Induction of Labour on Ward 314 – Standard Operating Procedure RDH Only

IP/SOP/04:21/I1

Contents

1. Purpose

This Standard Operating Procedure (SOP) outlines the operational management of Induction of Labour (IOL) on the maternity ward 314 at Royal Derby Hospital (RDH) for women who have been risk assessed as low or moderate risk and the expected related communication. This SOP should be read in conjunction with the clinical guideline.

2. Booking IOL

- **Consultant Led Care** - The obstetrician booking the IOL will discuss appropriate options with the woman and clearly document if the woman is suitable for inpatient or outpatient IOL. If inpatient IOL is required then a location must be documented (either 'suitable for IOL on ward 314' or 'high risk IOL on labour ward only') as per guideline.

- **Midwife Led Care** - The midwife booking the IOL will discuss appropriate options with the woman and clearly document if the woman is suitable for outpatient IOL. All women who are midwife led care requiring an inpatient IOL for post maturity would be considered suitable for IOL on ward 314 if they have no additional risk factors

- The IOL (and any required investigations prior to IOL, i.e Covid swabs) will be arranged by the health professional either directly through the spreadsheet or by telephoning labour ward. The woman is informed of the date of IOL, date of any appointments prior to IOL and of the location to attend, either ward 314 or labour ward. Women should be advised that at times of high activity there may be delays in starting an IOL and that there may be occasions when women booked for IOL on ward 314 may have their IOL moved to labour ward either due to a change in clinical circumstances or due to ward activity.

3. Operational processes

3.1. Staffing

A midwife will be allocated from the acute staffing for each shift to care for the IOL women based on ward 314.

At each shift handover the allocated IOL midwife will be identified on ward 314 board. Breaks will be facilitated by the ward coordinator but should be timed when activity for IOL women is minimal i.e not when CTG's are due.

In the event that there are no remaining women with Propess in situ on ward 314 and there are no women imminently booked for IOL who are suitable for management on ward 314 then the staff allocated to IOL will be redeployed.

In the event of last minute staffing shortage and difficulty in identifying a midwife who can safely care for the IOL on ward 314 all IOL should be cohorted back onto LW to allow safe provision of care.

3.2. Daily management of IOL activity

- Planned IOL activity will be reviewed at the morning operational huddle. Management and oversight of the IOL activity will be maintained by the clinical coordinating midwives of ward 314 and labour ward, alongside the midwife allocated to care for the IOL women. Any concerns should be escalated to the Senior Midwives for ward 314 and LW, who will escalate to Matron or Manager on call if they are unable to resolve.

- Beds for incoming IOL women (maximum of 4) will need to be identified by the ward 314 coordinator on the night shift after liaising with the IOL midwife and the LW coordinator.

- Maximum number of IOL to be accommodated on ward 314 is 6, including women remaining from the previous day or due to commence a second cycle

- The IOL midwife will liaise with the ward and LW coordinators to confirm bed status, number of women expected for IOL on ward 314 and any women currently on ward 314 with Propess in situ. The IOL midwife will carry an IOL phone for ease of communication.

- Women booked for outpatient IOL will be booked to attend LW. Depending on activity across the acute setting this may be altered on the day and women having outpatient IOL can be reviewed and the process commenced on ward 314 if necessary.

3.3. Outpatient IOL

This will usually occur on labour ward, however there may be times when activity and staffing makes it more appropriate for these woman to be assessed and Propess given on ward 314. This will be considered as part of the operational huddle Monday - Friday or by the LW and ward coordinators in conjunction with the duty consultant at the weekends and bank holidays.
In these circumstances the guideline for outpatient IOL should be followed.

Care is handed back to the LW coordinator for follow up and notes should be returned to labour ward at the time the woman is discharged, including the labour notes that have been commenced.

3.4. Inpatient IOL on ward 314 new admissions

Women for IOL on ward 314 will be given slots for admission at 7.30, 7.50, 8:10 and 08.30am.

Women will have an admission by the IOL midwife and labour notes should be commenced including all appropriate assessments.

Women will be reviewed as below by the Pregnancy Assessment Unit (PAU) consultant and a plan made for IOL including frequency of CTG's during IOL.

If on VE, following a satisfactory CTG, the bishop score demonstrates the cervix is favourable for ARM then transfer to LW should be arranged, otherwise continue with Propess IOL.

If CTG is not normal – continue CTG and escalate for urgent obstetric review and inform LW coordinator. As part of the obstetric review, if the decision is made to continue with the IOL, then consideration should be given to the most appropriate location in which to proceed. Transfer to LW should not be delayed awaiting obstetric review in the case of an abnormal CTG.

3.5. Obstetric review of IOL on ward 314

The ward round (WR) will be done between 9-10am by the consultant who is covering the morning PAU session. The PAU consultant will update the LW duty consultant afterwards. On some occasions a registrar will be covering PAU instead and will review the inductions at 9am.

Any concern regarding maternal or fetal condition should be escalated without delay for obstetric review and both the ward and LW coordinators should be informed. See below.

4. Escalation for obstetric review

Weekdays 9am - 5pm
Ideally calls for advice should go to the obstetrician covering PAU (usually a consultant). They will already have reviewed the women on 314 that morning so will be familiar with the clinical picture.

1) PAU Consultant / Specialist Registrar (SpR)

2) LW SpR/consultant

5pm - 9am
The Second on Specialist Registrar (SpR) should be contacted in the first instance. If unavailable, then the first on SpR should be bleeped.

1) 2nd on call SpR

2) 1st on call SpR

Weekends
2nd on SpR to see IOL women with the 314 antenatal ward round, then be bleeped for problems later. The IOL cases on 314 will be discussed as part of the medical handover on LW at 9am so a designated doctor can review them promptly.

5. Transfer to Labour Ward

5.1. Emergency Transfer to LW (ie fetal bradycardia)

In the case of a prolonged deceleration an urgent VE should be performed and Propess removed.

Bleep 3333, inform ward and LW coordinators and make arrangements for urgent transfer to LW. If there is a delay in obstetric review urgent transfer should not be delayed.

5.2. Non-emergency transfer to labour ward

The LW coordinator is responsible for ensuring the IOL women are transferred to LW at the appropriate time and should escalate any concerns regarding bed flow promptly.

Reasons for transfer

- Needing additional analgesia - see pain relief section below
- For intrapartum care - a VE should occur on the ward to confirm labour prior to transfer

The midwife taking over to provide 1:1 care on labour ward will attend ward 314 to take hand over from the IOL midwife and escort the woman to labour ward.

5.3. Delay in transfer

- In the event of a potential delay with IOL e.g. due to unit activity, it is the responsibility of the coordinating midwife from LW to inform the IOL midwife and the 314 coordinator.
- Communication between LW coordinator ,IOL midwife and Ward Coordinator will need to include any concerns regarding timing of transfer (ie CTG concerns/labour).
- Where there is a delay in transferring a woman to LW for ARM/augmentation an obstetrician will need to assess the woman's clinical situation, including the indication for IOL & maternal and fetal wellbeing.

5.4. In the event of SROM

- If SROM occurs whilst on the ward, there are no signs of active labour and maternal and fetal wellbing are satisfactory, Propess can be reinsertered as per the guideline and the woman can remain on the ward.

6. Pain relief on ward 314

Pain relief options should be discussed with women as part of the IOL process

Usual pain relief options for IOL would include paracetamol, TENS, water and Oramorph.

If pain continues from Propess, Pethidine can be considered. A VE should be performed prior to administration of Pethidine to exclude active labour.

If Pethidine is indicated this must be prescribed following discussion with an obstetrician on an individual basis.

Maximum of one dose of Pethidine to be administered on ward 314 (50-100mg dependent on maternal BMI).

If Pethidine is being administered to a woman during an IOL the 314 ward coordinator and LW coordinator should be informed.

Women requiring Entonox should be transferred to LW.

7. Storage of Propess

- Propess must be stored in the IOL freezer (-10 to -25°C). Store in the original container in order to protect from moisture. No thawing is required prior to use.
- The maximum and minimum freezer temperatures are to be checked daily

8. Ordering of Propess

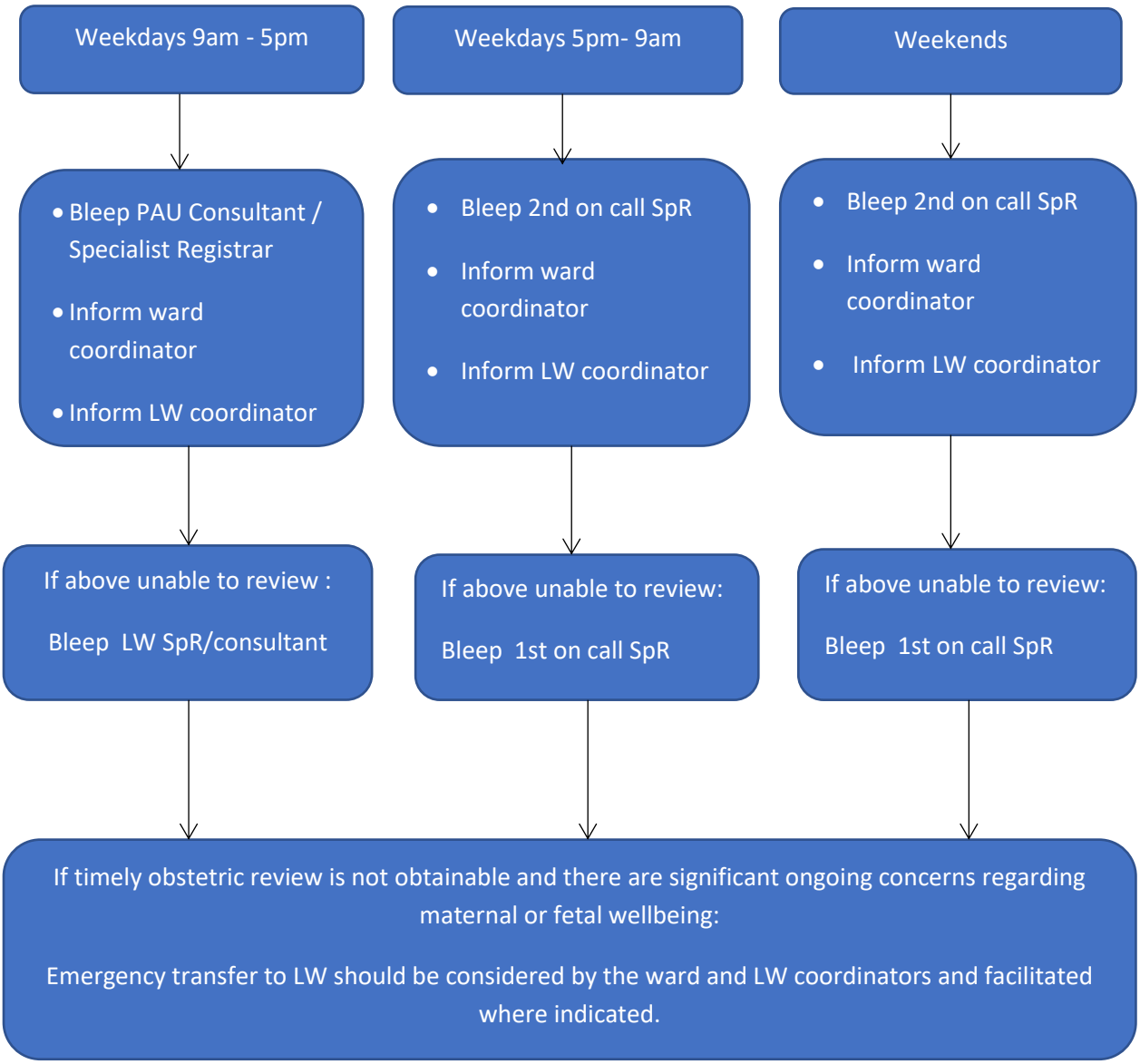
Ward coordinator on 314 to check stock numbers twice weekly, order weekly via dedicated stock requisition book on a Monday & if additional stock required on a Thursday & ensure stock rotation.

9. Training

Midwives who administer Propess will have completed the Propess competency package prior to administration.

Appendix A

Escalation for Obstetric Review during IOL on Ward 314



Documentation Control

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	1	March 2021	Miss J Rowley – Consultant Obstetrician Mandy Jones – Matron	New
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To be read in conjunction with:				
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