PURPOSE AND INTENT

To ensure all healthcare providers are provided a clear understanding of the process to book an induction of labour and the process that will be followed from prioritization to completion.

1. DEFINITIONS

2.1 Induction of Labour (IOL): The initiation of contractions in a pregnant woman who is not in labour to help her achieve a vaginal birth within 24 – 48 hours (Leduc et al., 2013).

2.2 Priority Designations:

Examples of High Priority – goal to initiate within 24 hour

- Placental insufficiency
- Intrauterine growth restriction with abnormal umbilical Doppler
- Premature rupture of membranes at or near term
- Atypical/abnormal fetal heart pattern
- Oligohydramnios
- Severe hypertension (i.e. BP >160/110 mmHg)
- Severe pre eclampsia
  - Submit diagnostic results with induction form
- Type 1 or 2 Diabetes – with poor glycemic control
- Chorioamnionitis
- Post term 42 weeks gestation or greater

Examples of Medium Priority - goal to initiate within 48 hours

- Post term 41 3/7 weeks gestation to 41 6/7 weeks gestation
- Gestational/chronic hypertension ≥ 38 weeks gestation when BP is not severe i.e. < 159/109 mmHg.
  - Submit diagnostic results with induction form
- Mild preeclampsia ≥ 37 weeks.
  - Submit diagnostic results with induction form
- Twins
  - dichorionic not before 38 1/7 weeks gestation when uncomplicated
  - monochorionic not before 36 1/7 weeks gestation when uncomplicated
- Type 1 or 2 Diabetes - well controlled
- Advanced maternal age of 40 years and 39 1/7 weeks or greater gestational age
- Unstable lie at greater than or equal to 38 weeks gestation, cephalic presentation
- Alloimmunization disease at or near term
- Other significant maternal medical /fetal conditions (e.g. Cholestasis with elevated bile acids greater than 40 or on Ursodiol, cardiac, thrombophilia requiring anticoagulant management, etc.)
- Intrauterine fetal demise

Low Priority – goal to initiate within 120 (5 days) hours

- Logistical indications i.e. history of rapid labour, distance to hospital and greater to or equal to 38 weeks gestation
- Psychosocial indications

2. **BACKGROUND**

Induction of labour in Canada has increased steadily from 1991 (12.9%) to 2000 (19.7%) and then remained steady at 19.1% as of 2005 (Canadian Perinatal Surveillance, 2008). The goal of induction is to achieve a successful vaginal birth that is as natural as possible. Women who are having or being offered induction of labour should have the opportunity to make informed choices about their care and treatment in collaboration with their health care providers (Leduc et al., 2013).

The Women’s Health Program is committed to having a process in place that supports the provision of accurate and consistent information to patients offered induction. The induction booking process is intended to inform and support the patient and health care team to ensure information regarding maternal and fetal risk factors are available to assist with the daily prioritization of these cases.

During times of high activity on the Labor and Delivery unit where resources do not permit the initiation of urgent IOL in a timely manner or if NICU is unable to accommodate the infant induction, redirection of the patient may be necessary using the approved escalation protocol.

3. **GUIDELINES**

4.1 The WRHA IOL booking form # NS01160 must be completed, in its entirety, and delivered to the site of preference when the responsible healthcare provider identifies a patient who requires IOL. This form may be faxed.

4.2 Review and give to all patients booked for induction of labour the WRHA Induction of Labour information teaching sheet for patients #W00278 (see Appendix A). These may be ordered from the hospital print shop.

4.3 Each site must develop a mechanism to ensure all healthcare providers have clear direction as to who the responsible physician is for prioritization of the patients that have been booked for IOL. This is usually the 24 hour on-call physician.

4.4 The responsible physician on-call for each medical group must be notified of delays in induction and the reason for the delays.

4.5 The responsible physician, in consultation with representatives from the other site and the patient and her family, will consider the diversion of patients to the alternate site when clinical resources are unavailable. See WRHA Perinatal Bed Management Contingency Guideline.
4. **PROCEDURE (Induction of labour process)**

5.1 The intent is to initiate the induction of labour within a reasonable time frame. Staff will strive to commence induction of high priority bookings on the day requested, medium priority within 48 hours, and low priority within 120 hours. When resources do not permit initiation of induction within this time frame, transfer of care to the other hospital for induction may be arranged, provided the other hospital is able to accommodate the patient. The patient and responsible health care provider will discuss and determine the need for IOL. See WRHA Perinatal Bed Management Contingency Guideline.

5.2 The majority of induction diversions will be in the medium priority category (within 48 hours). If it is clear that a hospital will not be able to initiate a particular medium priority induction (due to an unusually long induction list), then diversion may be done rather than waiting another day. Documentation of the induction diversion to an alternate hospital needs to be written on the Induction Booking Form and on an IPN if the woman is an in-patient. See WRHA Perinatal Bed Management Contingency Guideline.

5.3 IOL form # NS01160 shall be completed in its entirety before requests are submitted to the labour unit of preference. Prenatal records must accompany the IOL form as well as any other pertinent diagnostics (recent lab work, FAU reports). IOL Forms may be obtained from printing. HSC 787-4072, SBH [http://intranet.sbgh.mb.ca/DeptFacilitySup/files/AuthNewRevForms.pdf](http://intranet.sbgh.mb.ca/DeptFacilitySup/files/AuthNewRevForms.pdf) labour units.

5.4 All forms received by the laboring unit will be reviewed for completeness and have the patient information placed on the induction list for the day requested. Incomplete forms will be returned to office for completion. At SBH the list will be maintained on the NapaDex system. All induction forms will be kept in a designated area on the labour unit.

5.5 Prior to 2300, the physician deemed responsible for inductions will review the induction list for the following day and prioritize for the following 24 hour period according to the predetermined priority classifications, expert clinical judgment, and availability of clinical resources. The prioritization will be recorded and signed on the IOL scheduling form by the responsible physician.

5.6 Clinical Resource Nurses (CRN)/charge nurses will ensure that patients are called in for induction and document when they are expected to arrive on the IOL form when clinical resources are available. Patients may be called in for IOL at any time 24 hours a day, 7 days a week to begin the induction process if the patient is agreeable. If a patient declines induction this must be documented on an Integrated Progress Note (IPN) and attached to patient’s Prenatal Record in Triage or in the patient’s Medical Record.

5.7 CRNs/charge nurses will inform the physician responsible for prioritizing as well as the responsible group physician if acuity on the unit changes and patients are unable to be called in within the appropriate timeframe.

5.8 Patients who are unable to be called in, will be notified by the CRN or RN delegate and a conversation will ensue explaining the reason for delay. If the patient has concerns that the nurse is unable to answer, the patient will be instructed to call the on-call physician for the specific obstetrical group.

5.9 The responsible physician and the CRN/charge nurse will review the induction list throughout the day for accuracy and completion and reprioritize as necessary.

5. **REFERENCES**

6. **RESOURCES**

1) Burym, C., Assistant Professor Obstetrics & Maternal-Fetal Medicine, Director, Fetal Assessment Unit Director, Manitoba Obstetric Outreach Program St. Boniface Hospital, Winnipeg, MB

2) Morris, M. Medical Director, WRHA Women’s Health Program, Head, Department of Obstetrics, Gynecology, and Reproductive Sciences, Women’s Hospital.
Induction of Labour

Induction means “bringing on” labour so you can birth your baby. Induction of labour is a safe procedure. It is done when you or your baby’s health requires it.

While this fact sheet will provide you with information about the induction of labour, be sure to discuss this issue with your doctor if you haven’t already, or if you have more questions.

Your doctor will arrange for your induction at the hospital.

Although your induction may be asked for on a certain day, it may not happen on that day for many reasons. Each day, a doctor looks at the list of women scheduled for induction and decides who will be called first based on the health of the mother and baby.

When it is time for your labour to be induced you will be called and asked to come to Obstetrical Triage at St. Boniface Hospital or the Admitting Desk at Women’s Hospital. Although you may have indicated you’d prefer to deliver your baby at a particular hospital, in some circumstances it may be necessary for your induction to be performed at the other hospital. It is important that you discuss with your doctor arrangements for your delivery.

After checking in at St. Boniface Obstetrical Triage or the HSC’s Women’s Hospital Admitting Desk you will:
1. Have your blood pressure, pulse, and temperature checked.
2. Have a monitor applied to listen to your baby’s heart rate and keep track of your contractions.
3. Have an internal examination to find out how ready your cervix (neck of the womb) is for the induction to begin.
4. Be induced by the method best suited for you and your baby.

After your induction has started you may be observed at the hospital for several hours to find out if you are going into labour. Labour does not always start right away.

What might happen?
1. If you begin with strong labour, you will go to a Labour and Delivery Unit.
2. If your labour does not begin right away you may:
   a. Go home with a plan of when to come back.
   b. Go to the Antepartum Unit to continue being observed.
   c. Have the same induction method repeated.
   d. Have another induction method started.

There are several ways to “bring on” labour. You may want to talk to your doctor before your induction to learn about some of the methods.

If you have any questions, ask your doctor, midwife or nurses.

Be ready to come to the hospital at any time, day or night, because you may go into labour on your own or be called in for your induction. Being ready includes having child care in place for other children and a bag of personal items packed so you can go as soon as possible.

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