 24 hours after a second Propess then a consultant decision must be made whether a diagnosis of failed IOL is appropriate.

6.20 Failed IOL

The decisions regarding the management of a ‘failed induction’ must be made in accordance with the women’s wishes and with regard to the clinical circumstances and urgency of induction.

If it is not possible to perform an ARM 24 hours after insertion of a second Propess refer to a consultant obstetrician for an individual management plan.

Perform an antenatal examination to include:

- Fetal well-being with electronic fetal monitoring (CTG)
- Support, and make decisions in accordance with woman’s wishes and clinical circumstances

If at any time an IOL process has to be interrupted due to capacity on labour ward or cots in SCBU decisions should
be made by the consultant only on when and how the IOL will be recommenced. Only very rarely would it be necessary to attempt to transfer a mother to an alternative maternity unit once an IOL has begun, via the emergency beds service.

The consultant must liaise closely with the midwife in charge of Labour ward to ensure good communication about the situation and any risks posed to women currently in labour and the risk to delaying any on-going induction or induction waiting to be started.

Any decisions taken with each woman’s care must be documented in their maternity handheld notes. Complete a datix form if there is a significant delay in IOL.

If the decision is for LSCS and there is a delay between the decision to perform LSCS and its execution, the woman should be re-examined vaginally in case there have been significant cervical changes in the interim.

6.21 ARM

This must be performed on delivery suite.

Women with intact membranes should have an ARM prior to commencement of Oxytocin.

All women require review by an obstetrician prior to commencement of Oxytocin.

Oxytocin should usually be commenced 2 hours after ARM, to allow the woman a chance to spontaneously enter active labour. Occasionally it may be desirable to avoid waiting for 2 hours, for example in the presence of meconium, in which case the product literature advises that Oxytocin can be used half an hour after removal of Propess (see Appendix A for Oxytocin infusion regimen).

An antenatal examination should take place prior to the commencement of Oxytocin which should include:

- Maternal observations
- Uterine activity
- Abdominal palpation
- Vaginal Examination findings
- Liquor colour if SROM
- Fetal Heart via CTG

A second assessment may be required if commencement of Oxytocin is >2 hours since the decision or if the clinical picture has changed.
Where Oxytocin is being used for induction or augmentation of labour continuous CTG should be used.

All maternal observations should comply with the recommendations in guideline Care in Labour (1st and 2nd and 3rd stage).

Documentation of the Oxytocin regimen on the partogram and CTG should record the amount of Oxytocin being given i.e. milliunits per minute (mU/min) rather than the amount of volume being infused (mls/hour). Remember to time and sign each entry on the CTG.

Any woman requiring Oxytocin for delay in the first or second stage of labour should be examined by the obstetric middle grade doctor.

An individual management plan should be documented in the maternal labour notes when Oxytocin is commenced including a copy of the Oxytocin regime filed in the notes (this needs to be signed and dated).

Primigravid women can commence augmentation following discussion with the obstetric middle grade and an individual management plan being documented in the maternity notes.

Multiparous women should not be augmented either in the first or second stage of labour without consultant approval. An individual management plan must be documented in the maternity notes.

Augmentation for women with a previous caesarean section should be a consultant decision only.

Women with cardiac disease should have a specific plan of care documented in their maternity notes and should be discussed with the consultant.

6.22 Oxytocin regime (See Appendix A)

The Oxytocin dilution should be made up with 10IU Oxytocin in 500mls normal saline.

The starting dose should be 1-2 milliunits per minute, increased at intervals of 30 minutes.

The minimum dose possible of Oxytocin should be used and this should be titrated against uterine activity. If the CTG is normal, Oxytocin may be continued until the woman is experiencing 4 or 5 contractions every 10 minutes. Oxytocin should be reduced if contractions occur more frequently than 5 contractions in 10 minutes.

The woman should be advised to have a vaginal examination 4 hours after commencing Oxytocin. If there is less than 2 cm progress after 4 hours of oxytocin, further obstetric review is required.

Increases above 20 milliunits per minute should be discussed with the Middle Grade/Obstetric Consultant on call.

If higher doses are used the maximum dose used should not exceed 32 milliunits per minute. (The licensed maximum dose is 20 milliunits per minute)

6.23 Augmentation in the second stage of labour

All women must be reviewed by an obstetrician before commencement of Oxytocin in the second stage of labour.

Start at 10mu/min and increase at 10 minutes intervals to a maximum of 22 mu/min (see Appendix A)

If contractions are still suboptimal consult the obstetric middle grade regarding further management.

6.24 Hyperstimulation with Oxytocin

In cases of uterine hyperstimulation (>5 contractions in 10 minutes lasting for 20 minutes or individual contractions lasting ≥ 2 minutes) where there is also a identified non-reassuring or abnormal features on the CTG the Oxytocin infusion should be discontinued. A full assessment should then be carried out by an obstetrician before Oxytocin is recommenced.

If this does not reduce contractions tocolysis should be considered (subcutaneous terbutaline 0.25 milligrams).

In cases of suspected or confirmed acute fetal compromise, delivery should be accomplished as soon as possible, taking into account the severity of the CTG abnormality and relevant maternal factors.

7. Special Considerations

Propess must be stored in the Freezer and removed from the freezer in direct connection with insertion. If the Propess has been inadvertently stored outside these conditions do not use.

8. Evidence Base/References

Department of Health (DH). 2006. NHS Maternity Statistics, England: 2004-2005. London: Department of Health

Ferring Pharmaceuticals. 2012. Propess in practise: Your questions answered. [On-line]. Available: http://www.medicines.org.uk/emc/medicine/16898/SPC

National Institute for Clinical Excellence (NICE). 2007. Clinical guideline 55. Intrapartum Care. London: National Institute for Clinical Excellence

National Institute for Clinical Excellence (NICE) Clinical guideline 70. 2008. Induction of labour. London: National Institute for Clinical Excellence

NHS Litigation Authority. 2011. Clinical Negligence schemes for trust Maternity Clinical Risk Management Standards Version 1, 2011/12. [On-line].Available: http://www.official-documents.gov.uk/document/hc1012/hc11/1113/1113.pdf

9. Competencies and Training Requirements

See maternity training needs analysis.

Any practice changes that require training will be disseminated through the Specialist Midwife Practice Development.

10. Monitoring Arrangements

Document Monitoring Table

Element to be Monitored	Lead	Tool for Monitoring	Frequency	Responsible Individual/Group/ Committee for review of results/report	Responsible individual/ group/ committee for acting on recommendations/action plan	Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented
Compliance with the guideline	Clinical Governance Manager Lead Consultant Obstetrician Consultant audit lead	Audit	Every 3 years	Obstetrics and Gynaecology audit meetings and any other appropriate meetings	Clinical Services Managers Midwifery matrons Clinical unit Obstetrics lead	Consultant Obstetrician Audit lead, Matrons, Service manager.
Induction Rate	Clinical Governance Manager Lead Consultant Obstetrician Consultant audit lead	Audit Dashboard and E3	Every 3 years	Obstetrics and Gynaecology audit meetings and any other appropriate meetings	Clinical Services Managers Midwifery matrons Clinical unit Obstetrics lead	Consultant Obstetrician Audit lead, Matrons, Service manager.
Failed Induction rate	Clinical Governance Manager Lead Consultant Obstetrician Consultant audit lead	Audit Dashboard and E3	Every 3 years	Obstetrics and Gynaecology audit meetings and any other appropriate meetings	Clinical Services Managers Midwifery matrons Clinical unit Obstetrics lead	Consultant Obstetrician Audit lead, Matrons, Service manager.

11. Equality and Human Rights Statement

An assessment of this document has been carried out.

Appendix A – Modified Bishop's Score

SCORE	0	1	2	3
DILATATION	0	1 – 2	3 - 4	≥ 5
LENGTH	3	2	1	0
STATION	-3	-2	-1	0, +1
CONSISTANCY	FIRM	MEDIUM	SOFT	
POSITION	POST	MID	ANTERIOR	
				Total ……...

SROM [ ] ARM performed [ ] liquor colour …….. Date ……..Time ……

Dr prescribed & r/v patient [ ] signature of Dr ……..

Oxytocin checked by 2 registered professionals

Signature 1 ……

Signature 2 …….

OXYTOCIN REGIME

Augmentation of Labour

- 10iu Oxytocin in 500 mls Normal Saline
- Must be given via infusion pump
- Regime – (rate in mls per hour) / 3 = Rate in mu / min

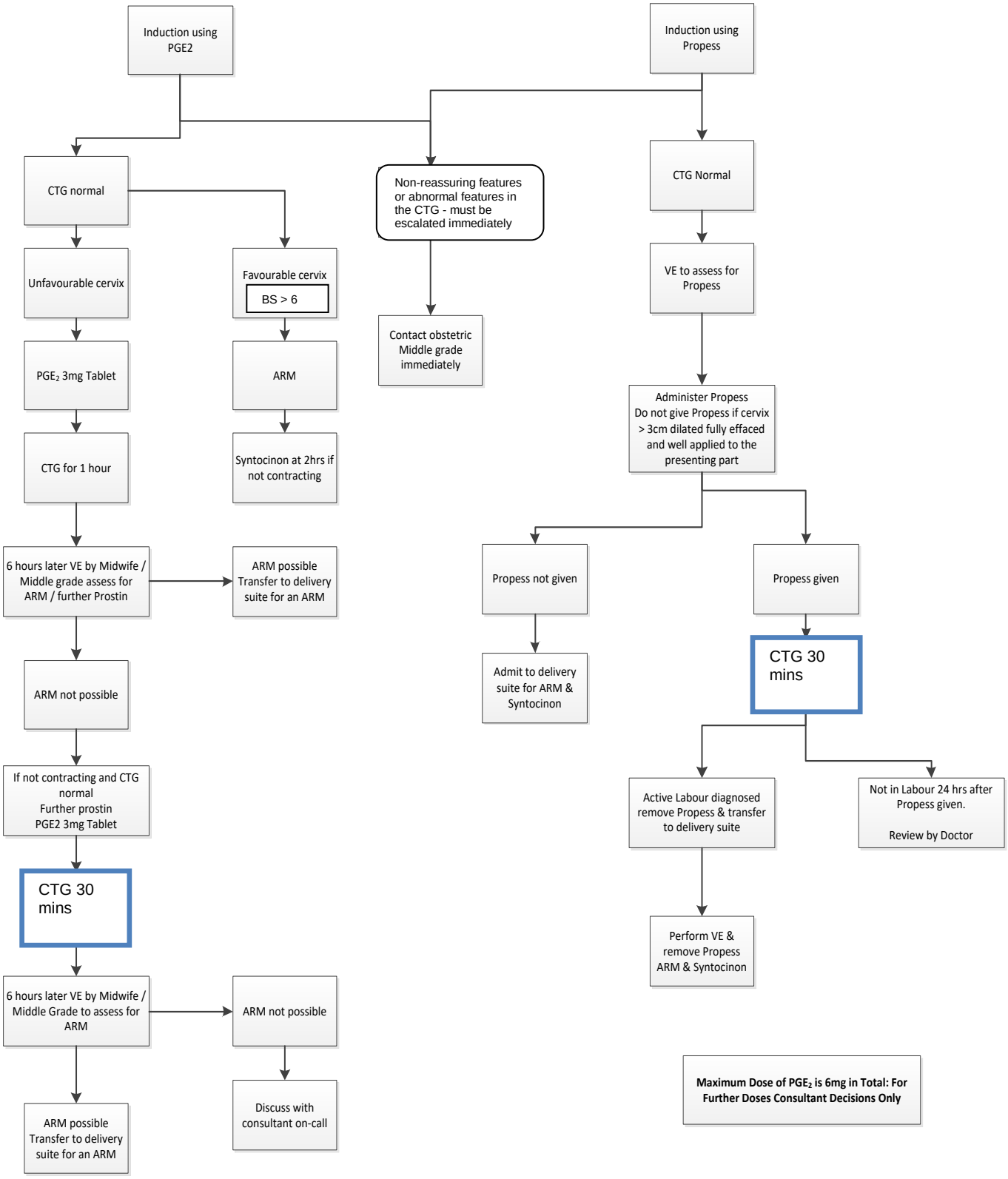
- **PPH**

First Stage			**Second Stage**			**40in Oxytocin in 500 mls Normal Saline**
Time after starting minutes	Oxytocin dose (mu / min)	Oxytocin pump Rate (mls / hour)	Time after starting minutes	Oxytocin dose (mu / min)	Oxytocin pump Rate (mls / hour)	
0	1	3	0	10	30	
30	2	6	10	12	36	
60	4	12	20	14	42	
90	8	24	30	16	48	
120	12	36	40	18	54	
150	16	48	50	20	60	
180	20	60	60	22	66	
210	24	72				
240	28	84				
270	32	96				

- Must be given via infusion pump
- Regime 125mls /hour for 4 hours
- It is not acceptable to increase the rate on a bag that has been used for augmentation – you must change the bag

Increases of Oxytocin above 20 milliunits per minute should be discussed with the Middle Grade/Obstetric Consultant on call.

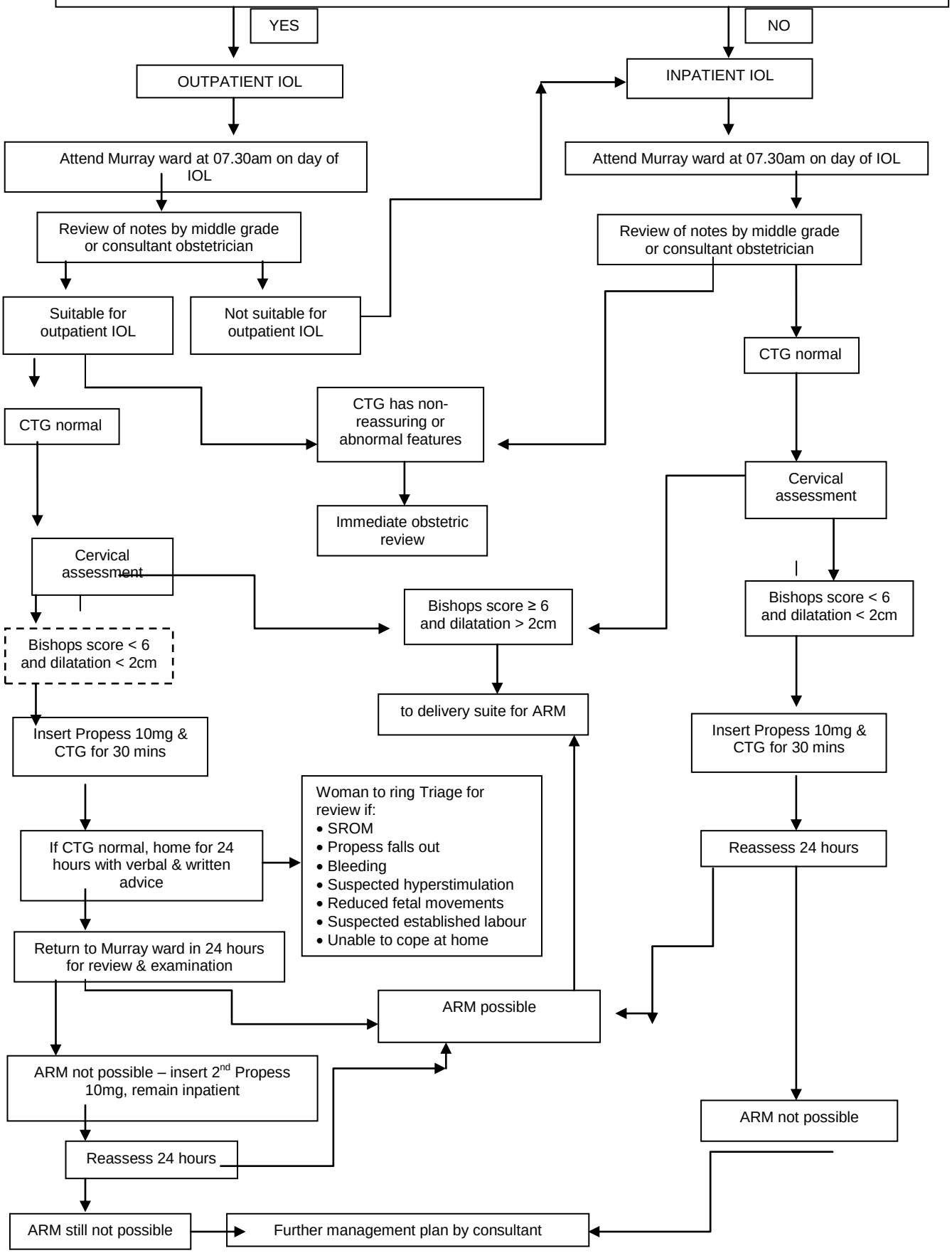
Appendix B – Flowchart for Propess or PGE2



Appendix C – Outpatient vs Inpatient

Risk assessment performed. Does the woman fit the following criteria?

- Low-risk / midwifery led care until point of IOL
- Primigravida
- BMI 18-34
- Age 18-39
- Gestational age 41+0 = 41+6



Appendix D– EHRA Form

A Due Regard, Equality & Human Rights Analysis form must be completed for all procedural documents used by East Sussex Healthcare NHS Trust. Guidance for the form can be found here on the Equality and Diversity Extranet page.

Due Regard, Equality & Human Rights Analysis

Title of document: **Induction and Augmentation of Labour**
Who will be affected by this work? Women being induced during pregnancy, and the healthcare professional providing this care
Please include a brief summary of intended outcome: To provide guidance for clinical staff on the management of Induction and augmentation of Labour IOL is only justified when there is greater benefit to the health of the mother and/or baby than if the pregnancy continues.

		Yes/No	Comments, Evidence & Link to main content
1.	**Does the work affect one group less or more favourably than another on the basis of:** (Ensure you comment on any affected characteristic and link to main policy with page/paragraph number)		
	• Age	No	
	• Disability (including carers)	No	
	• Race	No	
	• Religion & Belief	No	
	• Gender	No	
	• Sexual Orientation (LGBT)	No	
	• Pregnancy & Maternity	Yes	Women that are due to give birth however with certain high risk pregnancies Induction of labour sometimes occurs prior to or just after the Expected date of delivery
	• Marriage & Civil Partnership	No	
	• Gender Reassignment	No	
	• Other Identified Groups	No	
2.	**Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?**		N/A
3.	**What are the impacts and alternatives of implementing / not implementing the work / policy?**	N/A	
	Please evidence how this work / policy	N/A	

4.	**seeks to "eliminate unlawful discrimination, harassment and victimisation" as per the Equality Act 2010?**	
5.	**Please evidence how this work / policy seeks to "advance equality of opportunity between people sharing a protected characteristic and those who do not" as per the Equality Act 2010?**	N/A
6.	**Please evidence how this work / policy will "Foster good relations between people sharing a protected characteristic and those who do not" as per the Equality Act 2010?**	N/A
7.	**Has the policy/guidance been assessed in terms of Human Rights to ensure service users, carers and staff are treated in line with the FREDA principles (fairness, respect, equality, dignity and autonomy)**	N/A
8.	**Please evidence how have you engaged stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available?**	N/A
9.	**Have you have identified any negative impacts or inequalities on any protected characteristic and others? (Please attach evidence and plan of action ensure this negative impact / inequality is being monitored and addressed).**	no

Appendix E - Induction of Labour Pathway

PAS Label

Age			
Gravida	Parity		
Gestation			
Decision made by			
Discussed with the consultant	Yes	No	
Indication for IOL			
Previous C/section:	Yes	No	Reason for Previous C/S
Known GBS	Yes	No	Please ensure prescription for IVAB done prior to admission
Date booked in for IOL			
Leaflets provided	Yes	No	
Vaginal examination performed	Yes	No	

Assessment for induction of labour

Presentation:

Bishop score:

Score	0	1	2	3
Dilatation	Closed	1-2	3-4	5
Length	>4	3-4	1-2	0
Consistency	Firm	Medium	Soft	-
Position	Posterior	Middle	Anterior	-
Station	-3	-2	-1, 0	+1, +2

Total Score =	Date	Time
Method of IOL: ☐ Prostaglandins ☐ Cervical ripening balloon ☐ ARM		

Induction of Labour pathway

Time booked to come in:	
Time arrived onto the ward:	
Time seen by midwife:	
Time propess or balloon given:	
If propess not given time of ARM:	
Date and time to labour ward:	
As part of the ongoing audit could you please tick if the woman gives consent to be contacted post birth regarding her induction experience. ☐	