Induction of Labour – Propess, Cervical Ripening Balloon, Prostaglandin Gel

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1. **Purpose and Scope of document**

This guideline is intended to assist Midwives & Obstetricians in determining when, where & how to induce labour in pregnant women.

2. **Definitions**

Induction of labour is an intervention designed to artificially initiate uterine contractions leading to progressive dilatation and effacement of the cervix and the delivery of the baby. IOL is undertaken for a variety of clinical indications but should only be considered when a vaginal delivery is felt to be the appropriate method of delivery.

3. **Document Statement and Methods**

3.1 **Timing**

Induction of labour should be offered to women with uncomplicated pregnancies from T+11 to T+14.

**Recommendations on membrane sweeping**

Women should be offered a vaginal examination for membrane sweeping prior to the induction of labour. They should also be told that the procedure is safe but some discomfort & bleeding are possible after it.

- For nulliparous woman - At the 40 and 41 week antenatal visits
- For parous women - At the 41 week antenatal visit

**Contraindications for membrane sweep**

- Low lying placenta
- Undiagnosed vaginal bleeding in pregnancy
- High/unengaged head
- Presentation other than cephalic
- Macrosomia and previous precipitate labour – Induction has not been shown to improve outcome

3.1.1 **Process for dealing with maternal requests**

Induction of labour on maternal request or non-medical grounds is not advised. Any requests will need to be referred to the consultant.
3.2 Organisation

The woman should receive a patient information leaflet when the induction of labour is booked.

Women should be informed regarding:

- Indication for IOL
- Where, when & how it will be carried out
- Advice regarding support & pain relief including that IOL likely to be more painful than spontaneous labour.
- Risks & benefits of IOL
- Alternative arrangements if IOL declined

Vaginal assessment can be performed in either the community or hospital ANC. A Modified Bishop’s score should be documented – see Appendix - and arrangements made with M2 for admission on a suitable day. This should be coupled with stretch and sweep. (See 3.1 above)

The date of induction should be placed in the Induction Diary and the woman told what time to attend M2.

If the woman delivers prior to her date for induction then the Induction Diary will be amended by the M2 Ward Clerk on a daily basis for next 10 days. When overbooking does occur then the Delivery Suite Coordinator and Obstetric Consultant covering Delivery Suite should be informed.

When booking IOL from the Antenatal Clinic, method of induction i.e. Propess, Prostaglandin (Prostin) Gel or cervical ripening balloon (CRB) should be documented in the notes and Propess/Prostin should be prescribed along with appropriate analgesia, to avoid delays when the woman attends for admission.

Gyn Registrar on call for the evening should visit M2 everyday and check if the method of induction is documented in the notes. They should also check if there is any need for prescription of Propess/Prostin or insertion of CRB.

3.3 Low Risk Women (Induction on Antenatal Ward)

Women are admitted on the prearranged date and time to M2. A CTG is performed for at least 20 minutes prior to & 30 minutes following administration of the propess, prostaglandin gel or cervical ripening balloon.
Women with an unfavourable cervix should be given Prostaglandin Gel/Propess/Cervical Ripening Balloon in preference to amniotomy unless there are specific contraindications.

In the presence of strong uterine activity and an unfavourable cervix, prostaglandin gel/Propess/Cervical Ripening Balloon should not be used.

### 3.4 INDUCTION OF LABOUR WITH PROPESS®

#### 3.4.1 Pre-requisites/Indications for use of Propess®

Cephalic presentation  
Singleton pregnancy  
Low risks patients (Obstetrically and medically)  
Bishops Score < 6

#### 3.4.2 Contra-indications

<table>
<thead>
<tr>
<th>Fetal</th>
<th>Pregnancy</th>
<th>Maternal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe IUGR</td>
<td>Placenta praevia</td>
<td>Grand multi para ≥5</td>
</tr>
</tbody>
</table>
| Absent or Reversed End Diastolic Flow on Doppler | Vasa praevia                                  | Previous hysterosomy, classical caesarean  

<table>
<thead>
<tr>
<th>Abnormal CTG</th>
<th>Undiagnosed vaginal bleeding in pregnancy</th>
<th>History of myomectomy or other full thickness uterine incision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenting part above pelvic inlet</td>
<td>Pelvic structural abnormality</td>
<td></td>
</tr>
<tr>
<td>Cephalo-pelvic disproportion</td>
<td>Prior use of CRB or prostaglandin Gel</td>
<td>Active cardiac, pulmonary, renal or hepatic disease</td>
</tr>
<tr>
<td>Transverse lie</td>
<td>Any contraindication to labour induction</td>
<td>Active genital herpes</td>
</tr>
<tr>
<td>Oblique lie</td>
<td>Invasive cervical cancer</td>
<td>Untreated Severe maternal hypertension</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hypersensitivity to prostaglandins</td>
</tr>
</tbody>
</table>

#### Relative Contraindications

<table>
<thead>
<tr>
<th>Increased Pulsatility Index on Doppler</th>
<th>Multiple pregnancy Moved to relative CI as we have and are using this</th>
<th>Previous Caesarean section</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Asthma and glaucoma</td>
</tr>
</tbody>
</table>
Discuss with the Consultant or Middle Grade Doctor in case of doubt

3.4.3 Insertion of Propess®

- Maternal observations to be performed before insertion to include Early Warning Score (EWS)
- Perform abdominal palpation to assess fetal lie, presentation and 5ths palpable in the abdomen.
- CTG for 20-30 minutes and continue for at least 20 minutes post insertion.
- Perform vaginal examination and determine Bishop Score.
- If CTG is reassuring and Bishop Score is 6 or less, insert Propess as per instructions
- If Bishop Score is 7 or greater, arrange for transfer to CDS for ARM
- Use Modified Bishops score sticker and document in the notes.
- If the Propess insert falls out and has remained clean, i.e. dropped onto clean bed sheets and not dropped on to the floor or into the toilet it may be reinserted and used to the 24 hour limit.
- If the Propess is contaminated, a new one may be inserted and used up to 24 hours after the insertion of the first Propess®.
- Sufficient tape should be left to allow for easy removal when required.
- The woman should be advised to take extra care not to pull the insert out accidentally when going to the toilet or bathing.

3.4.4 The woman should be instructed to inform the midwife in case of:

- Regular and painful contractions (every 5 minutes or more frequent)
- Vaginal bleeding
- Rupture of membranes
- Propess falls out

3.4.5 Post Propess® Monitoring - Maternal

- Maternal observations should include as a minimum a EWS every 12 hours, unless differs from individual management plan (PROM, Diabetes etc – see appropriate guideline)
- Frequency of contractions
- Colour of liquor

3.4.6 Post Propess® Monitoring - Fetal

- Fetal monitoring with a CTG should be performed twice daily for all women being induced.
- Monitoring may be requested more frequently depending on the risk status
• CTG should be recommenced if the woman complains of any regular painful uterine activity at anytime or if clinically indicated (SROM, APH etc)

3.4.7 When to transfer to Delivery Suite

• When labour is established (Contractions are regular, painful, up to 4 contractions in 10 minutes, cervix is effaced, os is dilated > 3 cm)
• Do not remove Propess whilst waiting for transfer to Delivery Suite

3.4.8 When to remove Propess®

Propess is designed to remain in the vagina for up to 24 hours; however, it should be removed immediately in the following instances:

• Vaginal bleeding
• Uterine hyperstimulation or hypertonic uterine contractions
• Evidence of fetal compromise
• Evidence of maternal adverse prostaglandin effects
• Following 24 hours, even if labour is not established
• 30 minutes prior to starting an intravenous infusion of oxytocin

If in labour:

To remove Propess®, apply gentle traction on the retrieval tape (the insert will have swollen to 2-3 times its original size and be pliable).

Document time of removal in the patient notes.

3.4.9. 24 hours following 1st Propess:

Normal Progress of Labour

Yes

Leave Propess In-situ

No

Perform ARM and commence syntocinon within 30 minutes
• Perform a CTG for at least 30 minutes
• Remove the Propess® insert
• Perform a VE to assess suitability for ARM
• If suitable, transfer to Central Delivery Suite for ARM and/or oxytocin
• Oxytocin can be commenced 30 minutes after removal of Propess
• Oxytocin should be commenced with 30 minutes of normal CTG

3.4.10. If unsuitable for ARM

• Commence a further cycle of Propess®

3.4.11. 24 hours following 2nd Propess:

• If the woman is due for review before midday, the assessment should be done by the team at morning ward round to assess suitability for ARM
• If the woman is due for review after midday, the assessment should be done by the Gyn Registrar to assess suitability for ARM

• See instructions above (3.4.9) regarding procedures to be followed as is same following 2nd propess as with 1st.

• If unsuitable for ARM, further management should be discussed with woman’s Consultant or Consultant of the week

Subsequent management includes:

• Caesarean section
• Woman can have light breakfast on the day of 24 hours post 2nd Propess review.
• Or any other option decided by the woman’s Consultant or Consultant of the week

Maximum Propess that can be used is 2 (Maximum Propess that can be used with SROM is 1)

If there is a delay between the decision to perform LSCS and its execution, the woman should be re-examined vaginally in case there have been significant cervical changes in the interim.

3.4.12 Spontaneous rupture of membranes with Propess® in situ

• Commence CTG and assess contractions.
• Perform vaginal examination
• Propess can be left in situ if regular uterine activity is not established or os is not dilated
• Alternatively, the Propess can be removed and an oxytocin infusion is commenced 30 minutes later.
• Remove Propess® if hyperstimulated

3.4.13. Propess® for Spontaneous rupture of membranes

• Perform vaginal examination and determine Bishop Score.
• If CTG is reassuring and Bishop Score is 6 or less, insert Propess as per instructions and review for augmentation with syntocinon after 24 hours.
• If Bishop Score is 7 or greater, arrange for transfer to CDS for syntocinon
• Document findings in the notes.
• Use Modified Bishops score sticker to document the score
• If the Propess insert falls out due to flow of liquor, do not reinsert Propess, continue augmentation of labour with Prostaglandin gel, which should be inserted 30 minutes after removal of Propess

3.4.14. Management of Hyperstimulation - Uterine hyperstimulation can be

• Uterine Tachysystole is ≥ 5 contractions/10 min for at least 20 minutes
• Uterine hypertonus/hypertonicity: Single contraction lasting for ≥ 2 min
• If tachysystole or hypertonus is suspected, CTG monitoring should be commenced immediately.
• If the CTG is normal, CTG should be continued and the Middle Grade Doctor should be informed.
• If the CTG is suspicious or pathological, Propess should be removed and the Middle Grade Doctor informed immediately.
• Terbutaline 250 µg subcutaneous should be considered, however due to the short half-life of dinoprostone and the low dose released per hour, the hyperstimulation should resolve spontaneously in 15 – 20 minutes.

3.4.15. Maternal reaction is suspected if there is

• Nausea, vomiting, diarrhoea
• Fever, hypotension
• Vaginal irritation or oedema

3.5. INDUCTION OF LABOUR WITH CERVICAL RIPENING BALLOON (Cook Medical)

3.5.1. The Cervical Ripening Balloon (Cook Medical) CRB is a silicone double balloon catheter. It is indicated in non labouring women at term with a
singleton pregnancy, longitudinal lie, cephalic presentation, intact membranes, with an indication for induction of labour and no contraindications (see below).

- Appointment to M2 should be made for 18:00

### 3.5.2 Contraindications:

<table>
<thead>
<tr>
<th>Fetal</th>
<th>Pregnancy</th>
<th>Maternal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abnormal CTG</td>
<td>Polyhydramnios</td>
<td>Active genital herpes</td>
</tr>
<tr>
<td>Absent or reversed End Diastolic Flow on Doppler</td>
<td>Placenta praevia</td>
<td>Previous hysterotomy, classical caesarean section, cervical tear</td>
</tr>
<tr>
<td></td>
<td>Vasa praevia</td>
<td></td>
</tr>
<tr>
<td>Presenting part above pelvic inlet</td>
<td>Undiagnosed vaginal bleeding in pregnancy</td>
<td>History of myomectomy where there has been full thickness uterine incision</td>
</tr>
<tr>
<td>Cephalo-pelvic disproportion</td>
<td>Do not use if placenta was low lying at 20 week scan unless vasa praevia is excluded at a 36 week scan</td>
<td>Pelvic structural abnormality</td>
</tr>
<tr>
<td>Transverse lie</td>
<td>Prelabour rupture of membranes</td>
<td>Severe maternal hypertension</td>
</tr>
<tr>
<td>Oblique lie</td>
<td>Any contraindication to IOL</td>
<td>Invasive cervical cancer</td>
</tr>
<tr>
<td></td>
<td>Prior use of Propess/prostaglandin Gel</td>
<td></td>
</tr>
</tbody>
</table>

**Relative Contraindications**

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<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Severe IUGR</td>
<td>Multiple pregnancy</td>
<td>Grand multi para ≥5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Active cardiac disease</td>
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</tbody>
</table>

**3.5.3. Do not use balloon after/before Propess or Prostaglandin gel as this may increase the risk of adverse events associated with prostaglandins including:**

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Uterine hyperstimulation</td>
<td>Amniotic fluid embolism</td>
</tr>
<tr>
<td>Impaired utero-placental circulation</td>
<td>Pelvic pain</td>
</tr>
<tr>
<td>Tachysystole</td>
<td>Retained placenta</td>
</tr>
<tr>
<td>Uterine rupture</td>
<td>Severe genital bleeding</td>
</tr>
<tr>
<td>Placental abruption</td>
<td>Fetal bradycardia</td>
</tr>
</tbody>
</table>

For women with history of previous Caesarean, CRB is the locally agreed method of choice for induction, unless indicated otherwise by the Consultant.
3.5.4. Instructions for Use

Prior to use:

1) Confirm term, singleton, longitudinal lie, cephalic presentation, intact membranes
2) CTG for 30 minutes
3) Maternal observations to include an EWS

Insertion of balloon:

1) Perform vaginal examination under aseptic conditions
2) Calculate Bishop’s score. Insert CRB if Bishop’s score is 6 or less.
3) Insert a Cusco’s speculum and visualise the cervical os.
4) Insert the catheter through the cervix until the vaginal balloon is in the cervical canal.
5) Inflate the uterine balloon with 40ml normal saline through the red Check-Flo valve (U)
6) Once inflated, pull back until the uterine balloon is against the internal cervical os
7) The vaginal balloon is visible outside the external cervical os. Inflate with 10ml normal saline through the green Check-Flo valve (V)
8) Once the balloons are situated on each side of the cervix, inflate the vaginal balloon until a volume of 40ml is achieved. Then add 40ml to uterine balloon so that 80ml is in this balloon and then do the same for the vaginal balloon and thus each balloon contains 80ml.

**DO NOT PUT MORE THAN 80ML IN EITHER BALLOON**

9) Occasionally inflation of the vaginal balloon can cause discomfort in which case can try removing 20ml fluid.

Alternatively:

If the cervix is very posterior or unfavourable, balloon insertion may be difficult:
1) Place the patient in lithotomy position
3-9) As above

3.5.5. After insertion:

1) Repeat CTG for 30 minutes after insertion
2) If reassuring, discontinue, allow woman to mobilise
3) The balloon may fall out as the cervix dilates. If not, remove after 12 hours
4) If the membranes rupture spontaneously whilst the balloon is in place, both balloons should be deflated and the device removed
3.5.6. Post Cervical Ripening Balloon Monitoring - Maternal

- Maternal observations should include as a minimum a EWS every 12 hours, unless differs from individual management plan (PROM, Diabetes etc – see appropriate guideline)
- Frequency of contractions
- Colour of liquor

3.5.7. Post Cervical Ripening Balloon Monitoring - Fetal

- Fetal heart should be auscultated at least every 12 hours of at least one minute.
- CTG should be recommenced if the woman complains of any regular painful uterine activity at anytime or if clinically indicated (SROM, APH etc)
- Monitoring may be requested more frequently depending on the risk status

3.5.8. After 12 hours:

- Perform a CTG for at least 30 minutes
- Remove the CRB
- Perform a VE to assess suitability for ARM
- If suitable for ARM, transfer to Central Delivery Suite for ARM and/or oxytocin
- If unsuitable for ARM, further management should be discussed with Middle Grade Doctor or Consultant regarding Caesarean section
- If there is a delay between the decision to perform LSCS and its execution, the woman should be re-examined vaginally in case there have been significant cervical changes in the interim.

3.6 INDUCTION OF LABOUR WITH PROSTAGLANDIN GEL

Primigravida are given 2mg Prostaglandin E2 gel and multigravida 1 mg Prostaglandin E2 gel if the Bishop’s score is ≤ 6

3.6.1 Insertion of Prostaglandin Gel

- Maternal observations to be performed before insertion to include Early Warning Score (EWS)
- Perform abdominal palpation to assess fetal lie, presentation and 5ths palpable in the abdomen.
- CTG for 20-30 minutes and continue for at least 30 minutes post insertion.
- Perform vaginal examination and determine Bishop Score.
• If CTG is reassuring and Bishop Score is 6 or less, insert Prostaglandin Gel as per instructions
• If Bishop Score is 7 or greater, arrange for transfer to CDS for ARM
• Use Modified Bishops score sticker and document in the notes.

3.6.2 Post Prostaglandin Gel Monitoring - Maternal

• Maternal observations should include as a minimum a EWS every 12 hours, unless differs from individual management plan (PROM, Diabetes etc – see appropriate guideline)
• Frequency of contractions
• Colour of liquor

3.6.3 Post Prostaglandin Gel Monitoring - Fetal

• Fetal heart should be monitored, when the woman due for further Prostaglandin Gel insertion, otherwise at least every 12 hours of at least one minute.
• CTG should be recommenced if the woman complains of any regular painful uterine activity at anytime or if clinically indicated (SROM, APH etc)
• Monitoring may be requested more frequently depending on the risk status

3.6.4 Reassessment after initial Prostaglandin Gel

• After six hours a CTG should be performed then the Bishop Score reassessed. If it remains less than or equal to 6, below seven a further dose of prostaglandin gel 1 mg is administered. The CTG is continued as above.
• If the Bishop Score is more than 6, the woman is to be transferred to Delivery Suite for amniotomy +/- oxytocin.
• If uterine activity or spontaneous rupture of membranes do not occur, no further action is necessary until the following morning. If Bishop's Score remains less than seven, 1 mg Prostaglandin E2 Gel should be given.

Three doses of prostaglandin gel is the maximum recommended dose. If further doses are thought to be beneficial, this should only be prescribed after discussion with the woman’s Consultant or Consultant of the week.

3.7 Breech Presentation

Women with a breech presentation should be counseled and offered ECV or Caesarean Section. If they wish to deliver vaginally, then spontaneous labour should be awaited. In certain circumstances IOL will be offered only after discussion with that woman’s Consultant, with the woman having been made aware of the associated risks.
3.8 Amniotomy (Induction On Central Delivery Suite)
This should not be used as a primary method of Induction of Labour and should only be considered where there are relative contraindications to the use of all the 3 methods for induction of labour unless Bishop Score is > 7
Women should be advised to attend M2 at the time specified at induction booking so that they can be transferred to Delivery Suite for 0900 and be reviewed on the Delivery Suite Obstetric Ward Round.

A 20 minute CTG is performed prior and immediately following amniotomy.

Intravenous access should be obtained and oxytocin commenced to obtain 4-5 contractions per ten minutes (see oxytocin guideline).

3.9 Method Of Induction In High Risk Women Include:

<table>
<thead>
<tr>
<th>High Risk Factor</th>
<th>Prostaglandin Gel</th>
<th>Propess</th>
<th>Cervical Ripening Balloon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe IUGR</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Previous Caesarean Section</td>
<td>Yes</td>
<td>Relative CI</td>
<td>Yes</td>
</tr>
<tr>
<td>Severe Pre-eclampsia</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Grand Multiparity ≥ 5</td>
<td>Yes</td>
<td>No</td>
<td>Relative CI</td>
</tr>
<tr>
<td>Polyhydramnios</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Pre-gestational or Gestational Diabetes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Multiple Pregnancy</td>
<td>Relative CI</td>
<td>Relative CI</td>
<td>Relative CI</td>
</tr>
</tbody>
</table>

- Women with either Pre Gestational Diabetes or Gestational Diabetes without any evidence of fetal compromise should be considered low risk with respect to site for IOL. These women can safely be induced on M2.

This list is not exhaustive

3.10 Individual Management Plan When Induction Of Labour Fails
If induction fails to start labour, the healthcare professionals should discuss this with the woman and provide support. The woman’s condition and the pregnancy in general should be fully reassessed. Fetal wellbeing should be assessed by electronic monitoring. Discussions between the woman & her medical team should determine the ongoing management.
The individual management plan options include

1. A further attempt to induce labour
2. Waiting if there are no pressing maternal or fetal needs for delivery
3. Elective Caesarean Section
4. If in doubt, discuss with the woman’s Consultant or Consultant of the week

3.11 Individual Management Plan For Women Who Decline IOL

In some cases women will decline IOL when recommended by the Medical team. In these cases the reason for the patient’s refusal should be clearly documented in the notes. Arrangements should be made to increase fetal and maternal surveillance. This should at least include an ultrasound scan, (frequency of scan at Consultant’s discretion) with a documented maximal pool depth, and CTG performed daily from T+14 onwards. A further offer of induction should be made if there is deterioration in the maternal or fetal condition.

4. **Linked guidelines**

- Oxytocin Use for Induction and Augmentation of Labour
- Prelabour Rupture of Membranes
- Guideline For The Management of Pregnant Women With Pre-Existing & Gestational Diabetes
- Induction Of Labour In Late Intra Uterine Fetal Death (IUFD)
- Patient Observation Policy

5. **Monitoring, Evaluation and Review**

**Audit Standards**

Adherence to this policy will be audited at least once in every three year period. The results of the audit will be considered by the Women’s Quality Forum. If deficiencies in care are identified the Women’s Quality Forum will agree an action plan to improve care and be responsible for monitoring the implementation of the action plan.

**Record Keeping**

These guidelines assume that all aspects of the woman's care will be discussed with her and that she will be helped to make appropriate choices concerning her care. An accurate contemporaneous record of all information given of progress made and individual plans will be kept.
6. References

- NICE Clinical Guideline 70 Induction of Labour - July 2008
- NICE Clinical Guideline 62 Antenatal Care - March 2008
- Lyrenas Sven et al., In vivo controlled release of PGE2 from a vaginal insert (0.8mm, 10mg) during induction of labour, BJOG, February 2001, Vol. 108, pp169-178.
- ® - Ferring Pharmaceuticals
7. Appendices

**Modified Bishop’s score**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dilation (cm)</td>
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</tr>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Length of Cervix (cm)</td>
<td>&gt; 4</td>
</tr>
<tr>
<td></td>
<td>2 – 4</td>
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<tr>
<td></td>
<td>1 – 2</td>
</tr>
<tr>
<td></td>
<td>&lt; 1</td>
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<tr>
<td>Fetal station</td>
<td>-3</td>
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<td>-2</td>
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<td></td>
<td>-1 / 0</td>
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<td>+1 / +2</td>
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<td></td>
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<td>Position</td>
<td>Posterior</td>
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<td></td>
<td>Mid / Anterior</td>
</tr>
<tr>
<td>Total Score</td>
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</tr>
</tbody>
</table>
8. Equality Impact Assessment Initial Screening Tool

This Initial Screening Tool is the first step in completing an Equality Impact Assessment (EIA) of your ‘activity’ (strategies, functions, policies, procedures, projects, services etc). Once this is completed, it will be apparent whether or not a full EIA is required.

This proforma should be used in conjunction with the EIA Guidance available on the Trust’s intranet website under A-Z Services, using the Equality & Diversity link, where you will also find links to the Trust’s Single Equality Human Rights Scheme (SEHRS).

| 1. Directorate | Women’s Children’s and Out Patients |
| 2. Department | Obstetrics & Gynaecology |
| 3. Name of ‘activity’ being assessed | Guideline for Induction of Labour – Propess, Cervical Ripening Balloon, Prostaglandin Gel |
| 4. Person completing this form | Miss Narmada Katakam |
| 5. Date | 13/6/11 |

<table>
<thead>
<tr>
<th>Patients</th>
<th>Staff</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Equality Target Groups (ETGs) (See guidance for detail)</th>
<th>7. Which of the following Equality Target Groups will this ‘activity’ impact on?</th>
<th>8. Could this ‘activity’ have a positive and/or negative impact?</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>no</td>
<td>Positive*</td>
</tr>
<tr>
<td>A. Age</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>B. Disability</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>C. Gender</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>D. Race</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>E. Religion/Belief</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>F. Language</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>G. Sexual Orientation</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>H. Gypsy/Roma/Traveller</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>I. Carers</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>J. Employees</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

9. Consultation/Involvement – during the development of this activity? (see Guidance)

Q Pulse

10. Details of positive and negative impacts

Positive Impacts
Outlines delivery of current national standards for the management of these conditions. This guideline is intended to assist Midwives & Obstetricians in determining when, where & how to induce labour in pregnant women.

Negative Impacts None
11. Give details of actions required to remedy any negative impact(s) identified above.

<table>
<thead>
<tr>
<th>Action to address negative impact</th>
<th>Who</th>
<th>Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>None needed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12. If the actions in 11 above are completed (answer Yes or No) revisit section 12 when action in 11 complete

### Negative Impact

1. Will the activity present any **problems or barriers** to any community or group?

2. Will any group of people be **excluded** as a result of your activity?

3. Does the activity have the potential to **worsen** existing discrimination and inequality?

4. Will the activity have a negative effect on **community relations**?

### Positive Impact

1. Will the activity present any **problems or barriers** to any community or group?

2. Will any group of people be **excluded** as a result of your activity?

3. Does the activity have the potential to **worsen** existing discrimination and inequality?

4. Will the activity have a negative effect on **community relations**?

5. **Promote equality of opportunity**?

6. **Eliminate discrimination**?

7. **Eliminate harassment**?

8. **Promote good community relations**?

9. **Promote positive attitudes towards disabled people**?

10. **Encourage the participation** of disabled people?

11. **Consider more favourable treatment** of disabled people?

12. **Promote and protect human rights**?

### Decision

Work through the flowchart on page 24 of the Guidance, to determine whether you need to complete a Full EIA or not.

**Details of any objective justifications or amendments agreed with Divisional E&D Lead:**

**Full EIA required?** Yes □  Date approved by Divisional Boards:

**Completed by:** Miss Narmada Katakam  **Job Title:** Consultant in Obstetrics & Gynaecology

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*Induction of Labour – Propess, Cervical Ripening Balloon, Prostaglandin Gel 17-01-13  Page 18 of 20*
9. Consultation proforma

<table>
<thead>
<tr>
<th>Policy or procedure (summary of document):</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Induction of Labour</em></td>
<td></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Consultation Period</th>
<th>See Q-pulse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioning Department</td>
<td>Maternity &amp; Women’s Health</td>
</tr>
<tr>
<td>Consulted with:</td>
<td>See Q-pulse</td>
</tr>
<tr>
<td>Method used:</td>
<td>See Q-pulse</td>
</tr>
</tbody>
</table>

This consultation was carried out on behalf of: Mr A J Tomlinson

An external agency was used to perform this consultation: 

Contact details: 

Date feedback given: See Q-pulse

Feedback methods used: See Q-pulse

Policy or procedure improvements implemented as a result of this consultation: See guideline/SOP
MATERΝITY AND WOΜEN’S HEALTH

CONSULTATION LIST

Consultation should be sought from the following as a minimum:

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate Medical Director</td>
<td>Karen Bancroft</td>
</tr>
<tr>
<td>All Consultants – Obstetricians/Gynaecologists</td>
<td></td>
</tr>
<tr>
<td>Women’s Quality Forum members</td>
<td></td>
</tr>
<tr>
<td>Library Services Manager</td>
<td>Jean Williams</td>
</tr>
</tbody>
</table>

Please feel free to circulate more widely within your teams as appropriate

Consultation Period - One month