Training midwives to insert Cooks Catheters for Induction of Labour

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WCHN
Management of Induction of Labour at WCHN

- Inconsistent time/place for IOL activities
- Long waits at times pending medical/midwifery availability
- Cervical priming delayed: birthing after hours
- EDC not confidently calculated & recorded
- Midwives saw the need for better management
- Implement recommendations of OPRA/COPRA trials
- IOL was largely medical intervention
OPRA/COPRA - what can RM’s do?

- OPRA published May 2014: Prostaglandins & go home or stay in overnight
- Conclusions: uterine stimulation, may not be best agent for outpatient ripening
- COPRA RCT published 2015: cervical catheter & go home or stay in overnight
- Conclusions: no failed inductions, infections or uterine hyperstimulation and outpatient balloon catheter ripening should be further investigated
- Outpatient women reported feeling less isolated or emotionally alone
What we did

• Dedicated project management time to identify available clinical area
• EDC calculation/documentation
• Clerical input into computer booking process/template
• Women booked at 20 weeks for IOL at 41 weeks
• By 40 weeks, primary clinician confirms IOL appointment
• Revision of midwifery standards
• Identified RM’s with confidence & skills: Train the trainer
Barriers to overcome

• As it turned out—none!
• Use only product TGA approved for purpose: Cooks Cervical ripening balloon catheter (with stylet)
• Unavailability is a problem as it is our default method of IOL
• Women only receive PGE’s if not suitable for CRC, or as second intervention
• Medical staff embraced RM’s role
Benefits of CRC’s

• Clinically efficient
• Relatively safe
• Potentially cost effective
• No predicted incidence of uterine hyperstimulation
• At term, fewer maternal & neonatal side effects
• Improves Bishop scores
• Decrease interval until birth
Indications

• Facilitate IOL with unripe cervix
• Previous LSCS is controversial, decision by senior Obstetrician
Contraindications

- Any contraindication to induction of labour
- Low lying placenta
- Planned elective caesarean
- Maternal refusal
- Placenta praevia
- HIV infection
- Active herpes lesions
- Vasa praevia
- Malpresentation
- Ruptured membranes
- Abnormal fetal heart rate patterns
- Invasive cervical cancer
- Simultaneous use of pharmacological cervical priming (such as PGE2 or misoprostol) is not recommended
Is it safe? Potential Adverse Events

- Placental abruption
- Uterine rupture
- Spontaneous rupture of membranes
- Spontaneous onset of labour
- Device expulsion
- Device entrapment and/or fragmentation
- Maternal discomfort
- Failed dilation
- Cervical laceration
- Bleeding
- Risk of pre-term delivery in subsequent pregnancy
How to proceed

**Equipment**

- Bivalve speculum
- Cervical Ripening Balloon (latex-free) (double lumen)
- Sponge Forceps
- Bottle Sterile Saline solution
- Syringe – 60 mLs/20mLs
- Lubricating gel
- Tape
- Cardiotocograph machine
Procedure

• Abdominal palpation
• Cardiotocography (CTG) for at least 20 minutes
• Lithotomy position
• Vaginal examination and assign a modified Bishops score and determine her suitability for IOL with a transcervical catheter
• Pre-inflate each of the catheter balloons
• Insert the speculum and visualise the cervix
Pass the catheter through the internal os of the cervix using the stylet (or sponge forceps if no stylet)

Inflate the uterine balloon
Gently pullback until the inflated balloon abuts the internal cervical os
The proximal balloon should now be outside the external os and is inflated. Sterile saline is added to a maximum of 80 mL per balloon in 20 mL increments.

Both balloons are inflated to a maximum of 80 mL.
Eligibility for admission to PIAS/CRC

- Pregnancy is at term (37-42 completed weeks) and induction is being performed for post-dates or social reasons.
- **There is no reason to expect there would be any compromise to either the mother or the baby’s health and wellbeing, than an otherwise low risk woman spontaneously laboring outside of Delivery Suite area.**
- Fetus is singleton, appropriately grown by clinical examination, cephalic presentation.
- Any clinical suspicion of IUGR should be investigated by ultrasound assessment
- Woman has intact membranes and a Bishop score of < 6
- Cervical priming is being done for reasons other than fetal or maternal compromise
- Check no contraindications to balloon catheter priming
Staff Information on change of practice

• An additional option for care can now be offered to low risk women who are eligible for pre-labour cervical priming in PIAS to have overnight leave for 12 hours post cervical catheter insertion if eligibility criteria is met.

• At the point of informing the woman of her options, please advise her if you think she is eligible for PIAS care and can be considered for approx. 12 hours of overnight leave.

• Provide her with the patient information brochure on ‘Induction of Labour’.

• If the woman is eligible for overnight leave, at the time of confirming the booking for induction of labour, please notify the PIAS staff that the woman is informed.
# Personal portfolio record of Midwife/Medical Officer experience for accreditation to insert Cervical Ripening Balloon Catheter

Name: _________________________________________________________

The following must be satisfactorily completed before undertaking cervical catheter insertion.

## Part 1: Theoretical Component

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<td>1a. Have read and understood the practice implications related to W&amp;B divisional policies on the role of the midwife and medical officer in induction of labour.</td>
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<td>1b. Have read and understood the practice implications that detail contraindications / potential complications of Cervical catheter insertion and how to avoid them, ie WCHN clinical standard for ‘Induction of Labour – transcervical Balloon catheter’, WCHN clinical standard for ‘Vaginal Speculum Examination and swab Specimen Collection’, and WCHN clinical standard for ‘Artificial Rupture of the Membranes (ARM) by Midwives for Augmentation/Induction of Labour’. Midwife, and medical officer prn to complete the ‘Speculum examination by a Midwife’ education package (CET)</td>
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## Part 2: And all of the following

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<td>1a. Supervised catheter insertion by Obstetric Consultant/registrar/experienced midwife accredited to supervise Cervical catheter insertion (minimum 3 ) within the last 12 months.</td>
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<td>1b. Midwife/MO has viewed the recommended Product information guidelines, IOL unit flowcharts for the options of care /locations for care, for women suitable for cervical priming with balloon catheter, and emergency contingency plans should they be necessary.</td>
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## Part 3: Supervised Practice Component (three supervised cervical catheter insertions)

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