

INDUCTION OF LABOUR (IOL) WITH PROSTAGLANDIN, PROPESS, ARTIFICIAL RUPTURE OF MEMBRANES AND STRETCH AND SWEEP	CLINICAL GUIDELINES Register no: 04291 Status: Public
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1.0 Purpose

- 1.1 To provide guidance to ensure that if there is a clinical requirement for the artificial interruption of pregnancy that this is carried out in accordance with best practice in order for the outcome of the pregnancy to be better than it would have been if left to follow its natural course.

2.0 Equality and Diversity

- 2.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

3.0 Definition of Induction of Labour

- 3.1 Induction is the process of commencing labour artificially.
- 3.2 Stimulation is the process of inducing contractions when rupture of membranes (ROM) has occurred pre-labour.
- 3.3 Augmentation is the correction of an inefficient uterine action once labour has started.

4.0 Induction of Labour (IOL) in Viable Pregnancies

- 4.1 IOL is the process of inducing labour artificially. It's an intervention designed to artificially initiate uterine contractions leading to progressive dilatation and effacement of the cervix and birth of the baby.
- 4.2 Patients should be informed that the majority of women should go into labour spontaneously by 42 weeks. At the 38 week antenatal visit, all patients should be offered information about the risks associated with pregnancies that last longer than 42 weeks, and their options. The information should cover the following:
- Membrane sweeping: that membrane sweeping makes spontaneous labour more likely and so reduces the need for formal induction of labour to prevent prolonged pregnancy. The patient should be informed about the procedure for a membrane sweep and that discomfort and vaginal bleeding are possible from the procedure.
 - Induction of labour between 41+0 and 42+0 weeks.
 - Expectant management
- 4.3 An obstetric registrar or consultant must be involved in the clinical decision to delay a high risk IOL.

5.0 Indications for Induction of Labour

- 5.1 **Prolonged Pregnancy** - IOL in uncomplicated low risk pregnancy should be booked from 41 weeks and 3 days gestation to 41 weeks and 5 days gestation, to avoid the risks of post term pregnancy.
- 5.2 If a patient chooses not to have an induction of labour, her decision should be respected, and an individual management plan should be developed and recorded in the health care records. From 42 weeks, this should include the offer of increased antenatal monitoring consisting of at least twice weekly cardiotocography (CTG) and ultrasound estimation of maximum amniotic pool depth.

- 5.3 **Preterm pre-labour rupture of membranes after 34 weeks**, the maternity team should discuss the following factors with her before a decision is made about whether to induce labour, using vaginal prostaglandin pessary:
- Risks to the patient (for example, sepsis, possible need for caesarean section)
 - Risks to the baby (for example, sepsis, problems relating to preterm birth)
 - Local availability of neonatal intensive care facilities
- 5.4 All discussions and decisions should be documented and form part of the patient's individual management plan.
- 5.5 **Pre-labour rupture of membranes at term** (at or over 37 weeks) patients should be given information regarding induction of labour or expectant management. Induction of labour is approximately 24 hours after pre-labour rupture of the membranes at term. All discussions and decisions should be documented and form part of the patient's individual management plan.
- 5.6 **Patients with a previous caesarean section** - IOL can be offered with vaginal prostaglandin pessary or caesarean section or expectant management on an individual basis, taking into account her circumstances and wishes. However, she should be informed of the increased risk of emergency caesarean section during induced labour and increased risk of uterine rupture.
(Refer to the 'Management of vaginal birth after caesarean section'. Register number 06030)
- 5.7 **Breech presentation** where external cephalic version is unsuccessful, declined or contraindicated, and the patient chooses not to have an elective caesarean section, induction of labour should be offered, if delivery is indicated, after discussing the associated risks with the patient.
- 5.8 **Intra Uterine Death** - in the event of an intrauterine fetal death; the patient should be offered induction of labour. Caesarean section should only be offered in the case of placenta praevia major.
(Refer to the 'Guideline for the use of Mifepristone, Misoprostol and Prostin in a Termination of Pregnancy for Fetal Abnormalities or Intrauterine Death'. Register number 06032)
- 6.0 Contraindications for Induction of Labour**
- 6.1 Suspected fetal macrosomia - in the absence of any other indications, induction of labour should not be carried out simply because a healthcare professional suspects a baby is large for gestational age (macrosomic).
- 6.2 Precipitate labour - to avoid a birth unattended by healthcare professionals, induction of labour should not be routinely offered to patients with a history of precipitate labour.
- 6.3 Severe growth restriction with fetal compromise, IOL is not recommended.
- 6.4 Maternal requests for induction of labour - It should not be offered routinely unless under exceptional circumstances (partner soon to be posted abroad with armed forces) and at or after 40 weeks. (Refer to Appendix D)

6.5 When it is agreed that the fetus or mother will benefit from higher probability of a healthy outcome than if birth is delayed.

7.0 Process of Induction of Labour

7.1 Provided that the pregnancy is normal and there is no scar on the uterus, a midwife can make the decision for induction for post-maturity.

7.2 All other indications should be agreed with the obstetric consultant/ registrar (SpR) under whom the patient is booked.

7.3 When the patient is reviewed for an induction of labour (IOL) date in the Antenatal Clinic by the obstetric registrar/ patient's consultant, an individual management plan for the type for IOL should be recorded in the patient's healthcare records. The obstetric registrar/ patient's consultant should prescribe the appropriate vaginal delivery system at this appointment to avoid any unnecessary delays as appropriate.
(Refer to the guideline entitled 'Management of proposs for IOL'; register number 09125)

7.4 Low risk patients that attend a midwives' antenatal appointment should be suitable for proposs for IOL. This should be documented in the Antenatal Care Record as part of the patient's individual management plan for IOL.

7.5 When patients are assessed antenatally for planned management of IOL, the obstetric registrar/ consultant/ midwife should clearly identify the management pathway for IOL; ensuring the following is completed and documented in the Antenatal Care Record:

- IOL has been discussed
- IOL patient information leaflet has been discussed and given
- IOL has been booked; recording the date, time and location
- Verbal consent has been obtained i.e. that the woman has agreed to the IOL and has understood the IOL patient information leaflet; and in addition, that the discussion and verbal consent has been documented in the health care records

7.6 In addition, the patient's prescription chart should be completed in full including; medication written in capitals, legible date, dose, route and signature required by the obstetric registrar/ consultant; indicating the method of induction agent i.e. proposs or prostin. The prescription chart should be secured in the patient's handheld records.

7.7 The IOL process may be delayed or the appointment re-arranged when there is the potential risk for patient safety to be compromised. The decision to delay or re-arrange an IOL appointment will be made by the senior midwifery team and registrar/consultant obstetrician. The woman should be clearly informed of any delay and the rational should be documented in the woman's health care records.

7.8 Confirm the gestation from the booking scan which occurs around 12 weeks of pregnancy or in the absence of this scan, any ultrasound scan < 24 weeks.

7.9 The patient should understand that IOL may be less efficient and commonly more painful than spontaneous labour; and epidural analgesia and assisted delivery are more likely to be required. Also, it is important to remember that the patient may be disappointed by the need for induction and must be able to make informed choices.

7.10 If a patient does not have the capacity to make decisions, follow the DOH guidelines; 'Reference guide to consent for examination of treatment'.

- 7.11 When the patient is admitted, gestation and indication for the induction should be confirmed before the induction is commenced and documented in the Antenatal Care Records.
- 7.12 Induction for postdates with no other complications may be commenced on the Antenatal Ward/ DAU. Once artificial rupture of membranes (ARM) is possible, the patient should be transferred to the Labour Ward.

8.0 Process for Membrane Sweeping

- 8.1 Membrane sweeping prior to the formal induction of labour - patients should be offered a vaginal examination for 'sweeping' of the membranes.
- 8.2 A membrane sweep should be offered to all patients during this assessment, as this increases the rate of spontaneous labour and so reduces the need for formal induction of labour.
- 8.3 At the 40 and 41 week antenatal visits, nulliparous patients should be offered a vaginal examination for membrane sweeping; the midwife should ensure that the 41- 42 week visit page in the Antenatal Care Record is completed.
- 8.4 At the 41week antenatal visit, parous patients should be offered a vaginal examination for membrane sweeping; the midwife should ensure that the 41- 42 week visit page in the Antenatal Care Record is completed.
- 8.5 In the event a vaginal examination is carried out to assess the cervix consent should be obtained from the patient prior to performing a membrane sweep.
- 8.6 Additional membrane sweeping may be offered if labour does not start spontaneously.
- 8.7 Patients should be informed of the following:
- Sweeping of the membranes is not associated with an increase in maternal or neonatal infection
 - Sweeping of the membranes is associated with increased levels of discomfort during the procedure and vaginal bleeding

9.0 Methods for Induction of Labour and Management (Refer to Appendix B)

- 9.1 Vaginal prostaglandin pessary is method of induction of labour. It is a tablet containing a synthetically made hormone called prostaglandin. Its purpose is to help induce labour by encouraging the cervix to soften and shorten ('ripen') to allow it to be more favourable in allowing labour to progress.
- 9.2 When used to ripen the cervix, prostaglandins increase the likelihood of a successful induction of labour and achieving a vaginal delivery in 12 -72 hours.
- 9.3 The options for prostaglandin administration in this Trust are as follows:
- Intravaginal prostaglandin pessary containing 3mg of dinoprostone
 - Propess® which is a controlled vaginal delivery system containing 10mg of dinoprostone

- 9.4 Propess® is a controlled vaginal delivery system: Propess® is presented as a pessary contained in knitted polyester retrieval tape. The release rate is approximately 0.3mg per hour over 24 hours in patient with intact membranes; release being higher in patients with pre-labour rupture of membranes.
- 9.5 Propess is a controlled release system which will reduce the risk of hyperstimulation as bolus doses are not being administered. In addition, propess also has the advantage of being easily removed in cases of hyperstimulation as it has a retrieval tape.
- 9.6 Propess can be given to women with spontaneous rupture of membranes for induction of labour.

10.0 Procedure for Administering Propess® for IOL

- 10.1 Use Propess® as per instructions and in line with training sessions.
- 10.2 Discuss the procedure and the IOL patient information leaflet (if this has not already been discussed at the antenatal clinic appointment)
- 10.3 Batch numbers must be written in patient's notes and a separate diary must be maintained on DAU with patients name, date, indication and batch number.
- 10.4 An abdominal palpation should be performed prior to an auscultation of a fetal heart, cardiotocography (CTG) and vaginal examination.
(Refer to the guideline entitled 'Abdominal palpation and examination in pregnancy (07043)
- 10.5 Perform a CTG and complete antenatal assessment to confirm healthy fetal wellbeing.
- 10.6 Insert Propess® as follows:
- Decontaminate hands
 - Put on gloves and apron
(Refer to the Trust guideline for the 'Prevention and Management of Latex Allergy in Health care Workers'. Register number 04089)
 - Perform vaginal examination to determine the Bishop's score
(Refer to Appendix A)
 - If the Bishop's Score < 5 insert propess held between index and middle finger into the posterior fornix
 - Withdraw the fingers carefully allowing the pessary tape to follow fingers and hang outside the vagina
 - The tape should be folded and inserted into the vagina, do not leave the tape hanging out of the vagina
 - Remove gloves and apron, wash hands
 - Commence a CTG for 30 minutes following insertion of propess
 - Reassess if the patient has spontaneously ruptured her membranes (SROM), or is in labour or there is evidence of hyperstimulation
 - There is no need to perform digital vaginal examination 6 hourly
- 10.7 The patient should inform the midwife of the following circumstances:
- If the pessary becomes dislodged when visiting the toilet, the midwife can assess that it is suitable enough for reinsertion otherwise a new device needs to be inserted

- If the patient requires analgesia, spontaneous rupture of membranes (SROM) occurs or if the patient is in labour. Women with a history of SROM should return to DAU for review and further CTG monitoring to assess the fetal wellbeing.
- 10.8 A repeat CTG should be performed 6 hours following insertion of Propess® and if not in labour and the assessment at that time is normal, the patient can be sent home.
 - 10.9 On going home the patient should be advised to contact the DAU on 01245 513355 if they start contracting overnight. If not, the midwife responsible for discharging the patient post Propess® insertion should specify a time; 22-23 hours post Propess® insertion to return to the DAU for a further review by the obstetric registrar/ consultant on call.
 - 10.10 The pessary should be removed after 24 hours or if the patient is in established labour i.e. painful, regular uterine contractions, requiring pain relief.
 - 10.11 The patient should be reviewed by the obstetric registrar/ consultant on call after 24 hours if not in labour and an individual plan of care should be documented by the obstetric registrar or consultant on call in the patient's Antenatal Care Record.
 - 10.12 If the Bishops score is < 6 following review of the patient, the obstetric registrar/ consultant on call should consider the administration of a prostin 3mg pv in the continuing management of the IOL process.
 - 10.13 If the Bishops score is >7 and the membranes are still intact, an artificial rupture of the membranes procedure should be performed prior to commencing oxytocin (syntocinon®).
 - 10.14 Oxytocin (syntocinon®) for induction and augmentation of labour should be commenced 2 hours after the removal of Propess® or artificial rupture of membranes.
(Refer to the guideline for the administration of oxytocin (syntocinon®) for induction and augmentation of labour

11.0 Procedure for Administering Prostin Pessary for IOL

- 11.1 Discuss the procedure and the IOL patient information leaflet (if this has not already been discussed at the antenatal clinic appointment)
- 11.2 An abdominal palpation should be performed prior to an auscultation of a fetal heart, cardiotocography (CTG) and vaginal examination.
(Refer to the guideline entitled 'Abdominal palpation and examination in pregnancy (07043)
- 11.3 Perform a CTG and complete antenatal assessment to confirm healthy fetal wellbeing.
- 11.4 Insert Prostin as follows:
 - Decontaminate hands
 - Put on gloves and apron
(Refer to the Trust guideline for the 'Prevention and Management of Latex Allergy in Health care Workers'. Register number 04089)
 - Perform vaginal examination to determine the Bishop's score and document findings in the Antenatal Care Record
(Refer to Appendix A)
 - If the Bishop's Score < 5, the intravaginal prostaglandin 3mg pessary should be inserted into the posterior fornix using gel lubrication

- Remove gloves and apron, wash hands
- Commence a CTG for 30 minutes following insertion of the pessary
- Reassess if the patient has spontaneously ruptured her membranes (SROM), or is in labour or there is evidence of hyperstimulation

11.5 The first dose of intravaginal prostaglandin 3mg pessary should be administered followed by a second dose of intravaginal prostaglandin 3mg pessary after 6 hours, if labour is not established (with a maximum dose of 6mg in 24 hours (one cycle).

11.6 A full cervical assessment must be recorded after every vaginal examination stating the Bishops score. The first assessment is 6 hours after the insertion of the first intravaginal prostaglandin 3mg pessary. Prior to each subsequent insertion of intravaginal prostaglandin 3mg pessary refer to points 11.2 to 11.4 and follow the procedure outlined (Refer to Appendix A)

11.7 If the labour is progressing well an artificial rupture of membranes (ARM) is not necessary.

11.8 If a third intravaginal prostaglandin 3mg pessary is necessary, a careful review by the obstetric registrar or consultant is required.

12.0 Observations during IOL Procedure

12.1 Patients recommended for IOL using the vaginal prostaglandin pessary or propess should have their observations as a minimum recorded twice a day prior to the establishment of labour on the Modified Early Obstetric Warning System (MEOWS) chart to include:

(Refer to the guideline entitled 'Management of the severely ill pregnant patient; register number 09095)

- Temperature
- Pulse
- Respiratory rate
- Blood pressure (BP) systolic and diastolic with mean arterial pressure (MAP) recordings

12.2 A 30 minute CTG should be performed prior to insertion into the posterior fornix of the intravaginal prostaglandin 3mg pessary or propess controlled vaginal delivery system.

12.3 If the cardiotocograph (CTG) is categorised as abnormal or the patient is contracting; intravaginal prostaglandin pessary should not be used and the obstetric registrar/consultant on call should be informed to review the CTG trace. The decision to continue the IOL as planned will be at the discretion of the obstetric registrar/consultant on call. All discussions and conversations should be documented in the Antenatal Care Record.

12.4 Following insertion of the vaginal prostaglandin pessary or propess, the patient should be advised to lie down on her side for at least 30 minutes and have continuous fetal monitoring (CTG) during this time and until normality is confirmed.

12.5 Auscultate the fetal heart when the contractions or tightenings increase after cessation of post insertion CTG.

12.6 Once contractions are reported or detected, fetal wellbeing should be assessed with continuous CTG monitoring. Once the cardiotocograph is confirmed as normal

intermittent auscultation should be used unless there are clear indications for continuous fetal monitoring.

(Refer to the 'Guideline for fetal heart rate monitoring in pregnancy and labour' Register number 04265)

- 12.7 High risk women (obstetric or medical) should remain as an inpatient in the Consultant-led Unit at Broomfield Hospital. They can be induced with Prostin or Propess®. The midwife should perform an additional cardiotocograph (CTG) prior to settling the woman for the evening and a subsequent CTG should be performed the following morning prior to the obstetric ward round. Maternal observations should be performed as per individual plan of care.

13.0 Pain Relief during Induction of Labour

- 13.1 Patients being offered induction of labour should be informed that induced labour is likely to be more painful than spontaneous labour.
- 13.2 Patients should be informed of the availability of pain relief options in different settings. (Refer to 'Guideline for the management of normal labour and prolonged labour in low risk patient'. Register number 09079)
- 13.3 During induction of labour, healthcare professionals should provide patients with the pain relief appropriate for them and their pain. This can range from simple analgesics to epidural analgesia. (Refer to 'Guideline for the management of epidural analgesia'. Register number 09109)
- 13.4 Birth attendants (carers and healthcare professionals) should offer patients support and analgesia as required; and should encourage patients to use their own coping strategies for pain relief.
- 13.5 The opportunity to labour in water is recommended for pain relief if there are no clinical indications necessitating continuous fetal monitoring in labour.

14.0 Complications

- 14.1 **Uterine hypercontractility** (not secondary to oxytocin infusion) consider the following:
- Uterine hypercontractility
 - Consider tocolysis
 - Terbutaline 500mcgs subcutaneously
- 14.2 **Failed induction of labour** – this should be discussed with the patient and support provided. The patient's condition and the pregnancy in general should be fully reassessed, and fetal wellbeing should be assessed using electronic fetal monitoring. (Refer to the 'Guideline for fetal heart rate monitoring in pregnancy and labour'; register number 04265)
- 14.3 The subsequent management options for failed IOL include the following points:
- If the maximum dose of prostaglandin has been given and labour has not commenced, an ARM may be attempted by the obstetric registrar or midwife depending on clinical circumstances and indication for induction

- A further attempt to induce labour, the timing should depend on the clinical situation and the patient's wishes
- Caesarean section following discussion with the obstetric consultant on call
- Abandon induction and send the patient home (only suitable in low risk cases after discussion with obstetric consultant and a management plan documented in the health care records)

14.4 **Cord prolapse** is always a potential risk at the time of membrane rupture, especially when the membranes are ruptured artificially.

14.5 To reduce the likelihood of cord prolapse, which may occur at the time of amniotomy, the following precautions should be taken:

- Before induction, engagement of the presenting part should be assessed
- Obstetricians and midwives should palpate for umbilical cord presentation during the preliminary vaginal examination and avoid dislodging the baby's head
- Amniotomy should be avoided if the baby's head is high

14.6 Healthcare professionals should always check that there are no signs of a low-lying placental site before membrane sweeping and before induction of labour.

14.7 **Uterine rupture** at the time of induction of labour is an unusual event in the unscarred uterus. If uterine rupture is suspected during induced labour, the baby should be delivered by emergency caesarean section.

(Refer to 'Guideline for the management of emergency lower segment caesarean section'. Register number 04264)

15.0 Artificial Rupture of the Membranes

15.1 This option may be considered for multigravida with an engaged head and a favourable cervix with a Bishops score >8. However prostaglandins could also be considered with a favourable cervix.

15.2 An abdominal palpation should be performed to confirm presentation and engagement.

15.3 A vaginal examination is performed and the membranes ruptured using an amnihook. If the presenting part is high the decision to ARM needs to be reconsidered with the obstetric registrar or consultant on call.

16.0 Staffing and Training

16.1 All midwifery and obstetric staff must attend yearly mandatory training which includes skills and drills training.

16.2 All midwifery and obstetric staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal.

17.0 Supervisor of Midwives

17.1 The supervision of midwives is a statutory responsibility that provides a mechanism for support and guidance to every midwife practising in the UK. The purpose of supervision is to protect women and babies, while supporting midwives to be fit for

practice'. This role is carried out on our behalf by local supervising authorities. Advice should be sought from the supervisors of midwives are experienced practising midwives who have undertaken further education in order to supervise midwifery services. A 24 hour on call rota operates to ensure that a Supervisor of Midwives is available to advise and support midwives and women in their care choices.

18.0 Infection Prevention

- 18.1 All staff should follow Trust guidelines on infection prevention by ensuring that they effectively 'decontaminate their hands' before and after each procedure.
- 18.2 All staff should ensure that they follow Trust guidelines on infection prevention, using Aseptic Non-Touch Technique (ANTT) when carrying out procedures i.e. vaginal examinations and conducting deliveries.

19.0 Audit and Monitoring

- 19.1 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy (register number 08076), the Corporate Clinical Audit and Quality Improvement Project Plan and the Maternity annual audit work plan; to encompass national and local audit and clinical governance identifying key harm themes. The Women's and Children's Clinical Audit Group will identify a lead for the audit.
- 19.2 As a minimum the following specific requirements will be monitored:
- When membrane sweeping should occur
 - Gestation at which induction of labour should take place
 - Induction of labour in specific circumstances, which as a minimum must include:
 - i. Prolonged pregnancy
 - ii. Preterm pre-labour rupture of membranes
 - iii. Pre-labour rupture of membranes at term
 - iv. Previous caesarean section
 - v. Fetal growth restriction
 - vi. Maternal diabetes
 - vii. Intrauterine death
 - Methods of induction
 - Maternal observations that should be carried out during induction prior to the establishment of labour
 - Fetal observations that should be carried out during induction prior to the establishment of labour
 - Development of an individual management plan when induction of labour fails
 - Process for dealing with maternal requests for induction of labour
 - Development of an individual management plan when induction of labour is declined
- 19.3 A review of a suitable sample of health records of patients to include the minimum requirements as highlighted in point 19.2 will be audited. A minimum compliance 75% is required for each requirement. Where concerns are identified more frequent audit will be undertaken

- 19.4 The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.
- 19.5 The audit report will be reported to the monthly Directorate Governance Meeting (DGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.
- 19.6 Key findings and learning points from the audit will be submitted to the Clinical Governance Group within the integrated learning report.
- 19.7 Key findings and learning points will be disseminated to relevant staff.

20.0 Guideline Management

- 20.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.
- 20.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.
- 20.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are now downloaded from the intranet and filed appropriately in the guideline folders. 'Spot checks' are performed on all clinical guidelines quarterly.
- 20.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for future training needs will be met using methods such as 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

21.0 Communication

- 21.1 A quarterly 'maternity newsletter' is issued to all staff to highlight key changes in clinical practice to include a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly. Midwives that are on maternity leave or 'bank' staff have letters sent to their home address to update them on current clinical changes.
- 21.2 Approved guidelines are published monthly in the Trust's Staff Focus that is sent via email to all staff.
- 21.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.
- 21.4 Regular memos are posted on the guideline and audit notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folders.

22.0 References

National Institute for Clinical Excellence (2008) Antenatal Care. NICE:London.
National Institute for Clinical Excellence (2008) Induction of labour. NICE:London

Bishop Score Record Sheet

Definition - the Bishop score is a scoring system for cervical assessment prior to induction of labour.

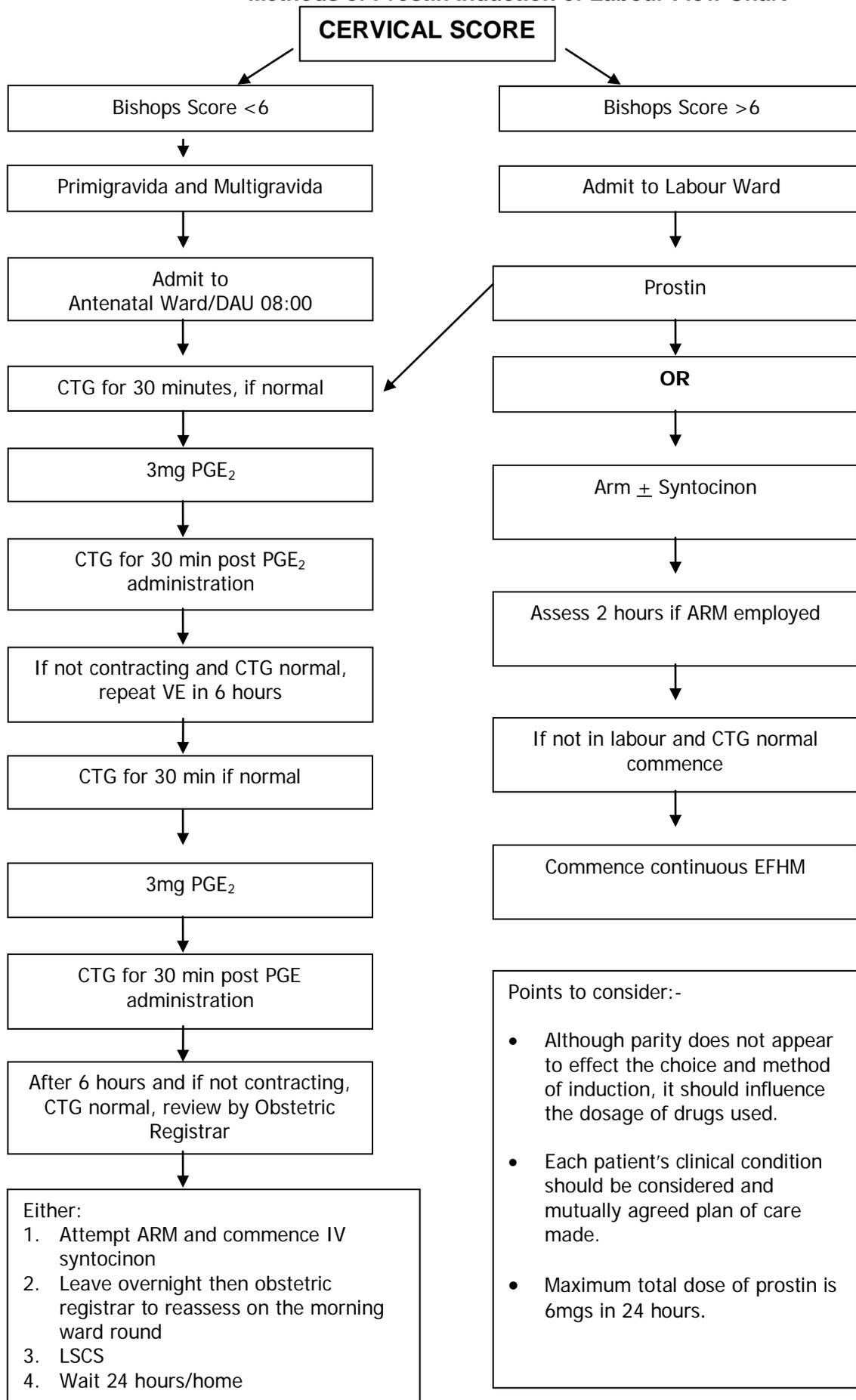
Determination of suitability for elective induction is made by evaluation of certain pelvic factors which usually precede the spontaneous onset of labour. Such factors are:

- Position of cervix
- Effacement
- Dilation
- Consistency
- Station of the presenting part

Each of these five pelvic findings is evaluated and scored. The total of five constitutes a guide for determining the proximity to the spontaneous onset of labour.

Modified Bishop Score	0	1	2	3	score
Dilatation	<1	1-2	2-4	>4	
Consistency	Firm	Ave	Soft		
Length of Cx (cm)	>4	2-4	1-2	<1	
Position of Cx	Post	Mid	Ant		
Station to spines	-3	-2	-1/0	+1/+2	

Methods of Prostin Induction of Labour Flow Chart



NB: Oxytocin should not be started for 6 hours following administration of vaginal prostaglandins.

Maternal Request for Induction of Labour prior to 41 Weeks Gestation

1. Reasons why women request induction of labour:

- Increased feelings of safety
- Desire to shorten the duration of pregnancy.
- Discomfort
- Convenience
- Previous poor experience

2. Women who request induction are more likely to have had problems during their current pregnancy, complications in their previous pregnancies, problematic menstrual periods, and to be more anxious about their labours than those women who choose a spontaneous onset of labour.

3. Risk associated with induction of labour for maternal request:

Assuming that the woman is healthy, with an uncomplicated pregnancy, the risks of continuing the pregnancy should be equivalent to that of the general population. The risks of induction of labour for the mother will also be equivalent to those of the general population. However, any potential benefits accrued are less easy to quantify. There is an increased risk of respiratory distress syndrome in the baby if labour is induced before term. Therefore, it is important that these risks are highlighted in any discussions regarding induction prior to term.

4. Recommendations:

Where resources allow, maternal request for induction of labour should be considered when there are compelling psychological or social reasons and the woman has a favourable cervix. The psychological or social reasons should be discussed with the woman and the patient's obstetric registrar/consultant and an individual management plan should be completed accordingly.