INDUCTION OF LABOUR (IOL) PRIORITISATION TOOL

Induction of labour is initiated for a wide range of indications, with a varying degree of urgency dependent on clinical needs and risk factors. This prioritisation tool will assist in triaging the IOLs to ensure timely and safe delivery of care.

Additionally, the tool will be used in situations when there are staffing constraints, such as in the current COVID-19 pandemic situation where significant staff shortages are anticipated, or actual.

IOL staffing is required for;

- Administration of Misoprostol or insertion/monitoring of Foley catheter IOL
- Extra care prior to established labour
- Women/people establishing in labour (and possibly birth cares) and needing one to one care before their LMC arrives
- Women/people developing additional complications during their IOL, birth or immediate postpartum periods
- An urgent caesarean section
- Following up of women/people in the community after having mechanical IOL (Foley)
- Triaging women/people who have had IOL halted/deferred due to Birthing Suite acuity or staffing considerations
- Arranging ongoing monitoring/surveillance/USS for those who have their IOL deferred as indicated and ensuring clear and ongoing communications with both LMCs and Birthing Suite team

Initial prioritisation would be done at IOL booking and then reviewed at the daily MDT handovers, with consideration of actual and anticipated staffing and acuity needs for Birthing Suite and Maternity Ward areas in next 24-36 hours. Triage, pausing or deferring of IOLs and escalation will be done as needed. When staffing or capacity requires a review of IOLs **in progress** or planned, then the Prioritisation Tool will inform decision-making regarding delay, method of IOL or consideration of pausing initiated IOLs.

Any woman/person admitted from the community, with previously unbooked IOL, who is reviewed and deemed to need an IOL will have their IOL prioritised and triaged according to this tool. Their management in the acute setting will then be evaluated taking the above factors and priority scores of other cases into consideration.

This will be a shared responsibility involving ACMMs, SMO on call for O&G and, in some cases a senior Neonatal team member.

PRIORITY 1

Urgent IOL with immediate threat to health of woman/person or fetus

For example, PET – serious/complex/deteriorating/multiple symptoms, PPROM with symptoms of chorioamnionitis, PROM with GBS, IUGR < 10th centile with abnormal Doppler +/- RFMs.

IOL immediately, with no delay or pause in the process. Consider mechanical IOL using catheter if there are staffing limitations with inpatient stay and monitoring of maternal/fetal wellbeing.

PRIORITY 2

IOL due to significant threat to health of woman/person or fetus

For example, PROM (negative GBS), pre-eclampsia – significant/unstable/symptomatic, twins with discordant growth with abnormal dopplers, significant fetal abnormality requiring NICU care.

IOL within the next 24 hours, with inpatient monitoring and option to escalate to Priority 1, if indicated. No further delay recommended. Consider mechanical IOL using catheter if there are staffing limitations with inpatient stay and monitoring of maternal/fetal wellbeing.

PRIORITY3

IOL due to increased threat to health of woman/person or fetus

For example, post-dates ≥ 41+1, complex combinations of women who would otherwise be in Priority 4, pre-eclampsia – moderate/stable/asymptomatic/> 38 weeks, cholestasis – after r/v of bile salts and LFTs, small baby < 10thcentile without abnormal dopplers.

IOL in the next 48 hours, with delay or pause possible, if needed. If delayed plan for monitoring with USS, daily monitoring (CTG, observations, clinical review) according to indication with option to escalate to Priority 1 or 2 if indicated. If commenced but paused, ongoing monitoring in Birthing Suite.

PRIORITY 4

IOL due to potential risk, based on generic risk factor/s, where there are no signs of clinical compromise of the woman/person or fetus.

For example, post-dates 40 weeks – 41+1, advanced maternal age, IVF assisted pregnancy, uncomplicated twin pregnancy (DCDA), GDM (well controlled), Large for Gestational Age (LGA) with additional factors (see below).

IOL within next 3-4 days, with monitoring every 48 hours, if delayed. Once started may be paused, with ongoing inpatient monitoring.

Mechanical catheter IOL option, with woman able to go home as appropriate, and clear plan of when to return and who to contact if concerned.

For Priority 3 and 4 the type of interim monitoring will be determined by indication for IOL, the current clinical review and timing of most recent USS.

EXAMPLES OF INDICATIONS FOR IOL

Priority 1 (P1)	Priority 2 (P2)	Priority 3 (P3)	Priority 4 (P4)
PPROM with symptoms of chorioamnionitis		Reduced FMS – 2nd presentation but normal scan and CTG	Post-dates 40-41+3
PROM with GBS	PROM with negative GBS	Postdates > 41+1	Advanced maternal age
IUGR < 10th centile with abnormal Doppler +/- reduced fetal movements		SGA < 10th % with normal dopplers	IVF pregnancy
Pre-eclampsia – serious/complex/ deteriorating/ multiple symptoms	Pre-eclampsia – significant/unstable/ symptomatic	Pre-eclampsia – moderate/stable/ asymptomatic/ > 38 weeks	DCDA twin pregnancy with no concerns
	Twins discordant growth, abnormal dopplers	Cholestasis – after r/v of bile salts & LFTs	GDM (well controlled)
	Significant fetal abnormality requiring NICU care	GDM (poor control)	LGA especially with additional indications eg previous 3/4th tear following counselling of alternative options
		Complex combinations of women who would otherwise be in P4	

ASSOCIATED DOCUMENTS

COVID-19 Surge Plan Birthing Suite (Ref.2408691)

Induction of Labour Guideline (GLM0035)

Safe Staffing Escalation (Ref.237532)