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TITLE: Induction of Labour

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1. Purpose

To provide optimal care throughout the antenatal, intrapartum and postnatal period for the woman/person and their baby, during the induction of labour process. This guideline aims to prevent inappropriate induction of labour and provide a standard care pathway for those who are induced.

2. Scope

This guideline applies to all Te Whatu Ora Lakes Obstetric medical staff, employed midwives, midwifery students and to all Lead Maternity Carers (LMC's) who have an Access Agreement with Te Whatu Ora Lakes, and the women they provide care to.

3. Definitions

AC	Abdominal Circumference
ARM	Artificial Rupture of Membranes
ART	Assisted Reproductive Technology
BMI	Body Mass Index
BPP	Biophysical Profile
CTG	Cardiotocograph
CPR	Cerebroplacental Ratio
DR	Dawes-Redman Criteria – for CTG analysis
EDD	Estimated Date of Delivery
EFW	Estimated Fetal Weight
FGR	Fetal Growth Restriction
ICSI	Intracytoplasmic Sperm Injection
IOL	Induction of Labour: the process of starting labour artificially as opposed to waiting for labour to commence naturally.
IVF	In-Vitro Fertilisation
LMC	Lead Maternity Carer
LMP	Last Menstrual Period
LSCS	Lower Segment Caesarean Section
MCA	Middle Cerebral Artery
MOH	Ministry of Health
O&G	Obstetrics & Gynaecology
PI	Pulsivity Index
PROM	Pre-labour Rupture of Membranes
SGA	Small for Gestational Age
USS	Ultrasound Scan
UA	Umbilical Artery
UtA	Uterine Artery

4. Overview

Induction of labour (IOL) is the process of artificially starting labour, instead of waiting for labour to start naturally.

Because IOL requires intervention it should only be considered and offered when there is evidence that it will benefit the health of a pregnant woman/person and/or fetus and that the health of both might be adversely affected if the pregnancy continues.

- IOL has risks and those risks, as well as the perceived benefits of the procedure and the likelihood of adverse outcomes, should be discussed with the woman/person to enable her/them to make an informed choice regarding whether or not labour is induced.
- It is important to individualise all decisions about IOL as some women/people may have several risk factors for adverse outcomes that present a cumulative risk.
- Prior to a decision for IOL it is important that accurate information is obtained to establish a gestational age of the pregnancy. Ideally there will be a reliable menstrual history supported by evidence from an early pregnancy ultrasound scan (USS).
- Early term birth (37 and 38 weeks' gestation) is associated with poorer neonatal and childhood outcomes compared with babies born at 39 to 41 weeks' gestation. Unless there is an evidence-based indication supporting earlier planned birth, continue expectant management to 39 weeks' gestation or more (MOH 2019)
- If, after discussion, the woman/person chooses to decline the offer of IOL, further discussion is required regarding the measures needed for ongoing monitoring of the pregnancy (see Section 4.3).
- As part of the consent process it is also important to inform the woman/person that IOL is not always successful, and provide information about the likely management should labour not start with this intervention (see [Section 10](#), 'Unsuccessful IOL').

4.1 Indications

IOL is indicated when the maternal and/or fetal risks of continuing the pregnancy outweigh the risks of IOL and birth. Specific circumstances are considered in [Section 5](#) below.

4.2 Contraindications

Contraindications to IOL are the same as those for vaginal birth. Specific circumstances where IOL is not recommended are described in [Section 5](#) below.

4.3 Care if IOL is Declined

A woman/person may decline advice for IOL, usually when this has been offered for prolonged pregnancy.

No form of increased antenatal monitoring has been shown to reduce perinatal mortality associated with post-term pregnancy. However, it is recommended to offer, from 42 weeks (via Day Assessment Unit or Taupo Maternity Unit), additional antenatal monitoring consisting of twice weekly cardiotocography (CTG).

4.4 Membrane Sweeping

Membrane sweeping refers to the digital separation of the fetal membranes from the lower uterine segment during vaginal examination. This helps to separate the cervix from the membranes and to stimulate the release of prostaglandins, encouraging spontaneous onset of labour.

Membrane sweeping is not a method of inducing labour but is the only intervention shown to reduce the need for formal IOL. Consider offering membrane sweeping at term to reduce the frequency of pregnancies continuing beyond 41+0 weeks' gestation (MOH, 2019).

- If offering membrane sweeping, consider performing it from around 39 weeks' gestation.
- Advise women/people there is no evidence of increased risk of maternal or neonatal infection.
- There may be some discomfort, vaginal bleeding and irregular contractions.
- If the cervix is closed and membrane sweeping is not possible, cervical massage around the vaginal fornices may achieve a similar effect.

4.5 Attendance of Lead Maternity Carer

If IOL is planned, the roles of care providers should be mutually agreed upon by the woman/person, the LMC and O&G Consultant and clearly documented in the clinical records. Especially if IOL is to be managed completely by Core Midwives.

When a decision is made between the hospital maternity team, the Lead Maternity Carer (LMC) and the woman/person for the LMC to provide midwifery care during IOL, Core Midwives will:

- Be responsible for negotiating with the LMC and the woman/person a clear written management plan for the initiation of the induction and the ongoing management of the induction.
- Assist the LMC to provide care according to the management plan for IOL and the wishes of the woman/person, until such time as labour is established and the LMC is in attendance⁴ or until the woman/person wants continuous support from her LMC.
- Provide the LMC reasonable notice of the need to be available to attend to the woman/person⁴ including if the woman/person wants continuous support from their LMC.

The LMC updates the Core Midwives with the care plan so the Birthing Suite workload can be planned and an effort made to meet the woman's/person's goals and expectations.

5. Specific Circumstances for IOL

5.1 Prolonged Pregnancy - \geq 41 Week's Gestation

Risk/Benefit	<ul style="list-style-type: none"> • Prolonged pregnancy (\geq 42 weeks) is associated with increased duration of labour, caesarean section for failure to progress and for fetal distress, operative vaginal delivery, post-partum haemorrhage (PPH) and large for gestational age babies. • The risk of stillbirth significantly increases in pregnancies which proceed beyond 42 weeks, and some studies have shown increased risk between 41-42 weeks. • The majority of pregnancies, which go beyond 42 weeks, however, are associated with good outcome for mother and baby. • N.B.: Women who are obese (BMI>30) have a higher rate of prolonged pregnancy
Recommendation	<ul style="list-style-type: none"> • For women/people with uncomplicated pregnancies; <ul style="list-style-type: none"> ○ offer serial membrane sweeps from term and then offer IOL at 41+5 to 42 weeks after review of dates. ○ refer to on call Obstetrician at 41+1 weeks with USS of growth and liquor having been done near 41 weeks. • Women who decline IOL at 42 weeks should be offered increased antenatal monitoring from 42 weeks (see below). However, there is no evidence that this reduces the risk of sudden stillbirth and this should be discussed with the woman/person. Discuss case with the appropriate team O&G Consultant.
Monitoring	<ul style="list-style-type: none"> • From 42 weeks via Day Assessment Unit or Taupo Maternity Unit; <ul style="list-style-type: none"> ○ twice weekly assessment of CTG should occur until delivery

5.2 Hypertension in Pregnancy

Risk/Benefit	Hypertension in pregnancy includes chronic hypertension, gestational hypertension and pre-eclampsia. There is an association between hypertension in pregnancy and increased maternal morbidity and mortality (Ministry of Health, 2017).
Recommendation	<ul style="list-style-type: none"> • For women with chronic hypertension and low risk of adverse outcomes, consider expectant management beyond 37 weeks' gestation with increased monitoring. • For women with gestational hypertension diagnosed after 37+0 weeks' gestation, consider IOL, to reduce the risks of severe hypertension, severe pre-eclampsia, HELLP syndrome, abruptio placenta, pulmonary oedema, severe renal impairment, and fetal growth restriction. • For women with pre-eclampsia diagnosed after 37+0 weeks' gestation, offer IOL.
Monitoring	Ongoing monitoring of symptoms, blood pressure, urinalysis, blood testing and assessment for fetal growth.
Guideline	Pre-eclampsia / Eclampsia Guideline - 196593

5.3 Advanced Maternal Age

Risk/Benefit	<ul style="list-style-type: none"> • Women/people who are older in pregnancy are at higher risk of pregnancy related complications, such as diabetes and hypertension. • The risk of stillbirth increases slightly for women who are 35 years of age or older. • The PMMRC reported that, in New Zealand in 2016, there was an association between maternal age of 40 years or older and perinatal death (PMMRC 2018). • There is currently insufficient high quality evidence to make a recommendation for IOL for maternal age to improve adverse outcomes.
Recommendation	<ul style="list-style-type: none"> • Inform women/people of the potential pregnancy complications in women aged 35 years or older and the association found in the PMMRC data on perinatal mortality in women aged 40 years or older. • For women/people of aged 40 years and over, consider offering IOL at around 40 weeks gestation.

5.5 Diabetes in Pregnancy

Risk/Benefit	<ul style="list-style-type: none"> • Diabetes in pregnancy is associated with an increased risk of adverse perinatal outcomes. • Timely diagnosis, treatment and continued follow-up are essential to prevent or minimise these adverse outcomes. • There is insufficient high quality evidence to show that IOL reverses these outcomes.
Recommendation	<ul style="list-style-type: none"> • For women with gestational diabetes, continue expectant management to at least 40 weeks' gestation, in the setting of good glycaemic control, normal fetal growth and no obstetric complications. • For women with type 2 diabetes, continue expectant management to 39 weeks' gestation, unless there are obstetric or fetal indications for earlier birth or diabetes complications, such as vascular disease. • For women with type 1 diabetes, manage on a case-by-case basis.
Monitoring	<ul style="list-style-type: none"> • In practice, women/people with pregnancies complicated by either pre-existing diabetes or gestational diabetes are monitored within the diabetic service • The Obstetric and Diabetes team will plan the IOL
Guidelines	<ul style="list-style-type: none"> • Diabetes in Pregnancy – Gestational Diabetes Mellitus - 2121097 • Diabetes in Pregnancy – Type 1 and Type 2 Diabetes - 2656754

5.6 Reduced Fetal Movements

Risk/Benefit	<p>Maternal perception of fetal movement has long been used as an indicator of fetal wellbeing.</p> <p>Reduced or decreased fetal movement is associated with adverse perinatal outcomes.</p> <p>There is currently insufficient high-quality evidence to make a clear recommendation about IOL for this condition.</p>
Recommendation	<p>Specialist medical opinion should be sought and further management individualised where there is concern due to reduced fetal movements (RFM).</p> <p>For women/people with RFM, in the presence of normal maternal and fetal assessment, continue expectant management.</p>

5.7 Pre-labour Rupture of Membranes (PROM) ≥ 37 Week's Gestation

Risk/Benefit	<ul style="list-style-type: none"> • The risk of infection increases with the duration membranes are ruptured prior to birth. • There is a risk of maternal morbidity due to infection, definite or probable early-onset neonatal sepsis and admission to special or intensive care setting.
Recommendation	<ul style="list-style-type: none"> • For women/people with PROM, share information with them as early as practical after rupture of membranes to support informed decision-making. • Women/people should be offered IOL at 24 hours post PROM, or as soon as practicable after that time. • Unless immediate IOL is planned, avoid digital vaginal examination. • Women/people should be offered intrapartum IV antibiotics to reduce the risk of GBS infection, to be commenced at the start of the augmentation process. • If neonates are at risk of early-onset neonatal group B streptococcal sepsis offer immediate IOL. • If liquor is meconium stained, consider immediate IOL. • Oral Misoprostol can be used for cervical ripening.
Monitoring	<ul style="list-style-type: none"> • For women/people who choose expectant management, identify and document a plan for ongoing maternal and fetal wellbeing assessment, and provide the opportunity to revisit the offer of IOL at any time. • Consider additional maternal and fetal monitoring as time goes on. • If any concerns about maternal or fetal wellbeing arise, then the clinician should re-discuss the benefits of IOL in light of the new context and re-offer IOL.
Guideline	<ul style="list-style-type: none"> • Pre-labour Rupture of Membranes - 43549

5.8 Obstetric Cholestasis

Risk/Benefit	<ul style="list-style-type: none"> • A multifactorial condition characterised by itching of the skin in the absence of a rash with abnormal liver function tests, neither of which has an alternative cause and both of which resolve after birth. • Systematic reviews found association with stillbirth only in women/people whose bile acids were ≥ 100 (MOH, 2019). • Individualised care required based on clinical considerations i.e. symptoms, gestational age at diagnosis and serum bile concentration in consultation with an Obstetrician. • Clinicians should be aware that fetal ultrasound and/or cardiotocography (CTG) do not predict or prevent stillbirth in Cholestasis.
Recommendation	<ul style="list-style-type: none"> • In women with peak bile acids 19–39 micromol/L (mild Cholestasis) and no other risk factors, advise them that the risk of stillbirth is similar to the background risk. Consider options of planned birth by 40 weeks' gestation or ongoing antenatal care according to national guidance. • In women with peak bile acids 40–99 micromol/L (moderate Cholestasis) and no other risk factors, advise them that the known risk of stillbirth is similar to the background risk until 38–39 weeks' gestation. Consider planned birth at 38–39 weeks' gestation. • In women with peak bile acids 100 micromol/L or more (severe Cholestasis), advise them that the risk of stillbirth is higher than the background risk. Consider planned birth at 35–36 weeks' gestation. • Advise women with Cholestasis and a twin pregnancy that the risk of stillbirth is higher compared with a twin pregnancy without Cholestasis.

5.9 Twin Pregnancy

Risk/Benefit	<ul style="list-style-type: none"> • Twin pregnancy is associated with higher rates of anomaly, preterm birth, pre-eclampsia, FGR, GDM and complicated birth. • There is a lack of high quality evidence to confirm benefits and harms of IOL or expectant management.
Recommendation	<p>In alignment with reviewed international guidelines (MOH 2019);</p> <ul style="list-style-type: none"> • For women with an uncomplicated monochorionic diamniotic twin pregnancy, consider offering IOL between 36 and 37 weeks' gestation. • For women with an uncomplicated dichorionic twin pregnancy, consider offering IOL between 37 and 38 weeks' gestation.

5.10 Small for Gestational Age (SGA) / Fetal Growth Restriction (FGR)

Isolated small for gestational age (SGA) is defined as estimated fetal weight (EFW) <10th centile.

Fetal growth restriction (FGR) is defined as either early onset or late onset:

Early Onset FGR: Diagnosed < 32+0 weeks is defined as;

- EFW customised or AC < 3rd centile OR
- UA with absent or reversed end-diastolic flow OR
- EFW customised or AC < 10th centile plus one or more of....
 - UA Doppler PI > 95th centile
 - UtA Doppler mean PI > 95th centile or bilateral notching

Late Onset FGR: Diagnosed ≥ 32+0 weeks is defined as;

- EFW customised or AC < 3rd centile OR two or more of the following...
- EFW customised or AC < 10th centile
- Slowing of fetal growth: decline in EFW or AC of > 30 centiles from 28+0 weeks gestation
- Any of: US Doppler PI > 95th centile or CPR < 5th centile or UtA mean PI >95th centile or bilateral notching

Risk/Benefit	Risk of neonatal mortality and morbidity
Recommendation	<p>FGR ≥ 32+0 weeks</p> <ul style="list-style-type: none"> • Isolated SGA: EFW and/or AC 3rd to <10th centile with normal UA, CPR and UtA Dopplers – IOL at 40+0 weeks (not earlier than 39+0). • FGR: EFW or AC < 3rd centile, two of three: EFW or AC < 10th centile, slowing fetal growth, abnormal UA, CPR or UtA Doppler – IOL by 38+0 weeks • FGR at high risk of deterioration – birth as soon as possible.
Monitoring	Fetal movement monitoring, twice weekly cardiotocograph (CTG), ultrasound scan and Doppler studies
Guideline	Prevention, Detection and Management of SGA or IUGR Fetus - 1561674

5.11 Reduced Liquor Under 41 Weeks Gestation

Risk/Benefit	<ul style="list-style-type: none"> • Decreased amniotic fluid volume (oligohydramnios) is usually associated with adverse perinatal outcomes and other pregnancy complications. • There is no high-quality evidence to confirm the benefits or harms of IOL or expectant management in the setting of isolated reduced liquor. • The finding of reduced liquor warrants a full clinical assessment, including history and examination of the woman/person to exclude spontaneous rupture of membranes (SROM) and identification of other antenatal risk factors.
Recommendation	In women with reduced liquor as an isolated finding at <41 weeks' gestation, in the presence of normal maternal and fetal assessment, consider expectant management.
Monitoring	<ul style="list-style-type: none"> • Clinicians could consider confirming the diagnosis with a repeat ultrasound scan. Single deepest pocket appears to be the most reliable measure to predict adverse outcomes. • If reduced liquor is persistent, then consider regular follow-up clinical assessment.

5.12 Antepartum Haemorrhage of Unknown Origin

An antepartum haemorrhage (APH), is defined as bleeding from the genital tract from 24 weeks' gestation up until the birth of the baby. It may be caused by placenta praevia, placental abruption, local tissue damage etc. but it is considered to be of unknown origin when a cause is not found.

Risk/Benefit	<ul style="list-style-type: none"> APH of unknown origin is associated with adverse perinatal outcomes, such as preterm birth, stillbirth, fetal anomalies and SGA. APH is an indication for assessment by an obstetric specialist and may require increased monitoring of the pregnancy (e.g. SGA, routine enquiry for intimate partner violence). If placental abruption was clinically diagnosed, most clinicians would recommend birth. However, there is no high-quality evidence to confirm the benefits or harms of IOL or expectant management for APH of unknown origin. There is currently insufficient high quality evidence to make a clear recommendation about IOL for this condition.
Recommendation	In women with antepartum haemorrhage of unknown origin, in the presence of normal maternal and fetal assessment, consider expectant management. If placental abruption is clinically diagnosed, birth would be recommended.
Monitoring	Assessment by an Obstetric Specialist and consider increased monitoring for SGA and routine enquiry for intimate partner violence.

5.13 Previous Stillbirth

Risk/Benefit	<ul style="list-style-type: none"> Large studies have shown an increased risk of recurrent stillbirth in a subsequent pregnancy but do not identify gestation at the first or any subsequent stillbirths and therefore cannot help with decision-making around timing of induction for a stillbirth (MOH, 2019). Many causes of stillbirth remain unknown, stillbirth is difficult to predict or prevent and maternal risk factors may still be present in the subsequent pregnancy. The anxiety of women who have experienced a previous stillbirth and the impact of that experience may affect decision-making in their current pregnancy.
Recommendation	Consider expectant management or IOL, based on a review of risk factors for recurrence and any other antenatal risk factors, and guided by maternal choice.

5.14 Intrauterine Fetal Death

Please refer to the Perinatal Loss Guideline: Second and Third Trimester Care (EDMS 2053162).

6. The Following are not Considered Indications for IOL

6.1 Assisted Reproductive Technology (ART)

Risk/Benefit	<ul style="list-style-type: none"> ART refers to procedures that involve the in-vitro handling of both human oocytes and sperm, or embryos, with the objective of establishing a pregnancy. There is no high-quality evidence to confirm the benefits or harms of IOL or expectant management of pregnancies conceived through ART (MOH, 2019).
Recommendation	<ul style="list-style-type: none"> In women who conceive using ART, in the absence of other risk factors or pregnancy complications, do not offer IOL.

6.2 Suspected Fetal Macrosomia without Diabetes

Risk/Benefit	<p>Defined as estimated fetal weight greater than the 90th centile on customised growth chart.</p> <p>Antenatal estimates of fetal weight are often inaccurate.</p> <p>It is important to provide information to pregnant women/people about the difficulty of assessing fetal size and diagnosing fetal macrosomia and the benefits and harms of IOL and expectant management.</p>
Recommendation	<p>In women with suspected macrosomia, in the absence of pregnancy complications, consider expectant management. IOL is not recommended.</p>

6.3 Maternal Obesity

Risk/Benefit	<p>There is an association with the degree of maternal obesity and the risk of stillbirth, with increasing risk as BMI increases, but there is no clear cut-off.</p> <p>There is no high-quality evidence to confirm the benefits or harms of IOL or expectant management in pregnant women/people with obesity.</p>
Recommendation	<p>For pregnant women/people with obesity, in the absence of other risk factors or pregnancy complications, do not offer IOL.</p>

6.4 No Medical Indication

Risk/Benefit	<ul style="list-style-type: none"> There is insufficient evidence to allow comment on the risks associated with IOL where there is no medical indication i.e. for maternal request. IOL should not be considered an option in the absence of a medical indication unless there is compelling psychological or social reasons, the woman/person has a favourable cervix and she is fully aware of the potential risks involved.
Recommendation	<p>IOL is not recommended in the absence of a medical indication.</p> <p>Manage maternal requests for IOL on a case by case basis.</p>

7. Pre-Induction of Labour Assessment

Prior to commencing IOL, complete the following:

- Review the maternal history
- Confirm the gestation
- Perform baseline observations: temperature, pulse, blood pressure etc. as per MEWS.
- Perform urinalysis if the woman/person has diabetes, hypertension or if there has been previous proteinuria.
- For women/people with pre-eclampsia, other medical conditions and other medical complications of pregnancy, ensure that blood is taken on the day of the IOL and results are available.
- Abdominal palpation to confirm presentation and engagement and auscultate fetal heart rate.
- Perform a baseline CTG for at least 30 minutes AND until the CTG is normal (Dawes-Redman (DR) can be used but CTG remains insitu for required length of time even if DR criteria have been met). If the CTG is abnormal the on-call obstetric team must be consulted.
- Vaginal examination (if required) to assess cervix and complete Bishop's score (see below).
- Where the presenting part is found not to be cephalic either on abdominal palpation or vaginal examination, the obstetric team must be consulted for further assessment.

Cervical Assessment

- The Bishop score is a method used to assess the state of the cervix.
- Each feature is scored and the scores are then totalled, using Bishop Score Sticker (below).
- The state of the cervix is one of the most important predictors of successful IOL.
- The cervix is unfavourable if the score is 6 or less.

Bishop Score Sticker

BISHOP SCORE:		CERVICAL RIPENING / INDUCTION OF LABOUR (Unfavourable Score = ≤ 6)			
Date:		Time:			
Score	0	1	2	3	
Dilation cm.	< 1	1 - 2	3 - 4	> 4	
Length of cervix cm.	3	2	1	0	
Station	- 3	- 2	- 1 or 0	+1 or +2	
Consistency	Firm	Medium	Soft	-	
Position	Posterior	Mid	Anterior	-	
Score = <input type="text"/>	PG Gel Dose:		Misoprostol:		
	ARM:		Synto:		
	Foleys Balloon:				
Print Name:			Designation:		

8. Booking Induction of Labour

These are booked by completing an Induction of Labour Referral Form (EDMS 2643367 – [see Appendix 1.](#)).

Submit the paper form;

- by hand to the Clinical Midwife Managers, Rotorua Maternity Unit **OR**
- by email to; Clinical.MidwifeCo-ordinator@lakesdhb.govt.nz
- **AND** copy to Corli.Roodt@lakesdhb.govt.nz

If the IOL is urgent (e.g. required within 48 hours) also text or call the Clinical Midwife Manager.

Once the IOL Request has been processed a copy of the form will be filed in the woman/person's clinical notes.

- Induction of Labour Referrals will be reviewed by a Clinical Midwife Manager. The on call Obstetrician will be consulted if needing to triage or prioritise due to higher demand than capacity.
- The Clinical Midwife Manager will communicate the outcome (i.e. date of IOL) to the LMC.
- There are usually two available spaces for IOL each day, Monday to Friday.
- If there is need for additional capacity (i.e. an additional one or IOL over the weekend), this must be in consultation with the Rotorua Birthing Unit Clinical Midwife Manager and the on-call Obstetric SMO of the day.
- Admission for IOL is at 0730hrs.
- Once a date has been booked, the woman/person presents and is admitted to the Rotorua Birthing Unit at the pre-arranged time (unless any issues necessitating hospital care arise prior to this).
- The Induction of Labour Front Sheet is completed and the relevant process of IOL is then followed.

9. Methods of Induction of Labour

Methods used for IOL include:

- Medical methods: Oral Misoprostol, Prostaglandin gel, Oxytocin infusion
- Surgical methods: Artificial rupture of membranes (ARM)
- Mechanical methods: Transcervical catheter (Foley) (Balloon Catheter)

9.1 Oral Misoprostol

ORAL MISOPROSTOL	
Indications	<ul style="list-style-type: none"> • Unfavourable cervix
Contraindications	<ul style="list-style-type: none"> • Vaginal birth contraindicated (e.g. placenta praevia/accreta, transverse lie, etc.) • Known allergy to misoprostol • Informed consent cannot be obtained
Cautions	<ul style="list-style-type: none"> • Prostaglandin hypersensitivity • Previous caesarean or any major uterine surgery - only after assessment and documented plan by Obstetric SMO • Abnormal CTG • IUGR and/or oligohydramnios • High parity > 3 • Malpresentation • Multiple pregnancies • Oxytocin administration • Cardiovascular disease • Raised intraocular pressure, glaucoma
Advantages	<ul style="list-style-type: none"> • Reduces number of vaginal examinations required which reduces the risk of infection and enhances woman's/person's experience • More effective than prostaglandin gel (Dinoprostone) at inducing labour • Reduced caesarean section when compared with other prostaglandins • The risk of hyperstimulation is the same as the risk with other prostaglandins • Can be used with or without intact membranes • Most women (65%) establish in labour within < 25 hours (Te Whatu Ora Mid-Central, 2022).
Dosage	The dose is 25 micrograms every 2 hours until labour is established with a maximum of 8 doses (200mcg) in 20 hours.
Administration	See Preparation and Administration of Oral Misoprostol (below) See Misoprostol - Instruction for Dilution Using Tablets (Appendix 2.)
Monitoring	Complete a CTG in all of the follow situations: <ul style="list-style-type: none"> • Prior to giving a dose of misoprostol (at least 20 minutes) • Following first dose of misoprostol (for at least 40 minutes) • Contracting regularly with increasing intensity, frequency and duration • Established labour (continuous CTG)

Process of Administering Oral Misoprostol

Prior to Admission

1. Decision is made for IOL after a consultation involving the woman/person, the LMC and an Obstetrician.
2. Information about IOL is provided to the woman/person prior to admission, if possible.
3. Arrange for the woman/person to present to Birthing Unit **before 0730hrs** on the day of IOL.
4. Oral Misoprostol is prescribed by a doctor on the medication chart prior to the woman/person arriving; **The dose is 25 micrograms every 2 hours until labour is established with a maximum of 8 doses (200mcg) in 20 hours.**

Woman/Person presents to Birthing Unit

5. The core Midwife completes a midwifery assessment (including CTG of at least 20 minutes' duration and MEWS) to ensure there are no contraindications and no change in the clinical picture that needs to be escalated to the Obstetric team.
6. Consider performing a baseline VE (i.e. only if contractions prior to admission or if a multip) and document Bishop Score – unless performed in last 48 hours or woman/person declines.
7. If cervix is fully effaced (and >3cm dilated in a multip) perform an ARM. If not suitable for Misoprostol or ARM, consider balloon catheter or prostaglandin.
8. Inform LMC of any changes or that IOL is to proceed.
9. Verbal consent for Misoprostol must be obtained from the woman/person and documented by the health professional administering the medication, as Misoprostol is not licensed for IOL in New Zealand - however, its use is well supported by evidence.
10. Prior to giving the first dose of Misoprostol, insert an intravenous (IV) line and take and send bloods for Full Blood Count (FBC) and Group & Hold (G&H)

Day One – First Dose

11. Prepare and give first dose of Misoprostol (as per 'Preparation and Administration of Oral Misoprostol')
12. Continue CTG for 40 minutes after 1st dose (not required after subsequent doses unless clinically indicated) to check for hyperstimulation and fetal response

Next Dose of Misoprostol

13. Perform a CTG for 20 minutes prior to the next dose of Misoprostol – usually this will be 1 hour and 40mins from the last dose of Misoprostol.
14. If a woman/person is contracting strongly 2 hours after being given a dose, wait for a further one hour before considering giving the next dose. If still contracting strongly perform a VE to assess progress.

Further Doses and Management

15. Administer the next dose of Misoprostol 2 hours after the last dose (after 20min CTG) and give repeated Misoprostol doses 2 hourly (up to 8 doses in 20 hours) until in established labour.

Established Labour is defined as;

Primiparous: regular, painful, contractions 3-4:10, fully effaced cervix ≥ 3cm dilated

Multiparous: regular, painful contractions at least 2-3:10, cervix ≥4cm dilated

16. Call LMC to inform them woman/person is in established labour (see definition Step 15 above) – note that labour and birth following Misoprostol can occur quickly.
17. Perform ARM when indicated: ensuring this is not within 2 hours of Misoprostol being given (to reduce the risk of hyperstimulation) and in consultation with the Obstetric SMO and Birthing Unit Coordinator to ensure safe staffing and patient acuity. (Ensure IV access is patent prior to performing ARM).
18. If membranes rupture spontaneously and there are contractions, perform a VE to assess. If not in labour wait 2 hours and reassess. If not in labour at that time continue Misoprostol dosing. Assess for GBS risk and if risk present, commence antibiotics.
19. If there is spontaneous rupture of membranes but no regular uterine activity, continue with Misoprostol. Start antibiotics immediately if at increased risk of GBS infection or at 18 hours if not.
20. **NOTE:** if contractions are adequate at 2 hours post Misoprostol and start to become less frequent or reduce in strength after that, continue to give further doses of Misoprostol (up to 8 doses).
21. Maximum of 8 x 25mcg doses in 20 hours. If not labouring after 8 doses, then allow a 4-6 hour break/rest time and restart with a second cycle of Misoprostol the following morning.
22. If hyperstimulation occurs, manage in accordance with [Section 11](#) of this IOL Guideline.
23. Notify an Obstetrician immediately if there is an adverse side-effect from Misoprostol.

Fetal Monitoring for Misoprostol IOL

Complete a CTG in all of the follow situations:

- Prior to giving a dose of Misoprostol (for at least 20 minutes)
- Following first dose of Misoprostol (for at least 40 minutes)
- Contracting regularly with increasing intensity, frequency and duration
- Established labour
- If there are any concerns

(N.B.: Dawes-Redman criteria can be applied to the CTG prior to the administration of the first dose of Misoprostol, but the CTG must remain on for the specified time, even if the Dawes-Redman criteria has been met. Dawes-Redman criteria should not be used once Misoprostol has been administered).

Complete a CTG Sticker and refer to an Obstetrician if the CTG is abnormal.

Continuous CTG is required once in established labour.

Maximum Misoprostol given and labour not established

- Request an Obstetric consultation and offer VE to be able to plan further management
- Only consider ARM if it is 2 hours after the last dose of Misoprostol and after consultation with the Obstetric SMO and Clinical Midwife Manager/Birthing Unit Coordinator and updating the LMC.
- Once ARM has been performed, if required, start oxytocin augmentation 4 hours after last dose of misoprostol
- The woman/person will be cared for in BU by core Midwives until labour is established, when the LMC will be contacted, if the arrangement is for them to attend to provide midwifery care (MOH, 2015).
- Alternatively, if ARM is not possible, offer resting time and repeat the 8 dose cycle 24 hours after the commencement of the IOL
- If ARM is not possible after two cycles of misoprostol, consider offering balloon catheter method of IOL.

Labour is established with Misoprostol

- Contact the LMC, providing reasonable notice of the need to be available to provide midwifery care. The core midwifery team will provide support to the woman/person until the LMC arrives and will support the LMC with care related to complexity as required (MOH, 2015).

Preparation and Administration of Oral Misoprostol

Equipment required:

- Pair of non-sterile gloves
- 1 x 20ml syringe
- 1 drawing up needle
- 1 x 3 ml oral syringe
- 1 x paper medicine cup
- 2 x 10 ml Water for Injection
- 1 x packet of Misoprostol 200 microgram tablets (1 x tablet for each administration)
- Medication Added label

Preparation instructions

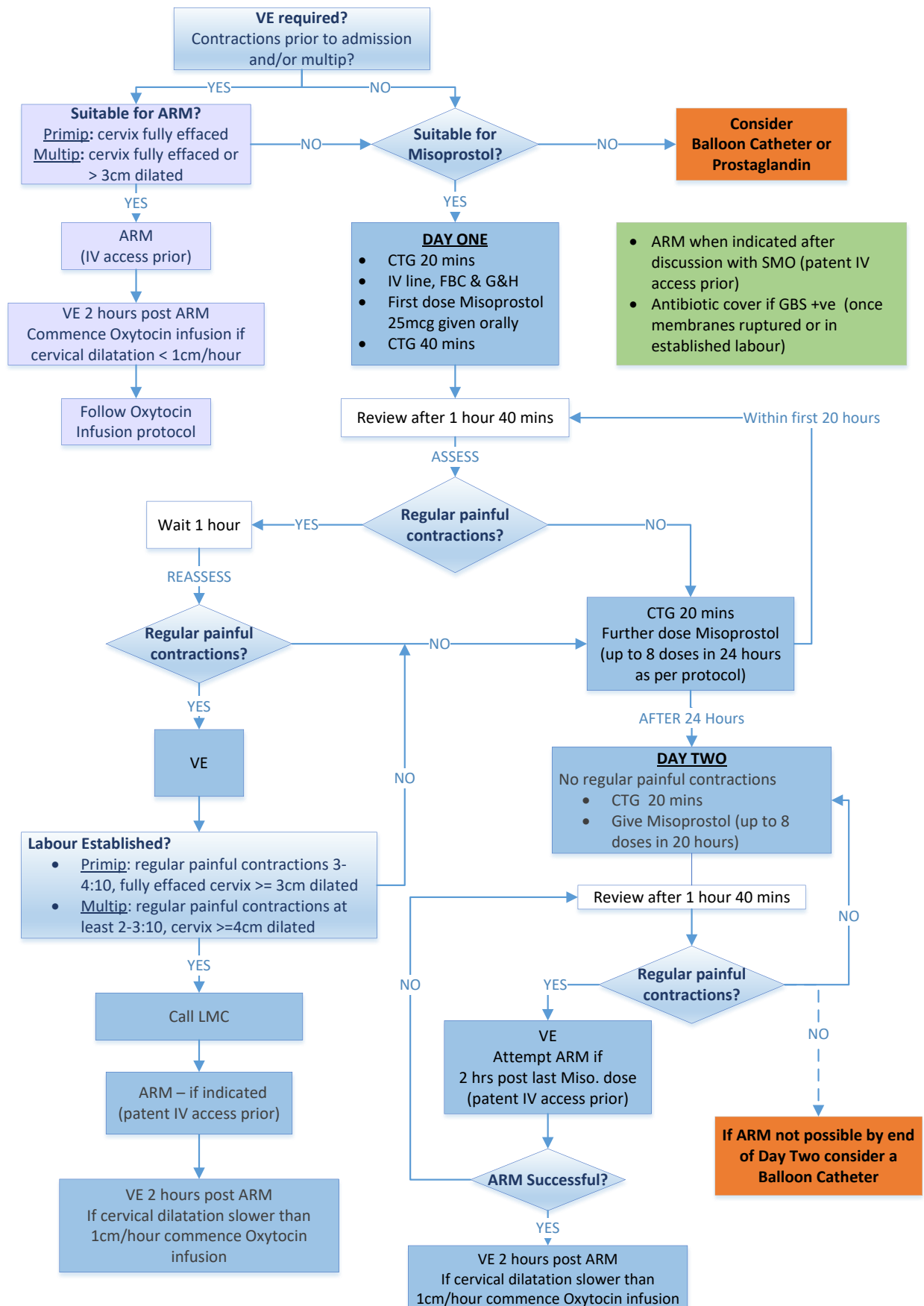
Prepare and give oral solution;

- a. Pour contents of 2 x 10ml water for injection ampoules into a medicine measure cup.
- b. Draw up 20ml of water into 20ml syringe, via the drawing up needle and discard remainder of water in cup (but keep the cup).
Note: The ampoules of 10ml water for injection usually contain more than 10mls, therefore the 20mls water needs to be measured
- c. Place ONE 200mcg Misoprostol tablet into the empty medicine cup and add the 20ml of water from the syringe.
- d. Use the drawing up needle on the 20 ml syringe to mix vigorously until tablet is fully dissolved.
- e. Ensure the tablet is fully dispersed then **immediately** draw up **2.5 ml** of the solution into the oral syringe (before the suspension settles).
- f. Label the oral syringe with a 'Medication Added' label
- g. Shake the oral syringe well immediately before administering the dose.
- h. Ask woman/person to squirt the solution into her mouth and swallow, to ensure they receive the full dose.
- i. Discard the remainder of solution and the paper medicine cup. Rinse the oral syringe with tap water and keep this and all the other equipment for the next dose.

See 'Misoprostol - Instruction for Dilution Using Tablets' ([Appendix 2.](#)) for pictorial representation of the above process.

Oral Misoprostol Induction Of Labour Process

- A decision is made for IOL in a three-way conversation with woman/person, LMC & Obstetrician
- Provide the woman/person with information and ensure the IOL process is understood
- If indicated, perform a VE to determine Bishop Score



9.2 Prostaglandin Gel

PROSTAGLANDIN E₂ GEL (PGE 2) ®	
Indications	<ul style="list-style-type: none"> • 1st line for cervical ripening for women with parity 4 and 5 needing prostaglandin induction (following consultation with the O&G Consultant on call). • It may also be used as a 2nd line agent if Misoprostol has failed in women with parity 0-3 where amniotomy is not possible.
Contraindications	<ul style="list-style-type: none"> • Known hypersensitivity to prostaglandin or other constituent of PGE 2 Gel ® • When labour has commenced • Any conditions not conducive to labour • When oxytocic drugs are being given • When the risk of uterine hyper stimulation would be inappropriate e.g. grand multiparity, previous major uterine surgery etc. • Active cardiac, pulmonary, renal or hepatic disease
Cautions	<ul style="list-style-type: none"> • If uterine activity is already present
Dosage	<ul style="list-style-type: none"> • Nullip: Bishop Score ≤5 – administer 2mg Prostaglandin gel, reassess in 6 hours No change – give further 2mg Prostaglandin gel Some change – give 1mg Prostaglandin gel • Multip: Administer 1mg Prostaglandin gel. Obstetric SMO may authorise 2mg in special circumstances.
Administration	<ul style="list-style-type: none"> • Verbal consent obtained from the woman/person. • Abdominal palpation. • Baseline maternal recordings (P, T, RR, BP) according to and documented on MEWS Chart. • Pre assessment CTG of at least 30 minutes (this must be reassuring). • Ensure prostaglandin is prescribed on the Medication Chart. • VE to assess the Bishops score (document in clinical notes using the 'Bishop Score' label). • Use Prostaglandin gel directly from the fridge where it is stored. • Insert Prostaglandin gel into the posterior vaginal fornix, not endocervical as this increases the risk of hyperstimulation. • Woman/person must remain semi recumbent post insertion of prostaglandin, during which time a post prostaglandin insertion CTG should be performed for a minimum of 30 minutes to assess fetal wellbeing and uterine activity. • Complete the Bishops score label with PGE2 and dosage in the clinical notes. • Woman/person may mobilise following the post CTG if maternal and fetal observations are within normal limits. • If repeated administration is necessary and is prescribed by Obstetrician, allow at least 6 hours between doses. • Prostaglandin induction should be carried out in the hospital and the woman/person should remain in hospital but encouraged to mobilise as freely as possible.
Monitoring	<ul style="list-style-type: none"> • After administration of vaginal prostaglandin when contractions begin, fetal wellbeing should be assessed with continuous electronic fetal monitoring. Once the CTG is confirmed as normal, intermittent auscultation should be used unless there are clear indications for continuous electronic fetal monitoring as outlined in Care Plan. • Unless uterine activity starts spontaneously, or spontaneous rupture of membranes occurs, the condition of the cervix should be assessed after 6 hours. • If hyper stimulation occurs, see section on the 'Management of Hyper Stimulation'.

9.3 Oxytocin Infusion

Oxytocin (Syntocinon®) stimulates the smooth muscle of the uterus to produce rhythmic contractions.

OXYTOCIN INFUSION	
Indications	<ul style="list-style-type: none"> To induce labour once the cervix is favourable.
Contraindications	<ul style="list-style-type: none"> Known hypersensitivity to any constituents of the product Hypertonic uterine contractions Vaginal delivery contraindicated Fetal compromise or malpresentation Known cephalopelvic disproportion Placenta previa, Vasa praevia, Placental abruption Cord presentation or prolapse Not within 6 hours of PGE 2 @ gel Not within 2 hours of administration of Misoprostol
Cautions	<ul style="list-style-type: none"> Presence of a uterine scar High parity (>4) Avoid prolonged use and monitor fluid intake in women with severe Pregnancy Induced Hypertension (PIH), or pre-eclampsia, severe cardiovascular disorders or oxytocin resistant uterine inertia due to oxytocin's slight anti-diuretic activity <p>If any caution applies then the decision to use Oxytocin should be made and documented by an Obstetric Specialist (SMO).</p>
Risks/Benefit	<ul style="list-style-type: none"> Restricts mobility and may increase the need for epidural Contractions are reported as being more painful
Dosage	<ul style="list-style-type: none"> Syntocinon® 10 iu (international units) in 500ml Sodium Chloride 0.9% Administer via infusion pump with sideline to main infusion of Sodium Chloride 0.9%. Set the infusion pump at 1 milliunit oxytocin per minute.
Administration	<ul style="list-style-type: none"> Assess fetal and maternal wellbeing prior to the commencement of infusion (baseline maternal recordings (P, T, RR, and BP according to and documented on MEWS Chart). Abdominal palpation – to rule out malpresentation. Ensure Syntocinon® is prescribed on the Medications Chart. VE to assess the Bishops score (document in clinical notes using the 'Bishop Score' label). Increase the infusion rate according to the regime in the Syntocinon Guideline (EDMS 43350).
Monitoring	<ul style="list-style-type: none"> Continuous CTG Aim for a maximum of 3-4 moderate to strong contractions in 10 minutes. Palpate uterine contractions every 15-30 minutes. The minimum dose possible should be used The infusion rate may be increased and also decreased, as per regime, as required. Unless uterine activity starts spontaneously, or spontaneous rupture of membranes occurs, the condition of the cervix should be assessed after 6 hours. If hyperstimulation occurs, see section on the Management of Hyper Stimulation below.

9.5 Artificial Rupture of Membranes

ARTIFICIAL RUPTURE OF MEMBRANES	
Indications	<ul style="list-style-type: none"> • Favourable cervix – Bishop score of 7 or more with presenting part fixed in the pelvis and well applied to the cervix. • May be used as initial method of IOL, especially in a multiparous woman/person or in combination with oxytocin infusion.
Contraindications	<ul style="list-style-type: none"> • Low lying placenta, placental praevia or vasa praevia • Non-cephalic presentation
Cautions	<ul style="list-style-type: none"> • Exercise caution when cephalic (head) presentation is high – due to risk of cord prolapse. Discuss controlled rupture with Obstetrician. • Active vaginal and other infections e.g. genital herpes, HIV, Group B Streptococcus, Hepatitis A, B or C.
Procedure	<ul style="list-style-type: none"> • Perform abdominal palpation to confirm presentation and engagement of the presenting part. • Confirm there is no cord or vessel presentation on vaginal examination • Rupture the membranes using an amnihook. • Following ARM examine to ensure there is no cord prolapse. • Auscultate the fetal heart rate for more than 30 seconds. • Document liquor colour and consistency. • Encourage mobilisation to promote onset of uterine contractions
Monitoring	<ul style="list-style-type: none"> • In a Primigravida woman/person, commence Syntocinon as soon as possible following ARM. • Multiparous woman, it is reasonable to consider commencing Syntocinon if there is no uterine activity after 2 hours. • The decision to perform ARM and await onset of contractions may be considered when there is; <ul style="list-style-type: none"> ○ a past history of rapid labour ○ grand multiparity ○ previous lower segment caesarean section or ○ when the woman/person has expressed a strong preference for giving some time to await spontaneous labour after ARM.

9.6 Balloon Catheter

A Balloon Catheter (e.g. Foley) offers a mechanical method for IOL that directly dilates the cervical canal and indirectly increases prostaglandin and/or oxytocin secretion.

BALLOON CATHETER	
Indications	<ul style="list-style-type: none"> • May be useful where the cervix is unfavourable and prior to oral Misoprostol. • May be considered in women/people with previous caesarean section or major uterine surgery. • Balloon catheter may be more appropriate in circumstances where the risk of uterine hyperstimulation has more consequences, such as severe SGA.
Contraindications	<ul style="list-style-type: none"> • Low lying placenta, placental praevia or vasa praevia • Non-cephalic presentation • Prior hysterotomy, classic uterine incision, myomectomy. • Pelvic structural abnormality. • Active genital herpes infection. • Invasive cervical cancer. • Abnormal fetal heart rate patterns. • Polyhydramnios. • Presenting part above the pelvic inlet. • Rupture membranes. • Any contra indication to labour induction.
Cautions:	<ul style="list-style-type: none"> • Antepartum bleeding • Inflammation of the cervix
Administration	<p>Obstetric Specialist to perform insertion of the balloon catheter on the Birthing Unit.</p> <p>Equipment:</p> <ul style="list-style-type: none"> • Dressing pack. • Chlorhexidine wash. • Sterile gloves. • 2 sponge forceps. • 30ml syringe. • 30ml sterile water. • Foley catheter with 30ml balloon capacity • Vaginal Speculum. • Catheter spigot. • KY jelly. • Light source.

BALLOON CATHETER cont'd	
Procedure	<ul style="list-style-type: none"> • Verbal consent obtained from the woman/person. • Advise woman/person to empty bladder. • Abdominal palpation. • Baseline maternal recordings (P, T, RR, BP) documented in clinical notes. • Pre assessment CTG of at least 30 minutes (this must be reassuring). • Position the woman/person in lithotomy position. • VE to assess the Bishops score (document in clinical notes using the “Bishops Score label”) and to decide for insertion with speculum or blind. • Insert a large vaginal speculum (if using). • Wash with chlorhexidine solution. • Put the sponge forceps on the anterior lip of the cervix for traction. • Place the second sponge forceps onto the catheter, on first click only (behind balloon) to aid insertion. • Advance the catheter through the cervix until the balloon sits completely in the cervical canal. • Fill balloon with 30ml sterile water. • Remove sponge forceps and check the balloon position with a gentle VE. • Spigot catheter end and secure to woman/person’s thigh. • Ensure the continuing CTG is reassuring post insertion. • Woman/person may mobilise following the post procedure CTG if maternal and fetal observations are within normal limits.
Monitoring	<ul style="list-style-type: none"> • Review after 12-24 hours. The woman/person is to notify staff if: <ul style="list-style-type: none"> ○ The catheter falls out (the woman/person will need to have a VE to assess if ARM able or needs reinsertion). ○ There are regular painful contractions, 5 minutes apart for a first baby, or 10 minutes apart for any subsequent babies ○ Membranes rupture ○ Baby seems to be moving less ○ There is fresh vaginal bleeding • After 24-hour post insertion, balloon catheter should be removed and the IOL process re-evaluated. Repeat CTG, maternal observations, palpation and VE. Findings all clearly documented in the maternal notes. • Consider using gentle traction BEFORE deflating balloon, however if significant resistance deflate balloon first.

10. Unsuccessful IOL

- Defined as the inability to perform an ARM after maximum dose of oral misoprostol has been administered OR 24 hours post Balloon Catheter insertion.
- In all cases of 'unsuccessful' IOL, the team should re-evaluate the clinical situation and re-confirm the clinical indication for IOL still exists.
- If the decision is made that birth is still required at this time, then the management options are;
 - **Rest day**
The woman/person is given a 24 hour 'rest period' after which the induction regime can be restarted. During this time, she/they may go into spontaneous labour.
 - **Alternative method of induction**
For those women/people who have had an unsuccessful trial of oral misoprostol, a Balloon Catheter induction will be offered.
For those women/people who have an unsuccessful trial of Balloon Catheter, a trial of oral misoprostol is appropriate, assuming there are no contraindications to this i.e. previous caesarean section (see section 9.1).
 - **Caesarean section**
In some circumstances it may be more appropriate to discuss and plan for the option of caesarean section, including the potential risks and complications of surgery and impact on future pregnancies.

11. Excessive Uterine Activity

- This may occur during the IOL process as tachysystole, uterine hypertonus or uterine hyperstimulation.
- Early recognition is essential as excessive uterine activity causes poor uterine placental perfusion leading to a decrease in fetal oxygenation and eventually fetal compromise.
- When assessing for excessive uterine activity, consideration should be given to both the duration and frequency of the contractions. The fetus needs 60-90 seconds between contractions to restore normal fetal oxygenation.

Excessive uterine activity without fetal heart rate abnormalities is defined as either:

- **Tachysystole:** > 5 contractions in 10 minutes, without fetal heart rate abnormalities, or
- **Uterine hypertonus:** contractions lasting > 2 minutes or occurring within 60 seconds of each other, without fetal heart rate abnormalities.

Excessive uterine activity with fetal heart rate abnormalities is defined as;

- **Uterine hyperstimulation** (either uterine tachysystole or hypertonus with fetal heart rate abnormalities)

Excessive Uterine Activity cont'd

Risks

- Uterine rupture
- Antepartum haemorrhage
- Amniotic embolism
- Precipitate delivery
- Fetal hypoxia
- Postpartum haemorrhage

Management

- **Uterine Hypertonus or Tachysystole:**
 - Continuous CTG
 - Consider reducing or stopping oxytocin infusion
 - Remain with the woman/person
 - Consider tocolysis*
- **Uterine Hyperstimulation:**
 - Continuous CTG
 - Reduce or stop oxytocin infusion
 - Remain with the woman/person
 - Left lateral position, IV fluids as required
 - Arrange URGENT Obstetric review
 - Consider tocolysis*
 - Consider urgent delivery
- Excessive uterine activity is frequently associated with oxytocin infusions, therefore judicious use of oxytocin and CTG monitoring with 1:1 care is required.
- Remove Prostaglandin gel from vagina (use a gauze swab on a sponge forcep).

Treatment

*Tocolysis regimes include:

- **Terbutaline 250 mcg** subcutaneously or intravenous (IV) – in Birthing Unit
- **Glycerin Trinitrate (GTN) 100-200 mcg** IV – in theatre

If significant fetal heart rate abnormality persists, urgent caesarean section delivery may be indicated.

12. Associated Documents

- Bishop Score Sticker
- Cardiotocograph (CTG) Sticker
- Fetal Monitoring Guideline (EDMS 2499948)
- Induction of Labour Front Sheet
- Induction of Labour Referral Form (EDMS 2643367)
- Maternity Early Warning System (MEWS) Chart
- Oral Misoprostol Induction of Labour (IOL) Record (EDMS 2947322)
- Perinatal Loss Guideline: Second and Third Trimester Care (EDMS 2053162)
- Syntocinon Guideline (EDMS 43350)



13. References

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8. Royal College of Obstetricians & Gynaecologists (RCOG) Intrahepatic cholestasis of pregnancy Green-top Guideline No. 43 June 2022

Authorised by: Maternity Continuous Quality Improvement (CQI) Meeting

14. Appendices

Appendix 1. Induction of Labour Booking Form

CREATIVE COMMONS COPYRIGHT - cc-by-nc-sa-4.0		Place Patient label here Please ensure you attach the correct patient label	 MATERNITY SERVICES
Induction of Labour (IOL) Booking Request Form			
Today's Date:		Urgent/Acute IOL required within 24 hrs:	<input type="checkbox"/> No <input type="checkbox"/> Yes
LMC:			
Requestor:		SMO Responsible for Decision:	
Requested Date Range for IOL:		From: To:	
EDD:	G:	P:	Gestation:weeksdays
Guidelines based indication for IOL		Other factor(s) (tick all that apply)	
<input type="checkbox"/> Multiple pregnancy		<input type="checkbox"/> Maternal age 35-39	
<input type="checkbox"/> Pre-eclampsia		<input type="checkbox"/> Obesity - Booking BMI:	
<input type="checkbox"/> Diabetes (Specify).....		<input type="checkbox"/> IVF Pregnancy	
<input type="checkbox"/> Small for gestational age (SGA)		<input type="checkbox"/> Slowing of growth	
<input type="checkbox"/> Intrauterine growth restriction (IUGR)		<input type="checkbox"/> Antepartum haemorrhage	
<input type="checkbox"/> Maternal age ≥ 40 years		<input type="checkbox"/> Maternal medical condition	
<input type="checkbox"/> Post-dates		<input type="checkbox"/> Fetal condition e.g. (↓ Liquor Vol. / CTG / BPP)	
<input type="checkbox"/> Hypertension, no pre-eclampsia		<input type="checkbox"/> PPRM by: History / Pad / Speculum / Amnisure (circle)	
<input type="checkbox"/> ↓Fetal Movements: Episode: <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd +			
<input type="checkbox"/> Other: (Specify e.g. TOP / Intrauterine Fetal Death)			
Preferred Method			
<input type="checkbox"/> Misoprostol *	<input type="checkbox"/> PGs	<input type="checkbox"/> Balloon	<input type="checkbox"/> ARM <input type="checkbox"/> Syntocinon
Rationale:			
*Verbal consent obtained for Misoprostol <input type="checkbox"/> Yes <input type="checkbox"/> No			
Other Concerns			
Previous Caesarean Section: <input type="checkbox"/> No <input type="checkbox"/> Yes		Short Inter-pregnancy Interval: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Other:			
Lakes IOL Leaflet Provided: <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> LMC Instructions Completed & Signed (See Over)	
Admin Use			
<input type="checkbox"/> LMC Advised		Care in Labour: <input type="checkbox"/> LMC <input type="checkbox"/> DHB MW	
<input type="checkbox"/> Scheduled in Book		Booked Date: Time:.....	
Notes:			

DO NOT WRITE IN THIS BINDING MARGIN

EDMS # 2643367 Version 1.2 Date: November 2023

INDUCTION OF LABOUR (IOL) BOOKING REQUEST FORM

CREATIVE COMMONS COPYRIGHT - cc-by6-nc-sa-4.0

Te Whatu Ora
Health New Zealand
Lakes

MUST attach Patient Label Here
Please ensure you attach the correct patient label

MATERNITY SERVICES

LMC INSTRUCTIONS

Please contact me to inform me when my client:

Has significant changes following review

Is requesting one-to-one midwifery care from an LMC Midwife

LMC please note: The effect of oral misoprostol on the cervix can cause sudden changes in labour progress that can result in birth occurring before there is time to notify an LMC or before an LMC is able to attend.

Signature (LMC):

Date:/...../.....

DO NOT WRITE IN THIS BINDING MARGIN

COMMUNICATION RECORD

Date	Time	Person Contacted	Summary	Contacted By (Signature)






INDUCTION OF LABOUR (IOL) BOOKING REQUEST FORM

EDMS #2466449 Version: 1.2.... Date: November 2023

Appendix 2. Misoprostol - Instruction for Dilution Using Tablets

Instructions for Dilution of Misoprostol Tablet

MATERNITY SERVICES

	<p>Prepare Equipment</p> <ol style="list-style-type: none"> You will need; <ul style="list-style-type: none"> Non-sterile gloves 1 x 20 ml syringe 1 x paper medicine cup 2 x 10 ml Water for Injection 1 drawing up needle 1 x packet of Misoprostol tablets (1 x tablet dissolved for each administration) 1 x 3 ml BD oral syringe 'Medication Added' label
	<p>Draw Up Water</p> <ol style="list-style-type: none"> Open 2 x 10 ml water for injection ampoules and draw up into 20 ml syringe with drawing up needle. <p>(There may be more than 20 ml water in the ampoules so it is important to measure this to get the right volume for dilution).</p>
	<p>Dissolve Misoprostol Tablet</p> <ol style="list-style-type: none"> Take ONE Misoprostol 200mcg tablet out of the blister pack and place it into the empty medicine cup. Add 20 ml Water for Injection from the 20 ml syringe to the medicine cup. Open a 3 ml BD oral syringe and, using the oral syringe, mix vigorously until the tablet has dispersed. <p><u>Note:</u> Sediment in the solution is from fillers in the tablet and does not change the dilution of the medicine.</p>
	<p>Draw Up Solution</p> <ol style="list-style-type: none"> Ensure tablet is fully dispersed then, using the oral syringe, immediately draw up 2.5ml of mixture out of the measuring cup before the suspension settles. Label the syringe with a 'Medication Added' label.
	<p>Administer Misoprostol</p> <ol style="list-style-type: none"> Ask the woman/person to squirt the 2.5 ml dose of fluid from the syringe into the mouth and swallow to make sure the full dose is taken. Discard the remaining mixture and the paper medicine cup. Then rinse the oral syringe out with tap water. Keep the oral syringe and all other equipment for the next dose. Once the course of Misoprostol is complete all equipment, including the oral syringe, 20 ml syringe, drawing up needle etc. should be discarded.