Worcestershire Acute Hospitals NHS Trust

Outpatient IOL Guideline

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

This document provides guidance on Outpatient Induction of Labour, including; the inclusion and exclusion criteria, process and relevant information to advise and perform n outpatient IOL.

This guideline is for use by the following staff groups:

Midwives and Obstetricians.

Lead Clinician(s)

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Approved by *Maternity Governance Meeting* on:	17th September 2022
Approved by Medicines Safety Committee on:	14th December 2022
Review Date: This is the most current document and should be used until a revised version is in place	14th December 2025

Key amendments to this guideline

Date	Amendment	Approved by:
June 2021	Timing of IOL in post-date pregnancies, inclusion criteria	MGM
August 2022	Timing of IOL in post-date pregnancies and update to guideline	MGM

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
Divisional Director of Midwifery
Consultant Obstetricians
Maternity Matrons
Obstetric Medical Staff
Community Midwifery Team Leaders
Inpatient Maternity Ward Managers
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Contents

1.0 Introduction

Women with uncomplicated pregnancies may be offered membrane sweep after 39 weeks and then induction of labour from 40+7 (NICE May 21).

The process for induction of labour should only be considered when vaginal delivery is felt to be the most appropriate route of delivery. This guideline refers to all women who are suitable for outpatient induction of labour.

Approximately 31% of labours in the UK are induced and this number is increasing. Many Trusts are now offering outpatient IOL for low risk women requiring Propess.

It is essential that outpatient induction of labour only be carried out with safety and support procedures in place, in low risk women.

This guideline should be used in conjunction with the Inpatient induction of Labour guideline.

2.0 Inclusion Criteria

Careful risk profiling is crucial to safe outpatient induction. Appropriate women should be:

- Primip with an uncomplicated singleton pregnancy or ≤ Para 3 (vaginal deliveries) with an uncomplicated singleton pregnancy
- Post-dates T+7 – T +14 weeks with an unfavourable cervix (Bishops score ≤ 6)
- Women being induced for social reasons at 40 – 41 weeks (Bishops score ≤ 6)
- Women being induced for pelvic girdle dysfunction at 40 – 41 weeks (Bishops score ≤ 6)
- No significant active medical disorders (e.g. severe asthma requiring previous hospital admissions, epilepsy, hypertension, pre-eclampsia, cardiac, renal and liver disease or glaucoma)
- No complications during this or previous pregnancies that may place the woman or her baby at increased risk (e.g. vaginal bleeding after 20 weeks' gestation in current pregnancy)
- No evidence or suspicion of Fetal compromise (e.g. intra-uterine growth restriction, oligohydramnios, polyhydramnios or Fetal heart rate abnormalities)

- No history of previous uterine surgery (Excluding straight forward hysteroscopy, D and C or EVAC.)
- No known hypersensitivity to prostaglandins
- Cephalic presentation
- On palpation and Vaginal Examination the head is not high and is fixed in the pelvis
- Ability to travel to Worcester Hospital within 30 minutes by her own transport should a need arise
- Good understanding of the English language and has access to a telephone
- The women has a competent adult to stay with her during the induction period
- The women is able to remove the Propess herself if necessary

3.0 Process of Outpatient Induction of Labour

- Eligible women should be offered the option of outpatient IOL at the time of booking the IOL.
- All women should be examined in the Hub to assess the Bishops score.
- Women with a Bishops score ≥ 6 can be booked for ARM for admission straight to Delivery Suite. They should be booked in the usual way via the Antenatal ward diary and listed on the Delivery Suite induction board. The woman should be triaged as if she was an inpatient.
- IOL should be booked by the Community Midwife by telephone with the relevant Hub. The process of induction of labour should be booked at least 2 days prior to the desired date for induction and should have started by T+13 for those that are post-dates. A record of outpatient IOLs should also be kept in the antenatal induction of labour ward diary.
- The Propess should be prescribed by a Doctor working in the Hub the week prior to the IOL date or in ANC if it is being organised from here.
- The booking form and checklist should be completed on Badgernet by the midwife requesting the IOL (Appendix 2).
- The woman should be provided with written and verbal information regarding the process (See patient information leaflet - Appendix 1).
- DAU at the relevant Hub should offer an appointment.

3.1 Initial Assessment

- DAU slots will be available at 15.30 and 16.00 Monday to Friday at the Alex, KTC and WRH and at WRH DAU on a Saturday and Sunday.
- In eligible women, an initial assessment with initiation of induction should occur in Day Assessment Unit at the relevant Hub and it should be ensured that the booking form and checklist has been completed appropriately by the CMW (Appendix 2).
- Prior to commencement of the induction process, baseline maternal observations should be recorded (blood pressure, maternal pulse, temperature, urinalysis).
- There should be an assessment of Fetal wellbeing via computerised CTG following auscultation of the Fetal heart with a Pinnard or Sonic aid.
- The abdomen should be palpated to confirm a longitudinal lie, cephalic presentation and to assess the level of Fetal head engagement

If any of the above are abnormal the women should be transferred to Worcester, if necessary, and reviewed by the on call obstetric team.

- If all of the above is reassuring, insert Propess and auscultate the FH for 1 minute post insertion as per IOL guideline.
- If any issues arise following insertion of Propess remove the Propess immediately and arrange urgent transfer to Worcester (if necessary) for review by the Obstetric Team.
- Ensure the checklist is completed (Appendix 3)

3.2 Insertion of Propess

- As per inpatient induction of labour guideline.

3.3 Discharge from Hospital

If the above has been satisfactory the woman can return home. She should be provided with verbal and written information explaining the next stage of the induction process. This should be documented on Badgernet.

The woman should be told how to remove the Propess before going home and an appointment arranged for the 09.00 hour telephone assessment with the Hub (WRH on a

Saturday and Sunday). Prior to going home, a trained member of staff should go through the leaflet (Appendix 1) with the woman, and clear instructions on how to contact Worcester throughout the day and night should be given.

The delivery suite co-ordinator should be informed of all outpatient IOLs.

Women should be instructed to contact triage on 01905 733196 if:

- They have painful tightenings / contractions
- They require pain relief
- They have any other concerns

Women should remove the Propess and contact the triage on 01905 733196 if:

- There is vaginal bleeding
- The membranes rupture
- The women has concerns regarding Fetal movements
- If there is evidence of maternal adverse effect e.g. severe nausea and vomiting
- If they are contracting > 5:10
- If contractions are lasting longer than 2 minutes

If the Propess is removed, falls out or drops within the vagina, patients should be advised to bring the Propess in a clean bag for re-insertion. If Propess is contaminated, a new pessary may be inserted, but total exposure time to Propess should not exceed 24 hours.
If a woman contacts triage she should be advised whether it is necessary to remove the Propess and where to attend if further assessment is required.

3.4 Criteria for readmission:

- Regular painful uterine contractions
- Any vaginal bleeding
- History of membrane rupture
- Reduced or absent fetal movements
- Evidence of adverse maternal reaction to Propess
- Two phone calls to Maternity Triage for any reason

3.5 Follow Up Telephone Assessment (Appendix 4)

Women should have a telephone assessment 09.00hrs the following day post-Propess insertion if they have not already been admitted. This call should be made by the midwife in the Hub (WRH DAU on a Saturday and Sunday) and should be documented On Badgernet. (Appendix 3).

The following should be documented:

- Frequency of contractions
- Any vaginal loss
- Fetal movements
- Experience of pressure/ pain
- Adverse effects from Propess e.g. nausea/ vomiting
- Propess in-situ

If the woman is well and none of the criteria for re-admission are met she can remain at home with instructions to return to the Hub (WRH on a Saturday and Sunday) at 24 hours post-Propess insertion or earlier if she has any concerns.

On return to the Hub the woman should be reviewed by a Midwife and this review should include:

- Baseline maternal observations (HR, BP, RR, Temp and urinalysis)
- An abdominal palpation to confirm longitudinal lie and cephalic presentation
- An assessment of fetal well-being with a CTG following auscultation of the fetal heart with a Pinard or Sonicaid.

The Propess should be removed and the woman re-examined to assess if ARM is possible. If it is delivery suite can be updated and the patient can remain at home assuming all of the above investigations are normal and there are no other concerns.
If there are any concerns or an ARM is not possible the woman should attend the Antenatal Ward for assessment and insertion of a second Propess following assessment by the Obstetric Team.

4.0 Admission to the Antenatal Ward

At any point following discharge women may be re-admitted, either in established labour, if they develop side effects or complications as a result of the use of Propess or if it is not possible to perform an ARM after 24 hours.

On re-admission review by a midwife should include:

- Baseline maternal observations (BP, RR, HR, T, urinalysis)
- Palpation of the abdomen to confirm longitudinal lie, cephalic presentation and level of fetal head engagement.
- Electronic Fetal Monitoring (EFM)

Ongoing management is as per inpatient induction of labour guideline.

References

GHNHSFT (2014) Outpatient Induction of Labour, A1109, Gloucestershire Hospitals NHS Foundation Trust

GHNHSFT (2012) Induction and augmentation of labour, including the use of syntocinon. Gloucestershire Hospitals NHS Foundation Trust

National Institute for Health and Clinical Excellence (2008). Induction of Labour. An update of NICE inherited clinical guideline D, Royal College of Obstetricians and Gynaecologists, London.

Kelly AJ, Alfirevic Z, Dowswell T. Outpatient versus inpatient induction of labour for improving birth outcomes. Cochrane Database of Systematic Reviews 2009, Issue 2. Art. N0.:CD007372. DOI: 10.1002/14651858.CD007372.pub2

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Appendix 1

Patient Information leaflet - Outpatient induction of labour

Why have an outpatient induction of labour (IOL)?

- Going home during the first stage of the induction reduces the amount of time you will need to stay in hospital before your labour begins
- Allows your birth partner to remain with you throughout the induction process
- Makes the process of induction feel more 'normal' as most women/birthing parent who have spontaneous labour are at home for the early part of it
-

You may be offered an outpatient IOL if:

- Your pregnancy is considered 'low-risk'
- You are at or have gone past 40 weeks but are not beyond 42 weeks.
- Your baby is well grown and all tests are normal
- This is your first full-term pregnancy or you have given birth vaginally three or less times.
- You have no relevant medical or obstetric problems
- You have not had any uterine surgery
- You have had no bleeding after 20 weeks of pregnancy
- You have a telephone
- You have understood the information and can communicate well in English
- You have an adult who will be with you at all times
- You have transport to get you to the hospital within 30 mins

Please note that situations and change at any stage and you might be advised to stay in hospital if any problems arise during the process.

What to expect on the day of induction

Whenever you attend the hospital, please remember to bring an overnight bag in case you do need to stay. Be prepared to spend about 2 hours at the hospital. The midwife looking after you will answer any questions you have and assess you and your baby's well-being. This will include checking your blood pressure, a urine sample and a baby's heart rate. The midwife will then do a vaginal examination. If it

is appropriate to do so, a Propess pessary will be placed in your vagina. This will stay there for 24 hours.

A Propess pessary feels similar to having a very small flat tampon inserted into the vagina. There is a string for ease of removal which will sit just inside your lower vagina. It will swell a little to stay in place. You will then be asked to lie down for about half an hour before a final check. Providing all is well, you will then be able to go home.

What should I be doing at home?

- Be mobile - Being as upright and as active as possible will encourage your labour to commence
- Eat and drink as normal
- Bath or shower as normal but avoid excessive use of soap
- Take care when washing/undressing/wiping not to dislodge the Propess if the string is just outside the vagina
- We recommend avoiding sexual intercourse
- Monitor your baby‘s movements
- Use a TENS machine if you would like, as you mobilise or rest

What are the possible side effects ?

There can be some side effects with Propess. They are usually mild and do not affect all women:

- Abdominal discomfort
- Nausea and vomiting
- Diarrhoea
- Vaginal swelling, discomfort or irritation
- Palpitations

If any of these occur to a distressing level, or you are unsure of what you are experiencing, you should phone the hospital.

When should I contact the hospital?

Please contact Triage on 01905 733196 if:

- You have regular painful contractions
- You require stronger pain relief
- You have any vaginal bleeding
- You think your waters have broken
- You are concerned about your baby's movements
- You have strong contractions lasting >2 mins or have more than 5 contractions in 10 minutes
- You have constant pain
- You feel unwell in yourself or have difficulty breathing
- You are experiencing side effects to Propess that concern you
- The Propess falls out – please bring it in a clean plastic bag
- You have any other concerns

When should I remove the Propess?:

- If you have more than 5 contractions in 10 minutes
- If your contractions last longer than 2 minutes
- You have any concerns about fetal movements
- Your waters have gone
- If there is evidence of maternal adverse effects e.g. severe nausea and vomiting
- There is vaginal bleeding

Please remove Propess immediately and contact Maternity Triage on 01905 733196 in this case.

What next:

We will contact you at a given time the following day after the insertion of Propess. Please ensure you have access to the telephone that we will ring, it is fully charged and you have reception. Be aware that a hospital call will come up as blocked, withheld or unknown.

Your agreed telephone review time is …….

If you have not been contacted within 2 hours of this time please ring the Hub where your Propess was inserted (WRH DAU on a Saturday and Sunday):

Kidderminster Treatment Centre	01562 513220
Alexandra Hospital	01527 512004Need to check number
Worcester Hospital	01905 760586Need to check number

What happens if labour does not start within 24 hours of the pessary being inserted?

If your labour has not started within 24 hours of having Propess you will be invited back to the Hub where your Propess was inserted or at WRH DAU on Saturday and Sunday. A time will have been agreed with you at the start of the induction process. The midwife will assess you and your baby's wellbeing. The midwife will also ask to perform an internal examination to remove the Propess and to assess your cervix. If your cervix is not ready the midwife or doctor will discuss further treatment with you and recommend you attend the Antenatal Ward at Worcester Hospital. A second pessary might be inserted. You will now likely stay in hospital until your baby is born.

If your cervix is ready, then the next step will be breaking your waters and starting a hormone drip on delivery suite. It may be that you are admitted to the antenatal ward to await this process but sometimes if there is a delay in the process you may be offered the option to wait at home. The midwife will discuss these options with you in more detail at the time.

Appendix 2

Patient details sticker

Booking form for outpatient IOL – To be completed by MW/Dr at time of booking

Date:	Gravida	Para
Gestation:		
Indication for IOL: Postdates (41-42 wks) □ PGP (40-41 wks) □ Social reasons (40-41 wks) □ Decision by Name: Designation: Date booked:		

Membrane sweep: Accepted Declined

Date:	Bishop score:	Done by:
Date:	Bishop score:	Done by:

Risk checklist completed:
(tick)

No significant active medical disorders (e.g. severe asthma requiring previous hospital admission, epilepsy, hypertension, pre- eclampsia, cardiac, renal and liver disease or glaucoma)	
No previous uterine surgery	
No known hypersensitivity to Prostaglandins	
No bleeding after 20 weeks gestation	
No complications in this or previous pregnancies	
No abnormal vaginal loss since last appointment	
Primip with an uncomplicated singleton pregnancy or ≤ Para 3 (Vaginal deliveries) with an uncomplicated singleton pregnancy	
Post dates T+7 or women being induced for social reasons/PGP at 40-41 weeks	
SFH within normal limits and along centile	

Allergies:	None Known	Other:
Recent Bloods date:	Hb:	Platelets:

Pre-requisites for outpatient IOL (please tick)

Ability to return to the hospital within 30 minutes by own transport	☐
Good understanding of English and access to a telephone	☐
Competent adult staying with the woman during the induction period	☐
Able to remove Propess herself if necessary	☐
Leaflet given	☐
IOL booked in IOL diary	☐
Consent	☐

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Patient details sticker

Appendix 3

Checklist for outpatient IOL – To be completed by Midwife at time of IOL

Date and time of admission:

Gestation on date of admission:

Patient contact number: Time for follow up phone call given ☐

Initial booking form completed ☐

No contraindications to outpatient IOL ☐

Pre-requisites for outpatient IOL met ☐

Maternal observations:

BP: / Pulse: Temperature: Urinalysis:

Ensure all observations are normal

Fetal movements:

Normal Reduced Excessive

If movements reduced or excessive NOT for outpatient IOL

Fetal assessment:

Longitudinal lie ☐ Cephalic ☐ Fetal head palpable /5

CTG meeting Dawes Redman Criteria Y ☐ N ☐ **(Ensure CTG normal)**

Vaginal examination:

Bishops Score: Head fixed in pelvis ☐

Propess inserted: Yes ☐ No ☐

Signature: Print name: Designation:

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Appendix 4

Patient details sticker

Outpatient Induction of Labour – Telephone Review

Time of call: Date:

Type of call: Routine call ☐ Other:

Call failed ☐ Tried again at _____:_____

Contractions: Regular ☐ Irregular ☐ Frequency in 10 minutes:

Analgesia used: ☐ Type and Dose:

Vaginal loss: None ☐ Clear ☐ Blood ☐ Mucus ☐ Green ☐

Fetal movements: Normal ☐ Reduced ☐ Excessive ☐

Pain other than contractions: Location Intermittent / Constant

Adverse effects from Propess?

Nausea ☐ Vomiting ☐ Vaginal soreness ☐ Other ☐

Propess still in situ? Y ☐ N ☐

Plan: Stay at home ☐ Attend Hub ☐ Attend Triage ☐

Signature: Print name: Designation:

Monitoring

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	These are the 'key' parts of the process that we are relying on to manage risk. We may not be able to monitor every part of the process, but we MUST monitor the key elements, otherwise we won't know whether we are keeping patients, visitors and/or staff safe.	What are we going to do to make sure the key parts of the process we have identified are being followed? (Some techniques to consider are; audits, spot-checks, analysis of incident trends, monitoring of attendance at training.)	Be realistic. Set achievable frequencies. Use terms such as '10 times a year' instead of 'monthly'.	Who is responsible for the check? Is it listed in the 'duties' section of the Policy? Is it in the job description?	Who will receive the monitoring results? Where this is a committee the committee's specific responsibility for monitoring the process must be described within its terms of reference.	Use terms such as '10 times a year' instead of 'monthly'.