PROTOCOL

Oxytocin (Syntocinon) Infusion - intrapartum

SCOPE (Area): Maternity Unit
SCOPE (Staff): Midwifery & Medical

BACKGROUND/RATIONALE

This guideline has been based on the Victorian Standard for Induction of Labour (IOL) – Oxytocin (Syntocinon) Induction and Augmentation of Labour Clinical Practice Guideline prepared by the Maternity Newborn Clinical Network which has the objective of providing Maternity Service providers in Victoria with an agreed Standard of Care based on the best currently available evidence.

EXPECTED OUTCOME

- Labour is induced or augmented using a protocol for intravenous oxytocin (Syntocinon) infusion to expedite birth where clinically indicated.

INDICATIONS

- Intrapartum syntocinon infusion for induction or augmentation of labour

PRECAUTIONS

This Protocol MUST be read and followed in conjunction with

CPG/S001 – Oxytocin (Syntocinon) – Induction, augmentation of labour and postpartum administration

This protocol is not for use when the lead obstetrician requests a variation to the syntocinon dose, rate or intervals.

ACTIONS

The medical officer must write up the order for the syntocinon infusion on an intravenous orders chart specifying the type of IV fluid and the dose of syntocinon. The rate can be documented as ‘APP’ (as per protocol).

- The midwifery staff will prepare and commence the infusion at 2 milliunits/min (12 ml/hr).
- The infusion MUST be delivered via a volumetric (Gemini) pump
- Monitoring must be attended as detailed in the CPG/S001 Oxytocin (Syntocinon) Infusions – Induction, augmentation of labour and postpartum administration
- Continuous Cardiotocography (CTG) monitoring must be in progress when the oxytocin infusion is running. It may be removed if the:
  → Woman needs to go to the toilet
The lead obstetrician has given permission and documented for intervals without the CTG insitu

- The lead obstetrician will be notified if any of the following occurs:
  - Uterine hyperstimulation occurs (Refer to CPG/U005 Uterine Hyperstimulation (tachysystole) - management of)
  - Abnormal CTG / fetal distress
  - Category 1 Caesarean Section
  - Signs of obstructed labour
  - Any other maternal or fetal complication occurs

- If at any time there is a concern for maternal or fetal wellbeing and the lead obstetrician is unable to be contacted / have not responded to their page the midwifery staff may cease the infusion.

**PREPARING AND ADMINISTERING THE OXYTOCIN (SYNTOCINON) INFUSION**

1. Add 10 units of oxytocin to a 1000mL flask of Compound Sodium Lactate (Hartmann’s solution) or Normal Saline. Label the flask and sign entries on the IV orders chart.

2. Commence the oxytocin infusion at 2 milliunits/min (12ml/hr) via a volumetric (Gemini) infusion pump.

3. Increase the rate every 30 minutes (per increment schedule below) aiming for 4 contractions in 10 minutes lasting 40-90 seconds each.

4. Once **4 contractions in 10 minutes** are achieved **maintain** the infusion rate.

5. Titrate the infusion rate as required to maintain 4 contractions in 10 minutes lasting 40-90 seconds each.

6. Once the maximum has been reached and a further increase in the infusion rate is required it must be discussed with the midwife in charge and the lead obstetrician.

| Table indicating mls per hour of oxytocin (Syntocinon) infused in measures of milliunits/minute in a solution of 10 units of oxytocin (Syntocinon) in 1000mL of solution |
|---|---|---|
| mls/hr | milliunits/min | Time     |
| 12     | 2              | 0        |
| 24     | 4              | 30 minutes |
| 36     | 6              | 60 minutes |
| 48     | 8              | 90 minutes |
| 72     | 12             | 120 minutes |
| 96     | 16             | 150 minutes |
| 120    | 20             | 180 minutes |
| 144    | 24             | 210 minutes |
| 168    | 28             | 240 minutes |
| 192    | 32             | 270 minutes |
Important considerations:

→ Once labour is established in a multigravida, consider slowly reducing the infusion rate, at 30 minute or greater intervals, being careful to maintain 4 contractions in 10 minutes.

→ Additional IV cannula is unnecessary unless it is indicated for an epidural, additional hydration or another infusion (e.g. MgSO4).

→ The oxytocin infusion should not normally be stopped during procedures’ (e.g. insertion of an epidural).

RELATED DOCUMENTS

Internal

CPG/I037 Induction of labour with Prostaglandin E2 (PGE2) Vaginal Gel (Prostin)
CPG/S001 Oxytocin (Syntocinon) – Induction and Augmentation of Labour
CPG/U005 Uterine Hyperstimulation (Tachysystole) – management of
PRO/T005 Tocolysis – Preterm Labour and Inhibition of Established Labour

External

RANZCOG Clinical Guidelines – Intrapartum Fetal Surveillance at

REFERENCES


<table>
<thead>
<tr>
<th>Reg. Authority: Pharmacy Advisory Committee</th>
<th>Date Effective: September 2006</th>
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<tbody>
<tr>
<td>Executive Director – Medical &amp; Nursing</td>
<td>Date Revised: June 2011</td>
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<tr>
<td>Clinical Services Director – Women &amp; Children’s Health</td>
<td>Date for Review: June 2014</td>
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<td>Service Director - Women &amp; Children’s Health</td>
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| Updated by: Midwifery Project Officer (2011) |