

Induction of Labour (IOL)

Document Type	Guideline
Function	Clinical Practice
Directorate(s)	National Women's Health
Department(s) affected	Maternity
Applicable for which patients, clients or residents?	All maternity women
Applicable for which staff members?	All clinicians in maternity including access holder lead maternity carers (LMCs)
Key words (not part of title)	prostaglandin, Foley catheter, oxytocin, cervical ripening
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1. Purpose of guideline

To provide guidance on the indications and timing for induction of labour (IOL); to guide clinicians to offer IOL when appropriate (ie where evidence shows that benefit to mother and/or baby outweighs the risk), and to avoid IOL when not appropriate, within Auckland District Health Board (Auckland DHB).

To describe the process of booking IOL (planned and urgent), which is the same for all practitioners.

To provide guidance on the effectiveness and safety of methods of cervical ripening and on clinical management of IOL.

To define the roles and responsibilities of practitioners looking after pregnant women at Auckland DHB undergoing IOL.

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2. Background

IOL rates have steadily increased over the last two decades. In 2013, one in three women who gave birth at Auckland DHB had their labour induced. Rate of IOL among standard primipara is one of the clinical maternity indicators identified by the NZ Ministry of Health, as part of its national quality and safety programme for maternity services.

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3. Definitions

The following terms are used within this document:

Acute or urgent IOL	The clinical risk indicates IOL should commence within 24-48 hours
BMI	Body mass index
CCM	Clinical Charge Midwife
CTG	Cardiotocography
DAU	Day Assessment Unit
EDD	Estimated due date
Hypertonus	Contraction lasting more than two minutes, or less than 60 seconds resting tone in between contractions
Induction of labour (IOL)	The artificial initiation of labour
L&BS	Labour and Birthing Suite
LMC	Lead Maternity Carer
LMP	Last menstrual period
PG	Prostaglandin
RCT	Randomized controlled trial
SMO	Senior Medical Officer
Tachysystole	More than 5 uterine contractions per 10 minute period
Uterine hyperstimulation	Tachysytole and/or hypertonus combined with fetal heart rate abnormalities
VBAC	Vaginal birth after caesarean
WAU	Women's Assessment Unit

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4. Reducing the risk of post-term IOL

a. Dating ultrasound scan

Gestation should be calculated using Naegele rule from the woman's LMP. If LMP is unsure or she has an irregular cycle, an ultrasound should be performed. Crown-rump length measurement is more accurate to estimate gestational age than mean sac diameter. Biparietal diameter may also be used. Ultrasound dating of pregnancy has been shown to reduce the need for post-term IOL compared to using LMP. If there is a discrepancy of more than 5 days between the EDD by LMP and by early (< 14 weeks) ultrasound scan, the scan EDD should be considered the best estimate; if 5 days or less, the EDD by LMP could be used. Once the EDD has been determined, it should not be changed. Ultrasound scans performed later in pregnancy are not as accurate for dating.

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b. Membrane sweeping

Membrane sweeping reduces the duration of pregnancy and increases the chance of spontaneous labour. Eight women would need to have membrane sweeping in order to prevent one formal post-term IOL. Each woman should be offered the option of membrane sweeping from 38 weeks, with the plan to perform membrane sweeping at 40 weeks. Recent evidence suggests that serial sweeping is no more effective than a single membrane sweeping. The woman should be informed to expect some discomfort during the procedure and some spotting afterwards.

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5. Indications and timing for elective/planned IOL

A woman who has an indication for elective IOL should be assessed by a specialist obstetrician, who should then make a management plan.

Midwives can use the post term virtual consultation (PTVC) pathway if specific criteria are met:

- A healthy woman, age < 40, and BMI < 35
- A healthy baby, normal customized estimated fetal weight, and normal fetal movements
- If previous caesarean, the woman has had formal consultation with specialist obstetrician, is clinically suitable for VBAC, and a care plan is documented in HealthWare
- The woman agrees to and understands that her LMC will undertake this virtual consultation, and has read and understands the “Induction of labour at Auckland City Hospital” information leaflet

Complete and fax a DD3073: Post term virtual consultation (PTVC) form, and relevant information such as ultrasound scans, to 630-9781. The SMO in Antenatal Clinic should contact the LMC with the date and time, by next business day, and should document a plan in HealthWare.

For a woman who does not meet the criteria for PTVC pathway, midwives should refer to Antenatal Clinic for a consultation well in advance. Complete and fax a CR3509: Maternity Secondary Referral form, and relevant information such as ultrasound scans, to 630-9781.

CR3509: Maternity Secondary Referral forms and DD3073: Post term virtual consultation (PTVC) forms can be found at the National Women’s Health website under the Health Professionals tab (or see associated Auckland DHB documents section below).

The Auckland Consensus Guideline (Auckland DHB, Waitemata DHB and Counties Manukau DHB) provides evidence-based recommendations for possible indications and timing of IOL. Feedback was obtained from midwives and doctors at all three DHBs and from the NZ College of Midwives. The full guideline with references can be found at the National Women’s Health website under the Health Professionals tab.

Below are summary statements from the guideline:

- A woman with an uncomplicated dichorionic/diamniotic twin pregnancy should be offered IOL at 37-38 weeks to reduce the risk of adverse neonatal outcome
- A woman with preeclampsia should be offered IOL at 37 weeks to improve maternal outcomes. A woman with hypertension no preeclampsia may be offered IOL from 37 weeks or expectant management (individualised)
- A woman with suspected small for gestational age fetus, and normal middle cerebral and uterine Doppler studies, should not be routinely offered IOL before 40 weeks. If these detailed Doppler studies have not been performed, IOL should be offered around 38 weeks

- A woman with gestational diabetes, a normally grown fetus, and good glucose control throughout pregnancy (irrespective of treatment type) should not be routinely offered IOL before 40 weeks
- A woman should be offered the option of IOL to reduce the maternal and neonatal risks associated with post-term pregnancy. IOL should be arranged around 41+5, but this can be individualised
- A woman \geq 40 years old may be offered IOL at 40 weeks

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6. Indications and timing of urgent/acute IOL

Reasons for acute IOL include (but are not limited to):

- Pre-labour rupture of membranes (PROM)
- Reduced fetal movements
- Reduced liquor volume (ultrasound estimate of maximum liquor pool depth $<$ 2 cm)
- Abnormal CTG or biophysical profile
- Prolonged latent phase
- Preeclampsia
- Suspected small for gestational age
- Intrauterine fetal demise
- Termination of pregnancy

A woman who has diagnosed pre-labour rupture of membranes from 37 weeks should be offered the option of IOL to reduce the risk of maternal and neonatal infection. A woman who does not meet clinical criteria for expectant management (see Rupture of Membranes in Pregnancy guideline) should be advised to have IOL. For a woman who chooses expectant management, IOL is appropriate approximately 24 hours after PROM. The woman should be provided with the “Pre-labour Rupture of Membranes” information leaflet to guide the discussion of risks and benefits of IOL vs. expectant management, and a plan documented.

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7. Antenatal fetal surveillance

Each woman should be counselled about monitoring daily fetal movements, and to report any reduction in movements to their LMC. The woman could be provided with the “Your baby’s movements and what they mean” information leaflet.

For a woman with antenatal risk factors or fetal concerns that do not need IOL, additional surveillance can be arranged in the community, or through DAU. Further information about DAU can be found at the National Women’s Health website under the Health Professionals tab.

Each woman should be informed that there is no high quality evidence that proves that additional fetal surveillance will reduce the risk of stillbirth.

To make an appointment in DAU, fax a referral form and ring DAU.

Those who may be offered additional surveillance include (but are not limited to):

- A woman aged 35 or more
- A woman with booking BMI of 35 or more
- A woman who conceived after IVF
- A woman with chronic or gestational hypertension
- A woman at 41+0 or more weeks’ gestation

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8. Planning IOL

The decision to plan an IOL should be at the level of the specialist obstetrician.

Give the woman the “Induction of Labour at Auckland City Hospital” information leaflet (available on internet) and use this to guide discussion. The woman should be able to ask questions and make informed decisions about their care.

Discussion should include:

- Primary reason for induction and other factors
- Alternatives to IOL
- Risks and benefits of induction vs. expectant management
- Proposed method of IOL
- Realistic expectation of duration of IOL

After discussion with the woman and her partner/family/whānau, a clear management plan should be documented.

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9. Booking elective IOL (see also figure 1)

To book an elective IOL, the referring doctor has two options:

Option (i) Referring doctor to phone 021-400-983, 0730 - 1800 Monday through Friday. The midwife should complete a CR2251: Elective Induction of Labour (IOL) Booking Request Form and place it in the induction binder in DAU. The following information will be immediately required: EDD, named obstetrician responsible for decision to induce, primary reason for induction and other antenatal risks, method and location of induction.

Option (ii) Referring doctor to fax completed form to DAU anytime (09-307-8904). The next business day the DAU midwife should phone the LMC (and/or referring doctor if appropriate) with date and time, and ensure form is complete, especially who is starting the IOL. The LMC (or referring doctor) is responsible to inform the woman of the date and time.

There should be a total of five elective IOL slots per day. PG IOLs can be booked to start at 0730, 0930, 1030, 1200 or 1630 as per referring doctor. Balloon IOLs by preference should commence at 0730. ARM IOLs can be booked to start at any time. There is no limit to the number of each method of IOLs per day, as long as the total number of elective IOLs in both WAU and L&BS together is no more than five.

Important: Elective IOLs can be booked no more than 7 days in advance no matter the indication, LMC type, method, or location. Exception is for medical reasons (eg anticoagulation) or where coordinating in advance with other services is required (eg NICU, paed surgery).

The booking form can be completed and faxed to DAU earlier than 7 days, but the date and time will not be scheduled until 7 days ahead. In this situation, the DAU midwife should ring or text the LMC (and/or referring doctor as appropriate) with the date and time.

Important: Ensure the woman is aware that date and time provided is a probable but not guaranteed booking, because of the potential need to make that time available to a woman of higher clinical priority for IOL or because of other service constraints eg staffing, or if a baby needs NICU and a NICU bed is not available.

The induction binder and the induction phone should be in DAU during DAU business hours. When DAU closes, the binder and phone should be handed to the WAU shift coordinator. At 1800 daily the ward clerk should add women having elective IOLs the next day to the expected arrivals on the Whiteboard, the binder should be locked in DAU, and the phone should be turned off.

The WAU flow coordinator should bring the induction binder to 0800 handover every day. The L&BS SMO should review the expected arrivals on the Whiteboard and the clinical details from the booking forms in the binder. The WAU flow coordinator should bring the binder back to WAU after handover; the ward clerk should place the booking forms for that day in the woman's clinical record. When the woman arrives, the ward clerk should start the IOL tab in

HealthWare. For IOLs starting on L&BS, the WAU flow coordinator can hand these booking forms to the ward clerk on L&BS prior to returning the binder to WAU.

Elective IOL booking forms can be completed in Microsoft Word, and can be found at the National Women's Health website under the Health Professionals tab. Paper copies can also be found in DAU, WAU and Antenatal clinic.

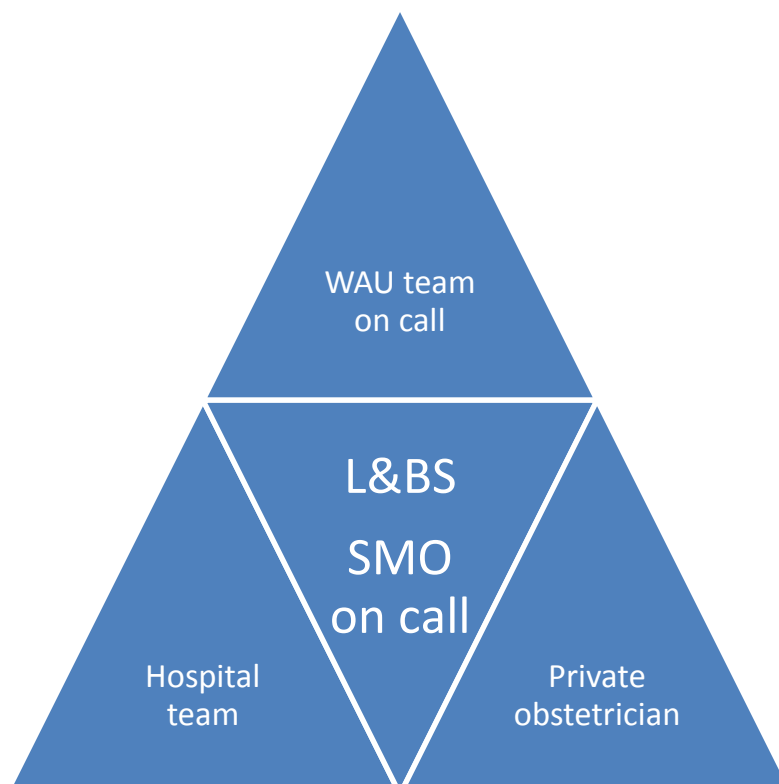
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10.Booking acute IOL (within 24 - 48 hours) (see also figure 1)

To book an acute IOL (within 24 - 48 hours), the referring doctor should phone the L&BS SMO on call to discuss indication and timing. If they agree to add on an acute IOL, the referring doctor should complete a CR2252: Acute Induction of Labour (IOL) Bookings required within 48 hours form, and give it to the ward clerk on WAU or L&BS (or fax and ring ward clerk directly to ensure receipt).

If after 2200 hours, please ring the L&BS CCM instead of the L&BS SMO on call.

The ward clerk should add the woman to the expected arrivals on the Whiteboard, and should place the form in the woman's clinical record. The referring doctor is responsible to inform the woman where and when to come for her IOL. The WAU flow coordinator should bring a copy of the acute forms to the 0800 handover.

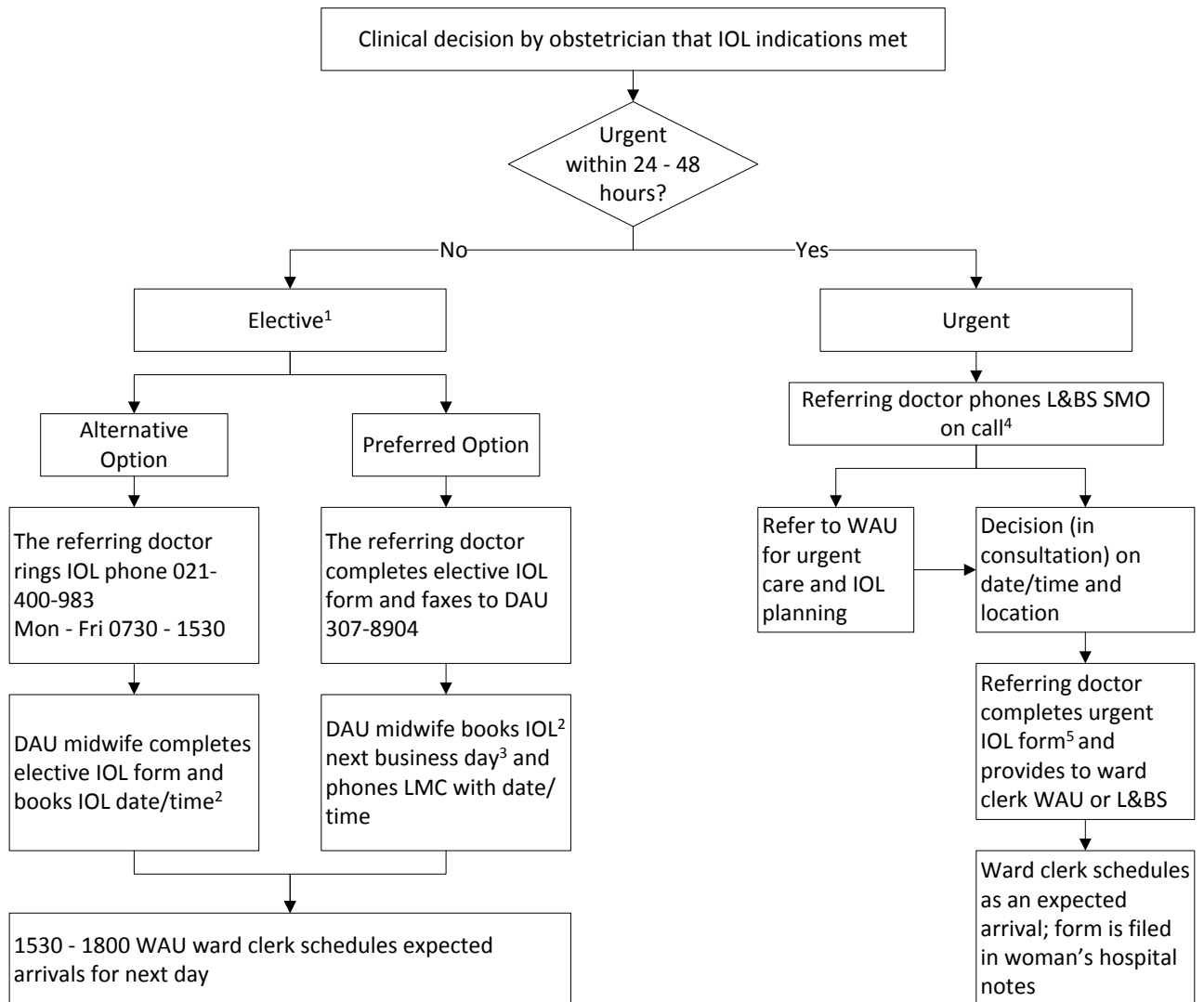


The Women's Health Service should try to accommodate a woman requiring IOL for intrauterine demise or termination of pregnancy at a date and time to suit her and her family/whānau.

Acute IOL booking forms can be completed in Microsoft Word, and can be found at the National Women's Health website under the Health Professionals tab. Paper copies can also be found in WAU.

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11. IOL booking



NOTES

- ¹ If requested date for IOL is > 7 days, then form will be filed in IOL binder (expected pocket). At 7 days, DAU midwife will book IOL and phone LMC with date/time
- ² To book IOL, DAU midwife uses booking schedule, selects date/time, and enters NHI into schedule; form is filed on appropriate day
- ³ WAU flow coordinator can also book elective IOL from 1530 - 1800
- ⁴ After 2200 phone L&BS CCM
- ⁵ IOL booking forms on nationalwomenshealth.adhb.govt.nz website

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12. Clinical prioritisation

If WAU is on RED+, or if L&BS is on RED, then, as outlined in the Women's Health Escalation Plan the L&BS SMO on call should clinically prioritise all IOLs and discuss deferring the least urgent IOL(s) with the obstetrician who booked it. The L&BS SMO on call should notify the woman's LMC of the decision to defer, and document the decision in the woman's clinical record. The LMC should notify the woman of the new date/time.

If agreement cannot be reached between L&BS SMO on call and the booking obstetrician, the service clinical director, secondary maternity, should be asked to mediate.

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13. Roles and responsibilities of practitioners

The L&BS team on call should document the roles and responsibilities of the LMC, hospital midwife, and obstetrician after 3-way discussion with the woman and her family/whānau.

The LMC is encouraged to be present for the start of the IOL and to formally hand over midwifery care to the hospital midwife. The hospital midwife should communicate regularly with the LMC to discuss the woman's progress, and mutually agree to when midwifery care is handed back to the LMC.

The obstetrician may recommend that clinical responsibility be handed over to them (eg for Syntocinon augmentation). If this is agreed, following a 3-way discussion with the LMC and the woman and her family/whānau, then this should be documented in the woman's clinical record.

A handover sticker may be used to aid clear documentation in the woman's clinical record.

Refer to Auckland DHB policy on handover.

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14. Starting IOL in WAU or L&BS

If IOL is not on the Whiteboard as an expected arrival, then discussion between the LMC and L&BS SMO on call, and between L&BS team on call and CCM on L&BS, should occur prior to starting an IOL, regardless of indication, LMC type, location, method and acuity. If IOL is on the Whiteboard, the IOL can be started without further delay.

To start an IOL, the LMC should:

- Confirm the named obstetrician responsible for management of the IOL (can use Handover sticker)
- Confirm the primary indication for IOL
- Identify other antenatal risk factors
- Confirm EDD (by scan < 14 weeks if available, otherwise best estimate by LMP or later scan)
- Ensure most recent ultrasound does not show low lying placenta/placenta praevia or non-cephalic presentation
- Confirm the woman’s informed consent to have IOL (see points above for discussion re IOL)
- Offer the “Induction of Labour at Auckland City Hospital” information leaflet
- Commence neonatal blue card by documenting above information and maternal blood results
- Perform assessment of
 - Maternal well-being (observations; urinalysis and blood tests only if indicated)
 - Fetal lie, presentation and engagement (abdominal palpation)
 - Fetal well-being (CTG)
- Document all of the above in a proper “admission note” or ask the medical team to do so – it is expected that every woman undergoing IOL has a complete and comprehensive note

If any concerns with any of the assessment, consult with the responsible obstetrician (if private), or L&BS team on call (if public). If no concerns, the IOL can be started without further delay.

The CTG at the start of the IOL should be documented in the woman’s clinical record. CTG sticker may be used.

The Bishop Score (BS) at the start of the IOL should be documented in the woman’s clinical record. BS sticker may be used.

SCORE	0	1	2
Position	Post	Mid	Ant
Consistency	Firm	Int	Soft
Length (cm)	3	1 - 2	< 1
Dilation	0	1 - 2	3
Station	-3	-2 - 1	0

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15. Management of IOL

A woman undergoing IOL and any woman with a planned IOL for that day should be reviewed at 0800 handover. Expected arrivals can be viewed on Whiteboard under “expected arrivals” tab, and the booking forms should be in the IOL binder.

It is expected that at all handovers, the L&BS registrar is knowledgeable about the primary indication for IOL and other antenatal risk factors, and about the management plan, for any woman having an IOL.

It is expected that every woman undergoing IOL be reviewed by the responsible obstetrician (if private) or L&BS SMO (if public) every day.

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16. Methods of cervical ripening

It is reasonable to offer either cervical ripening method for any indication for IOL.

A balloon IOL is recommended where maternal or fetal risks from tachysystole or hypertonus are increased; such as:

- Suspected SGA
- Oligohydramnios or decreased fetal movements
- Previous caesarean

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a) Prostaglandin E₂ (PGE₂, Dinoprostone) Vaginal Gel

A systematic review of 35 RCTs of 2 - 5 mg vaginal PGE₂ gel (vs. placebo) in women with an unfavourable cervix showed a significant improvement in Bishop score at 24 hours and a significant reduction in the need for oxytocin augmentation and in the incidence of meconium-stained liquor. PGE₂ gel was significantly associated with the complication of uterine hyperstimulation (RR 4.5). There was no difference in rate of vaginal birth within 24 hours or in caesarean rate.

Vaginal PGE₂ gel protocol

- Ensure CTG was performed and that fetal heart rate pattern is normal
- Ensure the woman's consent
- Site IV luer and send bloods for full blood count (FBC) and group and screen
- Position the woman comfortably on bed, perform vaginal examination, perform stretch and sweep if possible, and place gel in posterior fornix
- There is no need for a routine post-PGE₂ gel CTG in the absence of contractions
- The woman can then mobilize, eat and drink, shower and bathe
- Inform the woman of expected time of subsequent assessment
- Document abdominal palpation, BS (using sticker), CTG findings (using sticker), PGE₂ gel dose, and time of gel in the woman's clinical record (and on Whiteboard)

If the IOL process is occurring normally, routine fetal or maternal monitoring is unnecessary.

Vaginal PGE₂ gel recommended regimen

- PGE₂ gel should be formally prescribed on the standard medication chart.
- One dose of PGE₂ gel, followed by a second dose after 6 hours (minimum) if labour is not established. Starting Oxytocin should also be delayed by a minimum 6 hours after a dose of PGE₂ gel.
- More than two doses in 24 hours may be considered if there are no signs of uterine hyperstimulation and there has been a discussion with the responsible obstetrician (if private) or L&BS team on call (if public).
- Dose of 1mg or 2mg should be a clinical decision based on the woman's parity and BS. There is no good evidence to support a specific regimen of PGs in terms of starting dose or follow-up dose or total amount per 24 hours, regardless of parity.
- If after 24 hours labour is not established, the woman should be reviewed in person and examined by the responsible obstetrician (if private), or L&BS team on call (if public).

- At any point, if a woman has abnormal vaginal bleeding, painful regular contractions or spontaneous rupture of membranes, further maternal and fetal assessment should be performed. Routine monitoring is not necessary.

Maternal Complications/Possible adverse events:

Up to 5% of women undergoing PGE₂ IOL will experience uterine hyperstimulation. At any point, if there is uterine hyperstimulation, consult with the responsible obstetrician (if private), or L&BS team on call (if public). Place the woman in left lateral position and administer IV fluids. Refer to Auckland DHB Oxytocin guideline for options for acute tocolysis. Document findings and care plan in the woman's clinical record.

If there is uterine tachysytole or hypertonus, place the woman in left lateral position and administer IV fluids. Tocolysis is not usually required. Document findings and care plan in the woman's clinical record.

Some women will experience nausea, vomiting, diarrhoea, fever, and hypersensitivity reactions (e.g. anaphylactic reactions).

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b) Balloon catheter

A meta-analysis of 27 RCTs comparing outcomes after IOL with a Foley catheter balloon (vs. locally applied prostaglandins) showed a significant reduction in the complication of uterine hyperstimulation, no difference in caesarean rate, and no difference in time from start of IOL to birth.

Balloon catheter protocol

- Ensure CTG was performed and is normal
- Ensure the woman's consent
- Set up procedure room on WAU and ring responsible obstetrician (if private), or L&BS team on call (if public)
- Position the woman comfortably on bed in lithotomy position
- Perform sterile speculum exam (if difficult, can use larger size speculum, and/or condom to hold back vaginal walls), advance Foley balloon through cervix and *above* internal os, inflate balloon with 30 mL sterile saline then gently pull back until balloon abuts internal os (this also confirms correct placement) – attach spigot to end of catheterAuscultate FH
- Tape balloon to inner thigh on gentle tension while standing
- The woman can then mobilize, eat and drink, shower and bathe
- Inform the woman of expected time of subsequent assessment
- Document abdominal palpation, BS (using sticker), CTG findings (using sticker), and time of balloon in the woman's clinical record (and on Whiteboard)

Balloon recommended regimen:

The balloon should remain in situ for 24 hours. The woman could give a gentle tug every so often to see that it is still in correct place. After 24 hours, balloon can be deflated and removed. If BS > 5 then proceed to ARM (see below). If not, consider switching to PGs (see above).

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17. Artificial rupture of membranes (ARM)

Even if ARM is possible, there is research to suggest less postpartum haemorrhage and greater patient satisfaction with PG induction (compared to ARM plus IV syntocinon) in the setting of BS > 5.

ARM can occur on WAU if certain clinical criteria are met:

- Longitudinal lie, cephalic presentation, and stable presenting part (at least 1/5 descended)
- Cervix dilated less than 4 cm
- Not grand multip and no history of precipitous labour

The rationale for these criteria is to reduce risk of cord prolapse and of precipitous birth on WAU.

ARM protocol

- Ensure CTG was performed and is normal
- Ensure the woman's consent
- Site IV luer and send bloods for full blood count (FBC) and group and screen
- Perform vaginal examination, perform ARM and check amount and colour of liquor
- Position the woman comfortably on bed and perform CTG
- The woman can then mobilize, eat and drink, shower and bathe
- Inform the woman of expected time of transfer to L&BS
- Document abdominal palpation, BS (using sticker), CTG findings (using sticker), and time of ARM in the woman's clinical record (and on Whiteboard)

Maternal and fetal monitoring can be individualized. A woman can remain on WAU until she establishes in labour.

If there is minimal liquor or it is meconium- or blood-stained, consider further maternal and fetal assessment and transfer to L&BS.

If the CTG is abnormal, perform a sterile speculum exam to exclude cord prolapse or imminent birth.

The CCM L&BS should communicate regularly with the WAU midwives to arrange the transfer of a woman to L&BS.

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18. Oxytocin (Syntocinon)

Refer to Auckland DHB Oxytocin guideline.

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19.Supporting evidence

- [Auckland Consensus Guideline on Induction of Labour 2014](#). Wise M, McDougall J, Wotton J, Ansell L, Belgrave S, Farmer E, Wadsworth S
- Boulvain M, Stan CM, Irion O. [Membrane sweeping for induction of labour](#). *Cochrane Database of Systematic Reviews* 2005, Issue 1
- [Guidelines for Consultation with Obstetric and Related Medical Services](#) (Referral Guidelines). Ministry of Health; 2012
- Intrapartum Fetal Surveillance, 3rd edition. RANZCOG Clinical Guideline; 2014
- National Institute for Health and Clinical Excellence. Induction of labour. NICE Clinical Guideline 70; 2008
- Vaknin Z, Kurzweil Y, Sherman D. [Foley catheter balloon vs locally applied prostaglandins for cervical ripening and labor induction](#): a systematic review and metaanalysis. *Am J Obstet Gynecol* 2010;doi:10.1016/j.ajog.2010.04.038

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20. Associated Auckland DHB documents

- [Access Holders in Women's Health](#)
- [Informed Consent](#)
- [Intravenous Fluid Prescription - Adult](#)
- [Medications - Administration](#)
- [Medications - Allergies & Adverse Drug Reactions \(ADRs\) Identification, Documentation & Recording](#)
- [Medications - Intravenous & Infusions Administration](#)
- [Medications - Prescribing](#)
- [Nursing Led Handover](#)
- [Oxytocin \(Syntocinon\) for Induction & Augmentation of Labour](#)
- [Rupture of Membranes in Pregnancy](#)
- [Small for Gestational Age \(SGA\) over 34 weeks - Clinical Pathway](#)
- [Vaginal Birth After Caesarean \(VBAC\)](#)
- Women's Health Escalation Plan

Auckland DHB clinical forms

- [CR2251: Elective Induction of Labour \(IOL\) Booking Request Form](#)
- [CR2252: Acute Induction of Labour \(IOL\) Bookings required within 48 hours](#)
- [CR3509: Maternity Secondary Referral form](#)
- [DD3073: Post term virtual consultation \(PTVC\)](#)

Patient information leaflets

- [Induction of Labour](#) (Auckland DHB)
- [Term pre-labour rupture of membranes - Information for women at term \(37 or more weeks\)](#) (Auckland DHB)
- [Your Baby's Movements And What They Mean](#)

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21. Disclaimer

No guideline can cover all variations required for specific circumstances. It is the responsibility of the health care practitioners using this Auckland DHB guideline to adapt it for safe use within their own institution, recognise the need for specialist help, and call for it without delay, when an individual patient falls outside of the boundaries of this guideline.

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22. Corrections and amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed **before** the scheduled date, they should contact the owner or the [Clinical Policy Advisor](#) without delay.

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