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**MARIN GENERAL HOSPITAL  
DEPARTMENT OF NURSING  
WOMEN'S, INFANTS', AND CHILDREN'S CARE SERVICES**

**OXYTOCIN INFUSION**

**I. POLICY:**

It is the policy of Marin General Hospital (MGH) to provide safe care and treatment for any labor patient requiring stimulation of labor.

**II. PURPOSE:**

To outline nursing management during administration of Oxytocin for induction or augmentation of labor with a viable fetus. The goal of Oxytocin administration is to affect uterine activity sufficient to produce cervical change and fetal descent while avoiding fetal compromise and/or tachysystole.

**III. GENERAL INFORMATION:**

**A. Definitions:**

1. Induction of labor is the stimulation of uterine contractions before the spontaneous onset of labor, for the purpose of accomplishing vaginal birth. Augmentation of labor is the stimulation of ineffective uterine contractions after the spontaneous onset of labor to manage labor dystocia.
2. Uterine Tachysystole is defined as greater than 5 contractions in 10 minutes averaged over 30-minute window. Tachysystole applies to either spontaneous or stimulated labor and should always be qualified as to the presence or absence of associated Fetal Heart Rate (FHR) decelerations.
3. A Prolonged Contraction is defined as a single contraction lasting more than 120 seconds (2 minutes).
4. The FHR tracing should be interpreted and managed in the context of the overall clinical circumstances. (Refer to the Electronic and Uterine Monitoring Policy, #3050.06).
5. Physician with Cesarean Section (C-section) privileges and operative vaginal delivery privileges must be aware of the induction or augmentation of labor. A provider without these privileges will need an Obstetric (OB) consultant to perform any operative vaginal and/or cesarean delivery. The physician/certified nurse midwife (CNM) must document that such a consultation has taken place.
6. The attending physician or their representative must be readily available at all times. The indication for the Oxytocin induction or augmentation is determined and documented by the attending physician.

7. Oxytocin induction is initiated only if staffing is adequate to monitor the fetus and mother as defined per protocol. Oxytocin induction is to be discontinued if unit staffing does not allow the nurse to monitor the fetus and mother per protocol. Oxytocin induction is to be pre-scheduled, if possible, based on availability of beds and nursing staff.

**B. Indications for Induction:**

1. Indications for induction are not absolute. The following are examples of conditions that may be indications for induction of labor:
  - a. Chorioamnionitis
  - b. Pre-eclampsia, eclampsia
  - c. Premature rupture of membranes
  - d. Post-term pregnancy
  - e. Maternal medical conditions
  - f. Fetal compromise
  - g. Logistic reasons (History (Hx). of precipitous deliveries, family issues, etc.)

*NOTE: Elective induction prior to 39 weeks gestation is not recommended.*

**C. Contraindications:**

1. Placenta or Vaso previa
2. Abnormal Fetal presentation
3. Cord presentation
4. Prior classical uterine incision
5. Primary genital herpes infection
6. Pelvic structural deformities
7. Invasive cervical Carcinoma

**D. Adverse Effects:**

1. Adverse affects of Oxytocin are primarily dose related. The most common adverse effect is FHR decelerations associated with uterine tachysystole. If FHR decelerations and uterine tachysystole are present, refer to reassessment section for actions.

**E. Specific Procedural Information:**

1. **Pitocin Usage by Midwives:**
  - a. Section III of Midwife protocol indicates "Induction or augmentation of labor requires physician consultation."
  - b. Patients must be seen by CNM or MD within four hours before start of an induction and patient must be seen by CNM immediately prior to starting an augmentation.

<b>ASSESSMENT</b>	<ol style="list-style-type: none"> <li>1. Verify that patient has received informed consent by the physician/CNM for induction, including indications, risks, benefits and alternatives. (An induction consent should be signed by patient prior to initiating the induction (See Attachment B)</li> <li>2. May initiate Oxytocin induction/augmentation 30 minutes after Cervidil is removed.</li> <li>3. May initiate Oxytocin induction/augmentation 4 hours after the last dose of Misoprostol.</li> <li>4. Perform vaginal exam prior to <b>induction</b> of labor with Oxytocin for patients <b>with intact membranes</b> for:             <ol style="list-style-type: none"> <li>a. Cervical assessment (Bishop Score-dilatation, effacement, fetal station, cervical consistency, cervical position; see Attachment A).</li> <li>b. Station and presenting part.</li> </ol> </li> <li>5. May use Leopold's Maneuvers or ultrasound exam to confirm presentation. Notify physician/CNM if unsure of presentation.</li> <li>6. Prior to <b>initiation</b> of Oxytocin for <b>induction</b>, the nurse must:             <ol style="list-style-type: none"> <li>a. Complete a FHR assessment per Pre-Induction Checklist</li> <li>b. Explain the induction procedure to the patient.</li> <li>c. Complete the Pre-Induction Checklist (see Attachment D).</li> <li>d. For a medically indicated induction, the History and Physical (H&amp;P) update, prenatal records (including documentation of estimated fetal weight (EFW) and adequacy of pelvis) may be delayed, but should be obtained and placed in the chart as soon as possible.</li> </ol> </li> <li>7. Prior to <b>initiation</b> of Oxytocin for <b>augmentation</b>, the nurse must             <ol style="list-style-type: none"> <li>a. Complete a FHR and uterine contraction assessment per Pre Augmentation Checklist.</li> <li>b. Explained the augmentation procedure to the patient.</li> <li>c. Complete the Pre-augmentation Checklist (see Attachment D).</li> <li>d. For augmentations, the H&amp;P update, prenatal records, and adequacy of pelvis may be delayed but should be obtained and placed in the chart as soon as possible.</li> </ol> </li> <li>8. <b>If the Pre-Checklist criteria cannot be met, Oxytocin should not be initiated.</b> Contact physician/CNM for plan of care.</li> </ol> <p><u><b>Note:</b></u> <i>If, after reviewing the fetal heart rate strip and course of labor, the responsible physician/CNM feels that in his or her judgment, initiation of induction/augmentation or cervical ripening is in the best interest of the mother and baby, the physician/CNM should write or dictate a note to that effect and order the induction/augmentation or cervical ripening to proceed.</i></p>
<b>PLANNED STEPS</b>	<ol style="list-style-type: none"> <li>1. Start intravenous (IV) with 1000 mL Lactated Ringers (LR) as ordered by CNM/MD using a large bore 18 g intravenous catheter, (IV rate per MD order)</li> <li>2. Obtain an intravenous bag with an Oxytocin <b>concentration of 1 milliUnit/minute = 1 mL/hour</b> which results from a pre-mixed IV infusion bag of <b>250 mL LR solution with 15 units Oxytocin</b>. (See Attachment C) NOTE: This concentration of Oxytocin should only be administered via an infusion pump.</li> <li>3. Using infusion pump, piggyback Oxytocin solution into the primary IV line at the port closest to the IV insertion site.</li> </ol>

**PLANNED  
STEPS  
(CONT.)**

4. Begin and titrate Oxytocin infusion as ordered by the physician/CNM.
  - a. Start infusion at 1 milliUnits/min, per orders.
  - b. Increase Oxytocin infusion rate, as ordered by physician/CNM, until contractions are consistently 2-3 minutes apart and painful and/or there is evidence of cervical change.
  - c. If increase is ordered at 2 milliUnits/minute, may increase by only 1 milliUnit if 4 contractions in 10 minutes and/or when contractions are lasting greater than 90 seconds, to minimize risk of tachysystole.
  - d. May decrease Oxytocin rate when cervical dilatation reaches 5-6cm to reduce risk of uterine Tachysystole.
5. Increase the Oxytocin infusion rate only if all the In-use Oxytocin Checklist FHR and Uterine criteria are met. (See Attachment F).
6. Obtain a physician order for Oxytocin infusion of greater than 20 milliUnits/min. (the recommended maximum dosage)
7. **Per In-Use Oxytocin Checklist Criteria, if:**

In-Use Checklist Criteria		Infusion Titration Management
FHR <b>NOT MET</b>	Uterine Contraction (UC) <b>MET</b>	a. Decrease infusion rate of Oxytocin by 2 milliUnits/min or more and initiate intrauterine resuscitation measures. b. Notify physician/CNM if interventions not effective.
FHR <b>MET</b>	UC <b>NOT MET</b>	c. Decrease infusion rate of Oxytocin by 2 milliUnits/min every 10 minutes, or more frequently, until tachysystole or prolonged contractions have resolved. d. May resume increasing the Oxytocin infusion rate, as ordered above, when In-Use Checklist Criteria have been met. e. Consult physician/CNM for plan of care, after more than one sequential episode of Oxytocin adjustment for tachysystole or prolonged contractions, prior to resuming increase of Oxytocin.
FHR <b>NOT MET</b>	UC <b>NOT MET</b>	f. Discontinue Oxytocin. g. Initiate intrauterine resuscitation measures. h. Notify physician/CNM.

<p><b>PLANNED STEPS (CONT.)</b></p>	<p>8. If the <b><u>FHR assessment criteria</u></b> on the <b><u>IN-Use checklist</u></b> are <b><u>not all met</u></b>, notify the physician/CNM for plan of care. (Refer to protocol: Electronic Fetal and Uterine Monitoring #3050.06).</p> <p>9. If the <b><u>uterine assessment criteria</u></b> on the <b><u>IN-Use Checklist</u></b> are <b><u>not all met</u></b>, refer to Oxytocin/Augmentation Orders #M7400-0460 on MGH Intranet. For <b><u>Uterine Tachysystole</u></b> (defined as greater than 5 contractions in 10 minutes) or 2 prolonged contractions (defined as a single contraction lasting more than 2 minutes):</p> <p><b><u>IF ALL In-Use CHECKLIST FHR CRITERIA MET:</u></b></p> <ol style="list-style-type: none"> <li>Decrease infusion rate of Oxytocin by 2 milli Units/Min every 10 minutes, or more frequently, until tachysystole or prolonged contractions have resolved.</li> <li>May resume increasing the Oxytocin infusion rate, per order, when all In-Use Checklist Criteria have been met.</li> <li>Consult with physician /CNM for plan of care, after more than one episode of Oxytocin adjustment for tachysystole or prolonged contractions, prior to resuming any further increases of Oxytocin.</li> </ol> <p><b><u>IF ALL IN-USE CHECKLIST FHR CRITERIA NOT MET</u></b></p> <ol style="list-style-type: none"> <li>Discontinue infusion rate of Oxytocin</li> <li>Notify physician/CNM</li> <li>Give Terbutaline 0.25 mg subcutaneous (SQ), as ordered by the physician</li> <li>Implement Intra-uterine resuscitation measures when indicated, which may include: <ul style="list-style-type: none"> <li>Changing maternal position to where FHR pattern most improved.</li> <li>Avoid constant pushing (during 2<sup>nd</sup> stage).</li> <li>Begin oxygen per non-re-breather or face mask at 10 L/min.</li> <li>Bolus primary IV per physician/CNM order to correct maternal hypotension.</li> <li>Perform a sterile vaginal exam, as indicated, to check for Cord prolapse or imminent delivery.</li> <li>Place a fetal scalp electrode (FSE) as indicated (a qualified RN may apply FSE).</li> </ul> </li> </ol> <p>10. <b><u>Oxytocin administration may be resumed when all In Use Checklist criteria have been met.</u></b></p> <ol style="list-style-type: none"> <li>If the Oxytocin has been discontinued for less than 30 minutes, restart the infusion at ½ the PREVIOUS rate and increase as ordered by physician/CNM.</li> <li>If the Oxytocin has been discontinued for more than 30 minutes, restart the infusion at the INITIAL starting <b>rate</b> and increase as ordered by physician/ CNM.</li> </ol>
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<b>NOTIFI- CATIONS</b>	<ol style="list-style-type: none"> <li>1. Notify physician/CNM for any of the following: <ol style="list-style-type: none"> <li>a. Pre-Checklist criteria cannot be met.</li> <li>b. Oxytocin infusion reaches 20milliUnits/min./ or maximum ordered dose and further increases are indicated.</li> <li>c. After more than one sequential episode of oxytocin adjustment for tachystole or prolonged contractions, prior to resuming increase of Oxytocin.</li> <li>d. An elevated resting tone of the uterus (nl. = 12-14mmHg; &gt; 20 mmHg is abnormal and warrants further evaluation). (If an amnioinfusion is ongoing an artificial increase in baseline resting tone to 35-40 mm Hg may be present. When the amnioinfusion is shut off average resting tone should be restored).</li> <li>e. Non-reactive FHR with or without uterine tachysystole or prolonged contractions present.</li> <li>f. Labor not progressing.</li> <li>g. The Oxytocin infusion is discontinued related to unit staffing.</li> <li>h. Delivery is imminent.</li> </ol> </li> </ol>
<b>FOLLOWING DELIVERY</b>	Following Delivery, Discard smaller concentrated IV Pitocin 15/250mL bag and replace with Pitocin 20U/1000 mL IV bag to be continued on postpartum prn.
<b>PATIENT TEACHING</b>	<ol style="list-style-type: none"> <li>1. Instruct/review the following with the patient/significant other: <ol style="list-style-type: none"> <li>a. Ongoing plan of care</li> <li>b. Oxytocin (effects and desired response)</li> <li>c. Electronic fetal Monitor</li> <li>d. Pain Management</li> </ol> </li> </ol>
<b>REASSESSMENT</b>	<ol style="list-style-type: none"> <li>1. FHR and uterine contractions should be monitored continuous or performed per High Risk Pregnancy Guidelines. (Telemetry monitoring is a form of continuous Electronic Fetal Monitor [EFM]). Monitoring may be interrupted for a short time (i.e., to allow patient to use the bathroom).</li> <li>2. Assess the FHR and uterine activity every 15 minutes. Assess and document that all the In-Use Oxytocin checklist criteria have been met or not met every 30 minutes <u>and</u> with each change in Oxytocin rate.</li> <li>3. FHR and variability are evaluated and recorded every 15 minutes.</li> <li>4. Maternal blood pressure (BP) is monitored every 2-4 hours.</li> <li>5. Cervical changes are assessed as needed.</li> <li>6. If FHR decelerations and/or uterine tachysystole or prolonged contractions present, follow Oxytocin/Augmentation Orders #M7400-0460 management.</li> </ol>
<b>DOCUMEN- TATION</b>	<p>Document on the labor and Delivery Flow-sheet. Should include:</p> <ol style="list-style-type: none"> <li>1. Name, date, time</li> <li>2. Completion of Pre-Induction or Pre-Augmentation Checklist and In-Use Oxytocin Checklist</li> <li>3. Temperature, Pulse and Respiratory Rate every 4 hours and more frequently as patient condition indicates.</li> <li>4. BP every 2-4 hours.</li> <li>5. Fetal heart rate continuously on fetal monitor with documented assessment of baseline heart rate every 15 minutes, variability, decelerations etc.</li> </ol>
<b>DOCUMEN-</b>	<ol style="list-style-type: none"> <li>6. Oxytocin dosage change (increase/decrease) and time of change.</li> </ol>

<b>TATION (CONT.)</b>	Description of uterine contractile pattern (labor record) every 15 minutes. 7. All interventions and responses including: vaginal exams, medications, position changes, and patient's physical and emotional/mental status. 8. Physician notification and response. 9. Changes in patient plan of care.
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#### **IV. AGE SPECIFIC CONSIDERATIONS:**

N/A

#### **V. EQUIPMENT:**

1. Fetal Monitor
2. Continuous Infusion Pump
3. IV Start Kit, 18 gauge intravenous catheter
4. One liter LR for mainline
5. One 250 mL LR with 15 units of Pitocin
6. Mainline Tubing (1)
7. Primary Pump Tubing (1)

#### **VI. ATTACHMENTS:**

- ATTACHMENT A: Bishop Scoring System  
ATTACHMENT A1: Determining Adequate Uterine Forces Using Montevideo Units  
ATTACHMENT B: Consent for Induction of Labor  
ATTACHMENT C: Chart of Pitocin Increments Using Infusion Device  
ATTACHMENT D: Pre-Induction of Labor Checklist  
ATTACHMENT E: Augmentation Pre-Checklist  
ATTACHMENT F: In-Use Oxytocin Checklist

<b>REFERENCES &amp; APPROVALS</b>		
<b>REFERENCES:</b>	1. AAP/ACOG Guidelines for Perinatal Care 6th Edition – 2007. 2. Obstetrical Policy & Procedural Manual. 3. ACOG Practice Bulletin, Induction of Labor, Number 10, 1999. 4. ACOG Practice Bulletin, Dystocia and Augmentation of Labor, Number 49 December 2003. 5. AWHONN Cervical Ripening and Induction and Augmentation of Labor, 2 <sup>nd</sup> Edition. 2002. 6. Clayworth, S. The Nurse's Role During Oxytocin Administration. MCN, Vol. 25. (2) Pp. 80-84 March/April, 2000. 7. Sutter OB Quality Committee- Oxytocin Safety Initiative	
<b>WRITTEN BY:</b>	WIC/ K. Bunger/ A Davey/ Sutter OB Quality Committee	
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<b>APPROVED BY:</b>	OB MDCP:	<b>2/9/09</b>
	OB Department Education:	<b>3/24/09</b>
	P&T Committee:	<b>4/28/09</b> (order set) <b>3/23/10</b> (P&P)
	Forms Committee:	<b>5/5/09</b> (order set)
	Nursing Leadership Committee	<b>5/20/10</b>
	P&P Committee	<b>5/20/10 &amp; 9/16/10</b>
	MEC	<b>12/13/10</b>
	Quality and Safety Committee	<b>1/25/11</b>
	Board of Directors	<b>2/3/11</b>



## ATTACHMENT A

### Bishop Scoring System

Predictors of favorable outcomes through induction of labor include accurate assessment of gestational age, documented fetal maturity, and scoring indices, which demonstrate inducibility of the cervix. The Bishop scoring system is one of several scoring systems for evaluating inducibility. For example, with a Bishop score of 9 or more, the cervix is considered favorable and induction of labor should be successful (i.e., cervix is soft, effaced 50%, dilated 2 cm or more, and anterior in position with an engaged vertex). In contrast, if the Bishop score is low (5 or less), 10 to 12 hours of uterine contractions may be required to attain a cervix favorable for induction, Misoprostol, Cervidil, or PGE<sub>2</sub> Gel may be used (see procedure for Misoprostol, Cervidil, PGE<sub>2</sub> Gel.)

FACTOR					
Score	Dilation Effacement (cm) %		Station	Consistency	Position of Cervix
0	Closed	0-30	-3	Firm	Posterior
1	1-3	40-50	-2	Medium	Mid-Position
2	3-4	60-70	-1,0	Soft	Anterior
3	≥5	≥80	± 1m ± 2		

## **ATTACHMENT A-1**

### **Determining Adequate Uterine Forces Using Montevideo Units**

Internal uterine pressure catheter monitoring is a direct means of detecting frequency, length and strength of contractions; may be used to determine Montevideo units (MVU). Montevideo units are a unit of measure reflecting the intensity or force of a contraction. MVU are determined by taking the sum of the acme of the contractions in a 10-minute period. Adequate MVU are considered to be in the range of 200-240 if you subtract the baseline uterine tone from the total. Adequate MVU are considered to be 300 MVU. The Intrauterine Pressure Catheter (IUPC) is used when adequacy of uterine forces, cannot be evaluated any other way and membranes are ruptured and cervical dilatation is at least one centimeter.

## **ATTACHMENT B**

### **CONSENT FOR INDUCTION OF LABOR**

*Your doctor or midwife has recommended that you have an induction of labor. It is important that you and your doctor/midwife discuss the risks and benefits of induction and other possible options.*

*Your doctor/midwife is not an employee or agent of the hospital. They will provide you with additional information about induction and answer any questions you may have.*

#### **What is Labor Induction?**

Labor induction is labor that is started with medications to begin the process of childbirth. Labor may be induced for medical reasons or as an elective procedure. If there is concern for your health or the health of your baby, a medical induction is indicated.

Some of the medical reasons may include:

- diabetes
- high blood pressure
- post-dates (greater than 41 weeks or 1 week beyond your due date)
- prolonged rupture of the amniotic sac (bag of water)
- decreased growth of the baby
- abnormal fetal test results
- mother's medical condition

An "elective" induction is one in which the doctor/midwife and the patient choose to start labor without a medical reason. Reasons may include a prior rapid labor or living far away from the hospital.

#### **Risks of Induction:**

If this is your first baby and you are considering induction of labor, your risks for complications are considered higher than a non-induced labor. As compared to mothers who begin labor "naturally" on their own, risks of labor induction (elective or medically indicated) in a first time birth can include:

- A doubling (or more) in the cesarean section rate, especially if the cervix is not ready for labor (this is not the case if you are greater than 41 weeks or postdates).
- A longer labor and an increase in the use of vacuum or forceps for delivery.

If you have had a previous vaginal birth in the past, labor induction (medical or elective) does not appear to cause higher rates of complications when:

- The cervix is beginning to shorten (efface) and open (dilate), and
- The pregnancy is at least 39 weeks (so there are no concerns about the baby's maturity)

#### **Different Methods For Inducing Labor**

- Depending on your medical and pregnancy history and the status of your cervix, the induction may be started using medicine inserted into your vagina. This process can take some time (hours to days). Your physician or midwife may request that you to come to the hospital in the evening so that the medicine can be started in the evening and continue through the night.
- When your cervix is "ready", another medicine, oxytocin (Pitocin®) may be started through your IV. This medicine will be gradually increased until you are having strong, regular contractions. Contractions are closely monitored since too frequent contractions can decrease the fetal heart rate. This problem usually resolves by decreasing or stopping the Pitocin®.

**Different Methods For Inducing Labor-** (continued from page 1)

- In some cases, labor induction may be started by breaking the bag of waters, especially if you have already had a vaginal delivery, your cervix has started to dilate and the baby's head is low in your pelvis. Possible risks of breaking the bag of waters is that the umbilical cord could be compressed or slip below the baby's head. Infection could also be a possible risk. These complications rarely happen.
- The "Foley bulb", a small rubber tube with an inflatable balloon at the end, may be placed into the cervical opening; the balloon is inflated with water. The pressure of the balloon partially dilates the cervix and the Foley bulb falls out.

**Additional Risks, Benefits, or Alternatives**

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**If signed consent form is not received from doctor/midwife office, it is to be completed on admission to Labor and Delivery.**

**AUTHORIZATION AND CONSENT FOR INDUCTION OF LABOR**

My doctor/midwife (name of provider who discussed induction) \_\_\_\_\_ has discussed induction of labor with me.

My doctor/midwife has explained to me the risks, benefits, and alternatives associated with an induction of labor. I have had an opportunity to ask questions and all of my questions have been answered. I wish to go forward with the induction.

\_\_\_\_\_  
Date                      Time                      Signature (Patient/Mother-to be or Representative)

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Witness only required for telephone consent, physical inability to sign, or signature by mark.

\_\_\_\_\_  
Date                      Time                      Witness

Form # M6380-0446

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**CONSENT FOR INDUCTION  
OF LABOR**

**PATIENT LABEL HERE  
KEEP LABEL LEVEL, DO NOT PIVOT**

**ATTACHMENT C**

**Chart of Pitocin Increments Using Infusion Device**

15 u Oxytocin in 250 mL LR

**PITOCIN 15 units/ 250mL LR**

1 mu/min =	1 mL/hr
2 mu/min =	2 mL/hr
3 mu/min =	3 mL/hr
4 mu/min =	4 mL/hr
5 mu/min =	5 mL/hr
6 mu/min =	6 mL/hr
7 mu/min =	7 mL/hr
8 mu/min =	8 mL/hr
9 mu/min =	9 mL/hr
10 mu/min =	10 mL/hr
11 mu/min =	11 mL/hr
12 mu/min =	12 mL/hr
13 mu/min =	13 mL/hr
14 mu/min =	14 mL/hr
15 mu/min =	15 mL/hr
16 mu/min =	16 mL/hr
17 mu/min =	17 mL/hr
18 mu/min =	18 mL/hr
19 mu/min =	19 mL/hr
<b>20 mu/min =</b> <b>Maximum dose</b>	<b>20 mL/hr</b>

## ATTACHMENT D

### Pre-Induction of Labor Checklist:

Stimulation of uterine contractions (with Oxytocin or Prostaglandin) for the purpose of accomplishing vaginal birth before the spontaneous onset of labor (i.e. no contractions, or contractions without cervical change).

**Elective Induction:** Means without clear medical or obstetrical indication. (e.g., no indication given, macrosomia/Large for Gestational Age or patient or physician desire).

**Augmentation of Labor:** Stimulation of ineffective uterine contractions after the spontaneous onset of labor. (Refer to Pre-Augmentation Checklist).

Do not initiate Induction/Cervical Ripening, if checklist cannot be completed.

Y	N		Initials	Comments
		Physician/CNM order for induction		
		Physician with Cesarean Section privileges aware of induction, is readily available and this is documented in the medical record ( <i>if order written by physician or CNM without Cesarean Section privileges</i> )		
<b>*Shaded* items below may be delayed for medically-indicated induction</b>				
		* H&P (physician L&D admission form) on chart, completed no more than 7 days prior to induction and updated within 24 hours of admission.		
		* Prenatal (PN) Record on chart		
		* Adequacy of pelvis documented (H&P or PN Record)		
		* Estimated fetal weight or fundal height documented (H&P or PN Record)		
		Induction indication documented		
		Gestational age documented		
		Induction Consent form signed by patient		
		Cervical exam or Bishops score documented		
		Fetal presentation assessed and documented		
		EFM x 30 minutes (minimum)		
<b>FHR Assessment Criteria</b>				
		<u>All criteria must be met</u> <input type="checkbox"/> Moderate variability present <input type="checkbox"/> No late decelerations in last 30 minutes <input type="checkbox"/> No more than 2 variable decelerations greater than 60 sec. and less than 60 bpm below baseline within the last 30 min.		
<b>All Criteria Met/Not Met</b>				
		<u>All</u> Checklist Criteria met		

		Checklist Criteria <u>not</u> met, Physician/CNM notified		
<b><i>Written order and documentation should be completed by physician/CNM if criteria are not met and physician/CNM decides to proceed with induction</i></b>				
Nurse Signature _____ Date: _____ Time: _____				

## ATTACHMENT E

### Augmentation Pre-Checklist

**Augmentation of Labor:** Stimulation of ineffective uterine contractions after the spontaneous onset of labor.

**Do not Initiate Augmentation if checklist cannot be completed.**

Y	N		Initials	Comments
		Physician/CNM order for augmentation		
		Physician with Cesarean Section privileges aware of augmentation, is readily available and this is documented in the medical record <i>(if order written by physician or CNM without Cesarean Section privileges)</i>		
<b>Shaded* items below may be delayed for augmentation of labor</b>				
		* H&P (physician L&D admission form) on chart, within 24 hours of admission		
		* Prenatal (PN) Record on chart		
		* Adequacy of pelvis documented (H&P or PN Record)		
		Estimated fetal weight or fundal height documented (H&P or PN Record)		
		Gestational age documented		
		Cervical exam or Bishops score documented		
		Fetal presentation assessed and documented		
		EFM x 30 minutes (minimum)		
<b>FHR Assessment Criteria Met</b>				
		<u><b>All criteria must be met</b></u> <ul style="list-style-type: none"> <li><input type="checkbox"/> At least 1 acceleration of 15 bpm x 15 seconds in 30 minutes, or moderate variability for 10 of the previous 30 minutes.</li> <li><input type="checkbox"/> No more than 1 late deceleration occurred in previous 30 minutes.</li> <li><input type="checkbox"/> No more than 2 variable decelerations greater than 60 sec. and less than 60 bpm below baseline within the last 30 min.</li> </ul>		
<b>Uterine Assessment Criteria Met</b>				
		<u><b>All criteria must be met</b></u> <ul style="list-style-type: none"> <li><input type="checkbox"/> No more than 5 Uterine Contractions (UCs) in 10 min. averaged over 30-min. window.</li> <li><input type="checkbox"/> No more than 2 UCs lasting longer than 120 sec. in last 30 min.</li> <li><input type="checkbox"/> Uterus palpates soft between UCs.</li> </ul>		
<b>All Criteria Met/Not Met</b>				
		<u>All</u> Checklist Criteria met		
		Checklist Criteria <u>not</u> met, Physician/CNM notified		



***Physician/CNM order and plan of care should be documented if criteria are not met and physician/CNM decides to proceed with augmentation.***

Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

ATTACHEMENT F

**In-Use Oxytocin Checklist**

Assess and document that all the In-Use Oxytocin Checklist criteria have been met / not met every 30 minutes and with each change in Oxytocin rate. (Refer to Oxytocin Protocol when criteria not met.)

**Increase** the Oxytocin infusion rate only if:

- a. FHR assessment criteria have been met
- b. Uterine contraction assessment criteria have been met

Y	N		Initials	Comments
		<b>All FHR Assessment criteria met</b> Criteria include: <input type="checkbox"/> At least 1 acceleration of 15 bpm x 15 seconds in 30 minutes, or moderate variability for 10 of the previous 30 minutes. <input type="checkbox"/> No more than 1 late deceleration occurred in previous 30 minutes. <input type="checkbox"/> No more than 2 variable decels greater than 60 sec. And less than 60 bpm below baseline within the last 30 minutes.		
		<b>All Uterine Assessment Criteria met</b> Criteria include: <input type="checkbox"/> No more than 5 UC's in 10 minutes averaged over 30-minute window. <input type="checkbox"/> No more than 2 UC's lasting longer than 120 sec.(2 minutes) within the last 30 minutes. <input type="checkbox"/> Uterus palpates soft between UC's.		
<b>Criteria Met/Not Met</b> (Documentation should be completed by the physician/CNM if the criteria are not met and physician/CNM decides to continue with induction or augmentation.)				
		Checklist Criteria met		
		Checklist Criteria <u>not</u> met		
Nurse signature _____ Date/Time _____				