HCA
Quality, Safety & Performance Improvement

Oxytocin Order Set

Contradictions for Use:

♦ More than 1 previous C-section ♦ Placenta Previa ♦ Active genital herpes infection ♦ Invasive cervical carcinoma
♦ Breech or transverse lie ♦ Prior classical or low vertical cesarean section, uterine incision or surgery above the lower uterine segment

PRIOR TO OXYTOCIN INITIATION:

☐ 1. Reason for induction and gestational age are documented by the provider.
If induction reason is *elective*, cervix is favorable and gestational age is ≥ 39 weeks**

☐ 2. Prenatal Record and current H&P in medical record. *

☐ 3. Pelvis is documented by the physician to be clinically adequate (on prenatal or L&D H&P). *

☐ 4. Estimated fetal weight (EFW) is documented by the provider within the past week (clinical or ultrasound) to be ≤ 9 lbs 15 oz (4500 grams) in non-diabetic patients ***or*** ≤ 9 lbs 6 oz. (4250 grams) in diabetic patients (on prenatal record or L&D H&P). */**

☐ 5. Vertex fetal presentation is confirmed or provider is notified.

☐ 6. Cervix is assessed and status documented immediately prior to induction (unless cervical exam or ultrasound was performed by provider within previous 4 hours).

☐ 7. **Fetal Assessment (minimum 30 minute strip):**

☐ Two 15 beat x 15 second accelerations in previous 30 minutes, *or* BPP of 8/10 present in previous 4 hours, *or* adequate variability in previous 30 minutes. **/***

☐ No late decelerations.

☐ No more than 2 variable decelerations exceeding 60 seconds, and decreasing for greater than 60 bpm from baseline, in the previous 30 minutes.

If any of above are not met, the provider will review FHR strip and provide appropriate documentation.**

☐ 8. Appropriate consents including consent for induction of labor.

☐ 9. Physician readily available.

*** Documentation may be delayed in patients who present with rupture of membranes or spontaneous labor.**

**** If variance occurs, physician documentation prior to oxytocin initiation includes:**

1) Physician explanation of recommended order set to patient, reason for variance, and the risk/benefit of variance.
2) Patient response to explanation.

***** Does not apply to Oxytocin initiation for the purpose of OCT without intent to induce or augment labor.**

Oxytocin Administration:

1. Complete Oxytocin "In Use" checklist every 30 minutes.
2. Primary IV: 1000 mL _____ solution.
3. Oxytocin 30 units/500 mL NS, premixed, IVPB per infusion pump for a ratio of 1 milliunit = 1 mL. Use port closest to IV site.
4. Continuous Electronic Fetal / Uterine Monitoring.

Dosage:

1. ☐ Low Dose **Regimen A** ☐ Low Dose **Regimen B** ☐ High Dose **Regimen C** ☐ High Dose **Regimen D**

Regimen	Starting Dose	Incremental Increase (mU/min)	Dosage Interval (min)
Low Dose A	0.5 - 1	1	30 – 40
Low Dose B	1 - 2	2	15
High Dose C	~6	~6	15
High Dose D	6	6*, 3, 1	20 - 40
*The incremental increase is reduced to 3 mU/min in presence of hyperstimulation and reduced to 1 mU/min with recurrent hyperstimulation.			

2. Incremental Dose: Per ordered regimen until labor is established.
3. Maintain Oxytocin infusion at current rate (or decrease) when labor progress is adequate. Dosage of Pitocin is determined by uterine and fetal response; therefore the RN may increase, decrease or discontinue oxytocin based on patient assessment.
4. Obtain specific physician order prior to increasing oxytocin above 20 milliunits/minute.

Interventions:

1. Decrease or discontinue Oxytocin for non-reassuring FHR pattern unresponsive to nursing interventions *and/or* uterine hyperstimulation.
2. Notify the physician when discontinuing Oxytocin for non-reassuring FHR.
3. Once the issue for discontinuing Oxytocin has improved, the RN may restart Oxytocin at one half the rate previously being administered and resume above dosing.

TORB/VORB_____/_____
Physician's Signature Date/Time

Patient Identification