Standard Operational Procedure for Induction of Labour with Cooks Balloon

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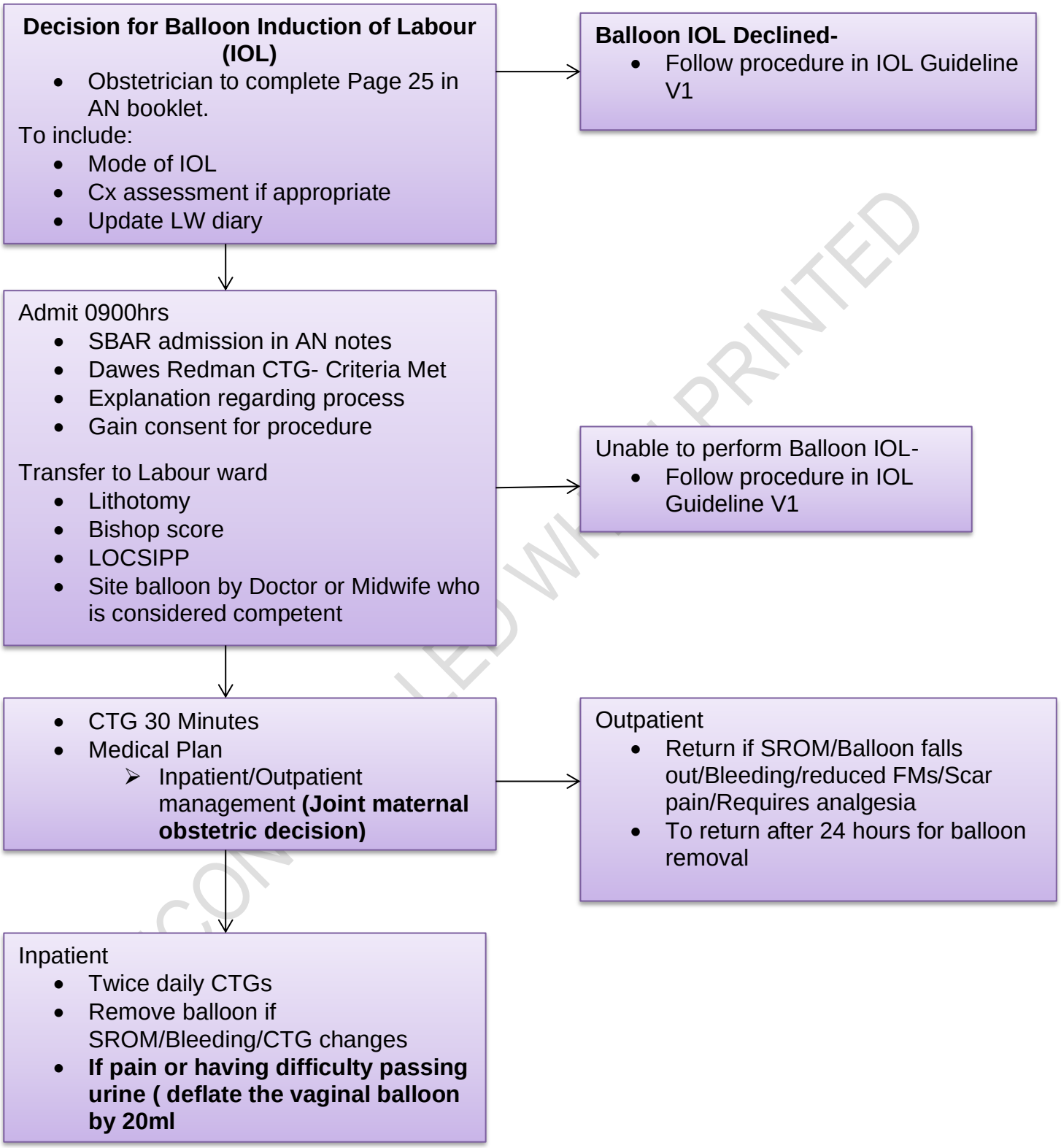
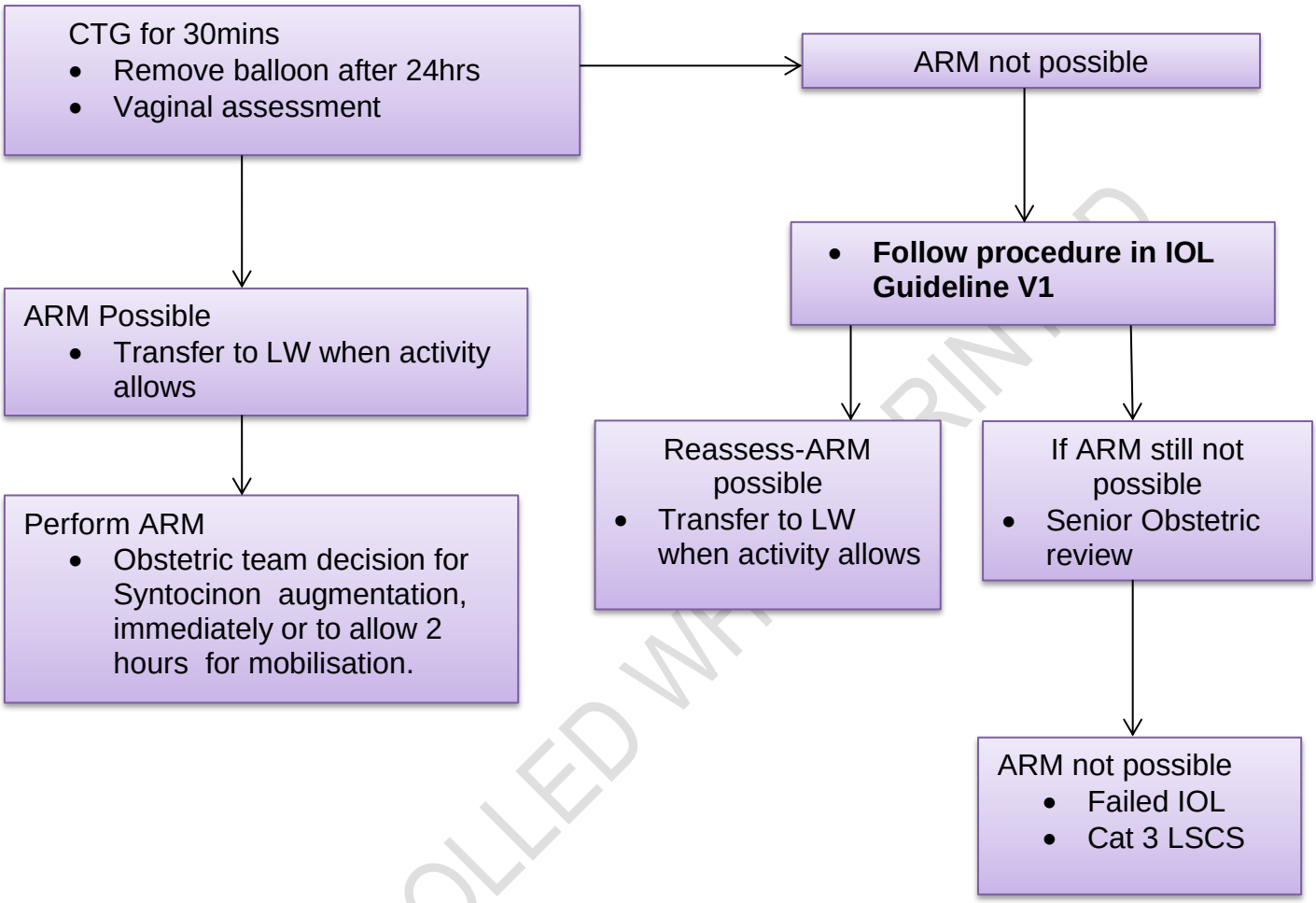
Flowchart for management of Induction of Labour with Cooks Balloon



Flowchart for management after 24 hours



1. Purpose/Background:

Induction of labour is indicated if the baby or woman will benefit from a higher probability of a healthy outcome than if birth is delayed.

This document provides evidence based guidance for women undergoing IOL with Cooks Cervical Ripening Balloon.

2. Scope:

This document is for use by all obstetricians and midwives and it applies to all women cared for by the Maternity Services at St Mary's Hospital NHS trust.

3. Responsibilities

It is the responsibility of all Midwifery Nursing and medical staff to:

- Access read understand and apply this SOP
- Attend any mandatory training pertaining to the SOP

It is the responsibility of the department to:

- Ensure the SOP is reviewed as required in line with trust and national recommendations
- Ensure the SOP is accessible to all relevant staff

4. Procedure:

4.1 Indication

- IOL with a Cooks cervical ripening balloon can be utilised for all woman, except the following:
    - Breech Presentation.
    - Severe fetal growth restriction with confirmed fetal compromise.
    - Ruptured membranes. The balloon should be removed if SROM occurs during the IOL process.
- The indicated method of induction should be documented on the IOL page of the antenatal notes (page 25), and entered onto the electronic labour ward diary by the decision maker.

- The women should be appropriately counselled and consented for a balloon induction and a patient information leaflet given. Perform cervical assessment (Bishop Score) if appropriate.
- Women should be admitted to the maternity ward at 0900hrs to commence the induction and an SBAR admission to be completed in the antenatal notes.
- A Dawes Redman CTG monitoring should be undertaken and criteria met.
- A full explanation of the procedure and consent confirmed prior to transfer to Labour Ward to site the balloon.

4.2 Balloon Insertion

4.2.2 On admission to Labour ward:

- Encourage the woman to pass urine before commencing the procedure.
- Complete the LoCSSip
- Give a full explanation of the procedure and gain consent.

4.2.3 Instructions for the insertion of Cook cervical ripening balloon

- Place the woman in lithotomy and insert speculum.
- Clean the cervix with an appropriate cleaning solution to prepare for device insertion.
- Insert the device into the cervix and advance until both balloons have entered the cervical canal.
- Inflate the uterine balloon with 40ml of normal saline using a standard 20ml Luer-lock syringe through the red Check-Flo valve marked ‘U’.
- Once the uterine balloon is inflated, the device is pulled back until the uterine balloon is against the internal cervical os.
- The vaginal balloon is now visible outside the external cervical os. Inflate the vaginal balloon with 20ml of normal saline using a standard 20ml Luer-lock syringe through the green Check-Flo valve marked ‘V’.
- Once the balloons are situated on each side of the cervix and the device has been fixed in place, remove the speculum.
- Add more fluid in turn to each balloon in 20ml increments until each balloon contains 80ml (maximum) of fluid. Do NOT overinflate the balloons.
- If desired the proximal end of the catheter may be taped to the woman’s thigh.

4.2.4 Care following insertion

- Following insertion of the balloon, a CTG must be undertaken for at least 30 minutes to confirm wellbeing.
- A plan of care to be completed, jointly with the woman to include ongoing inpatient or outpatient management.

4.2.5 Outpatient management:

- Return to unit if
    - SROM
    - balloon falls out
    - bleeding
    - reduced fetal movements
    - scar pain
    - Requires analgesia
    - Difficulty in passing urine.
- All women to return to unit after 24hrs for removal of balloon.

4.2.6 Inpatient management:

- Twice daily CTG
- Pain relief as required.
- Remove balloon if SROM/bleeding/CTG changes
- If difficulty in passing urine, deflate the vaginal balloon by 20mls.

4.2.7`Prior to removal of balloon:

- CTG monitoring for 30mins to confirm fetal wellbeing.
- Remove by deflating uterine and vaginal balloons.
- Vaginal assessment for suitability of ARM.

4.2.8 Ongoing management:

- If ARM possible-transfer to Labour Ward when activity allows.
- Obstetric team decision regarding timing of Syntocinon augmentation if indicated (immediate or after 1-2 hours to allow for mobilisation?).

ARM not possible:

- Follow procedure in IOL Guideline V1 (*September, 2020*)
- Commence Prostin IOL if indicated (contraindicated in the presence of lower uterine scar).
- If ARM possible, transfer to labour ward when activity allows.
- If ARM not possible after 2 doses of Prostin, for senior obstetric review.

ARM not possible after 2 rounds of Prostin:

- Category 3 Caesarean section for failed IOL

Regular senior obstetric review is required throughout the IOL process, and the woman's concerns and requests must be requested at all times.

5 Implementation/training/awareness

- This is a new document and it formalises current practice.
- Once ratified it will be available in all clinical areas within the Maternity Unit and on the intranet.
- All new, reviewed and ratified documents are notified to staff via the monthly maternity newsletter

6. Auditable Standards

All women will have a proforma completed for audit (see Appendix A)

7. Related Documents:

Guidelines/SOP's:

- SOP-Induction of Labour
- SOP use of Oxytocin

Patient Information:

- Induction of Labour

8. References:

- NICE guidance CG70 https://www.nice.org.uk/guidance/cg70, July 2008

- Dowswell T, Kelly AJ, Livio S, Norman JE, Alfirevic Z (2010). Different methods for the induction of labour in outpatient settings Cochrane Database of Systematic Reviews Issue 8.

9. DISCLAIMER

It is the responsibility of staff to check the Trust intranet to ensure that the most recent version/issue of this document is being referenced.

DOCUMENT HISTORY					
Date of Issue	**Version No.**	**Next Review Date**	**Date Approved**	**Director Responsible for Change**	**Nature of Change**
April 2021	V1	April 2024	13th April 2021	MCEG	New Document

Appendix A-Cervical balloon induction proforma

Date and time……

Patient sticker

Parity

Agrees to cervical balloon induction Y/N

Patient information given Y/N

Any contraindication to cervical balloon induction of labour Y/N

Maternal observations

BP Pulse Temperature

RR Sats MEOWS score

Abdominal palpation

Cephalic Y/N lie longitudinal Y/N membranes intact Y/N

CTG for 20mins prior to procedure reassuring Y/N

Method of balloon placement

Digital placement Speculum aided placement

Amount of water put in both balloons ……

Bishops score

Bishop's Score	0	1	2	3	Score
Position	Post	Centre	Anterior		
Consistency	Firm	Medium	Soft		
Length (cm)	> 2	2 – 1	1 – 0.5	< 0.5	
Dilatation (cm)	0	1 – 2	3 – 4	5 – 6	
Station to spines	-3	-2	-1	+1 – 2	
Comments / Plan				BS Total	

Suitable for outpatient care Y/N

Date and Time of balloon removal ……

Signature and designation of person performing the procedure ……..