The Dudley Group NHS Foundation Trust

Date: 27/11/2018

FREEDOM OF INFORMATION REQUEST014500 – Induction of labour

May I request the following information for FOI, please:

- In your trust, do you have a guideline/policy/protocol for the use of Oxytocin Or Syntocinon for induction of labour or augmentation of labour or progress in labour? (Maternity Services - Obstetrics)

- Can you provide a copy of the relevant guideline, please?

- In your trust, do you have a guideline/policy/protocol or specific section within the guideline for the use of Oxytocin Or Syntocinon in the Second stage of labour? Is there a specific regimen that is followed? (Maternity Services - Obstetrics)

- If yes, can you provide a copy of the relevant guideline or the relevant section, please?

Induction of labour guideline – relevant section 16.2, see below
Augmentation of labour guideline – whole document - see below
High risk woman in labour guideline – relevant section 11, see below

16.2 Oxytocin (Syntocinon) Regime

 In a primip who has not had prostaglandin Syntocinon should be started immediately following ARM unless they have established strong regular contractions. If prostaglandin has been given recently, delay the start of Syntocinon until 6 hours from the last prostaglandin dose.
 With an unfavourable cervix (i.e. less than 3cm dilated) once Syntocinon is commenced a VE should be delayed until six hours of regular contractions, unless clinically indicated before this.
 For multiparous allow 2 hours to see if contractions establish
 if no regular contractions; commence Syntocinon and reassess 4 hours from regular contractions,
 if regular contractions have established; re-examine four hours from onset of regular contractions
 Any women receiving Syntocinon for IOL or augmentation should be assessed and examined by the middle grade before Syntocinon Commencement. This assessment should be documented.
 10iu Syntocinon added to 49 ml Hartmann's solution should be given in a 50ml syringe **through a large bore cannula (16 gauge or more)**
 The infusion should commence at 2 mu/min and be doubled at 30 minute intervals in the first stage, 15 minute intervals in the second stage
 With pump calibrated at:
 ml/hour 0.6 ml/hour =2 mu/min
 0.6ml/hr = 2mu/min
 1.2ml/hr = 4mu/min
 2.4ml/hr = 8mu/min
 4.8ml hr = 16mu/min
 9.6ml/hr = 32mu/min
 Infusion should be increased at 30-minute intervals until the contractions are 4 in 10 minutes.
 Continuous CTG must be performed and a partogram commenced.
 In the event of signs of fetal distress or excessive uterine activity, the Syntocinon infusion should be discontinued or reduced and the Lead Midwife and Senior Obstetrician informed.

11.1 Care and observations in the third stage of the labour

• Observe the woman's general physical condition and listen to her own report of how she feels.
• Observe for any abnormal vaginal bleeding
 Record temperature, pulse and blood pressure after the birth on the labour report summary

11.2 Active management of the third stage of labour

• The use of syntometrine for the third stage of labour should be discussed and consent obtained.
• 1 ml Syntometrine to be given Intra Muscularly (IM) either with the delivery of the anterior shoulder or as soon as possible after delivery.
• If there is a cardiac condition, significant hypertension either antenatally or arising in labour, 10 units of Syntocinon IM (or 5 units IV) should be given with the delivery of the anterior shoulder.
• Clamp the cord after at least one minute from the complete delivery of the infant if the baby does not need to be moved to a resuscitaire.
• Deliver placenta by controlled cord traction
• Following delivery of the placenta, inspection of the perineum should be undertaken as per guideline on perineal repair and inspection.
• If the placenta and membranes are not delivered within 30 minutes of active management inform Registrar on call.
• Examine the placenta to ensure complete and cord vessels and record in intrapartum notes.
• All estimated blood lost to be recorded.

11.3 A physiological third stage may be conducted at the request of the woman – refer to the care of the low risk intrapartum care guideline.

11.4 Delayed Third Stage of Labour

The third stage of labour is diagnosed as prolonged if not completed within 30 minutes of the birth of the baby with active management and 60 minutes with physiological management. Referral to obstetrician required.
Changing from physiological management to active management of the third stage is indicated in the case of:
failure to deliver the placenta within 1 hour
Traction on the cord or palpating the uterus should only be carried out after administration of Syntometrine/oxytocin as part of active management.
If at any point in the third stage there is poor uterine contraction or tissue trauma resulting in post-partum haemorrhage. Refer to the guideline for Obstetric Haemorrhage (**H1**).
ne contraction rubbed up,
- cross-matching,
syntocinon infusion 40IU in 36mls of normal saline to be commenced at 10mls per hour.

11.4.1 Contraindications for Physiological Management of Third Stage

Expectant management is not recommended in the following circumstances:
known fetal macrosomia, carrier), of current coagulation disorder or deranged liver function, includes women with pre-eclampsia, obstetric cholestasis, fatty liver of pregnancy, IUFD and thrombocytopenia,
-coagulation treatment, duction of labour, Physiological management of the third stage is **only** appropriate for women who are at low risk of postpartum haemorrhage and who have had **uncomplicated** labour and birth. Intervention with active management should ensue if this situation changes during labour, including during third stage. Any circumstances, which may inhibit the uterus to function normally, such as oxytocin augmentation in labour, repeated doses of opiates, and early clamping and cutting of the cord are contraindications to expectant third stage.

11.5 Rhesus Negative Women Following Delivery

For women who are Rhesus negative a kleihauer sample must be taken – please refer to the Anti D guideline.

11.6 Swab Count Following Delivery

• Any swabs used at delivery must be checked with another member of staff and documented in the intrapartum notes.

THE DUDLEY GROUP NHS FOUNDATION TRUST
AUGMENTATION OF LABOUR WITH OXYTOCIN (SYNTOCINON®) GUIDELIN
GUIDELINE DETAIL

1. DUTIES/RESPONSIBILITIES

1.1 Senior Obstetrician

The senior obstetrician is responsible for developing a management plan for the woman requiring augmentation of labour.

1.2 Midwife

The midwife is responsible for ensuring she refers any suspected delay to the senior obstetrician and makes sure that the management plan developed by the obstetrician is followed.

2. CONTR-INDICATIONS FOR AUGMENTATION WITH OXYTOCIN IN LABOUR

The following are considered as contraindications for augmentation with oxytocin in labour:

- Patients with intact membranes
- Hypertonic uterine action
- Administration of prostaglandins < 6hrs previously
- Pathological Electronic Fetal Monitoring (EFM)

3. INDICATIONS FOR AUGMENTATION OF LABOUR

The following are considered as indications for augmentation with oxytocin in labour:

- Delay in established first stage
- Delay in active second stage
- Prelabour rupture of the membranes at term
- After delivery of first twin during vaginal twin delivery

If a low risk woman attends midwifery unit in latent phase of labour, she should be treated as per low risk guidelines. However, if there is prolonged latent phase of labour and she needs augmentation, it should be discussed with Obstetric registrar on call and a plan of care should be made.

4. ASSESSMENT PRIOR TO COMMENCEMENT OF OXYTOCIN

The following parameters should be considered in high risk women:

- cervical dilatation of less than 2 cm in 4 hours
- or a slowing in the progressive descent and rotation of the fetal head
- changes in the strength, duration and frequency of uterine contractions Augmentation of Labour with Oxytocin (Syntocinon)

5 IN CONFIRMED DELAY IN ESTABLISHED FIRST STAGE OF LABOUR:

- **Nulliparous** women: Following an abdominal and vaginal examination, an Obstetrician's advice should be sought and the use of Oxytocin should be considered. An individual management plan must be documented within the woman's intrapartum notes.

- The woman should be informed that the use of Oxytocin following spontaneous or artificial rupture of the membranes will bring forward her time of birth but will not influence the mode of delivery or other outcomes.

- **Multiparous** women with confirmed delay in the first stage should be assessed by a senior obstetrician, including an abdominal and vaginal examination, before deciding about the use of Oxytocin. An individual management plan must be documented within the woman's intrapartum notes.

5.1 In confirmed delay of active second stage in labour

For a nulliparous woman:
Birth would be expected to take place within 3 hours of the start of the active second stage in most women
Diagnose delay in the active second stage when it has lasted 2 hours and refer the woman to a healthcare professional trained to undertake an operative vaginal birth if birth is not imminent. [NICE 2007]
For a multiparous woman:
Birth would be expected to take place within 2 hours of the start of the active second stage in most women

Diagnose delay in the active second stage when it has lasted 1 hour and refer the woman to a healthcare professional trained to undertake an operative vaginal birth if birth is not imminent. [NICE 2007]
For a nulliparous woman, suspect delay if progress (in terms of rotation and/or descent of the presenting part) is inadequate after 1 hour of active second stage. Offer vaginal examination and then offer amniotomy if the membranes are intact. (NICE 2007, amended 2014)
For a multiparous woman, suspect delay if progress (in terms of rotation and/or descent of the presenting part) is inadequate after 30 minutes of active second stage. Offer vaginal examination and then offer amniotomy if the membranes are intact. [NICE 2014]
If full dilatation of the cervix has been confirmed in a woman without regional analgesia, but she does not get an urge to push, carry out further assessment after 1 hour. [NICE 2007]
In multiparous women in second stage, Oxytocin should be considered ONLY after examination by a registrar to exclude malpresentation like brow.

5.2 Prelabour rupture of the membranes at term (PROM)
Advise women presenting with prelabour rupture of the membranes at term
that:
The risk of serious neonatal infection is 1%, rather than 0.5% for women with intact
membranes
60% of women with prelabour rupture of the membranes will go into labour within
24 hours.
Induction/augmentation of labour is appropriate approximately 18 hours after
rupture of the membranes. Please refer to management of women with
prelabour rupture of membranes with preterm and term pregnancies

5.2 After delivery of first twin during vaginal twin delivery

Oxytocin infusion should be pre-prepared, ready to be commenced, in case of absence of uterine contractions after vaginal delivery of twin 1. This decision should be made by a medical doctor at the level of registrar or above.

5.3 Use of Oxytocin in Grand multiparty and women with Previous caesarean section
Women with 4 or more vaginal births or previous caesarean section who have a risk of rupture uterus or scar dehiscence, need an initial assessment by a doctor at the level of registrar or above and a plan should be clearly be documented about the duration of infusion and time scale for re-examination.

6. DOSE SCHEDULES FOR OXYTOCIN
 A dedicated intravenous cannula should be used for Oxytocin infusion NOT a Y connector. An anti reflux valve giving set should be used.

 10 units/1ml of Oxytocin in 49mls of normal saline 0.9% to be administered via syringe pump.

 Where Oxytocin is used, increment increase in rate of drug delivery is every 30 minutes (this can be shorter in the case of 2nd stage of labour which would be every 15 minutes and delay in delivery of twin 2 secondary to cessation of uterine activity and it can be individually tailored in case of temporary cessation of the ongoing Oxytocin infusion at the discretion of the attending obstetrician which should be clearly documented in the notes).

Oxytocin should be increased until there are 3-4 contractions in 10 minutes.
To commence at 2mU/min with the rate to be doubled at ½ hourly intervals until contractions are occurring at a rate of 4 in 10 minutes up to a maximum dose of 32mU/min. [Note: 2mU/min = 0.002 units/min] Augmentation of Labour with Oxytocin (Syntocinon)

Time Interval/Minutes	**Dose**	**Rate**
0	2mU/min	0.6mls/hr
30	4mU/min	1.2mls/hr
60	8mU/min	2.4mls/hr
90	16mU/min	4.8mls/hr
120	32mU/min	9.6mls/hr