

The following guidelines are intended only as a general educational resource for hospitals and clinicians, and are not intended to reflect or establish a standard of care or to replace individual clinician judgment and medical decision making for specific healthcare environments and patient situations.



Guideline Suggestions for Elective Labor Induction

Definitions:

Elective Induction: Induction of labor when there is no clear medical benefit to mother or child for delivery at that point in time compared with continuation of pregnancy.

Medically Indicated Induction: Induction of labor when there is clear medical benefit to either mom or baby from ending the pregnancy rather than continuing it.

Labor: Painful and regular contractions with progressive cervical change

Commonly used indications for labor induction that make the induction Elective:

- Post maturity (gestational age <41 weeks)
- Macrosomia or impending macrosomia
- Amniotic Fluid Index (AFI) > 5
- History of fast labors
- Advanced cervical dilation
- Prodromal or impending labor
- Previous maternal pelvic floor injury (e.g., 4th degree laceration)
- Psychosocial issues:
 - Partner soon leaving town
 - Including leaving for prolonged military engagements
 - Family in town
 - Maternal exhaustion or discomforts
 - Psychiatric issues (anxiety or depression)
 - Adoption

Recommended Criteria for initiating an elective induction:

- Patient must have documented fetal maturity by clinical or laboratory criteria. Clinical criteria is 39 completed weeks gestation or greater by ACOG criteria for dating pregnancy when an amniocentesis is not performed.

Current guidelines for Assessing Fetal Maturity (ACOG Prac Bull #97; August 2008)

- Fetal heart tones have been documented for 30 weeks by Doppler.
- It has been 36 weeks since a positive serum or urine human chorionic gonadotropin pregnancy test.
- Ultrasound measurement at less than 20 weeks of gestation supports gestational age of 39 weeks or greater
- An ultrasound supports menstrual dating if:
 - obtained in the first trimester with CRL measurement within 1 week of menstrual dating
 - Obtained at up to 20 weeks with assessment by multiple fetal biometric parameters that is within 10 days of menstrual dating
- Amniocentesis and documentation of fetal maturity
- Bishop score: > 8 nulliparous, > 6 multiparous
 - In certain situations, such as a partner leaving for prolonged military duty, induction with an unripe cervix may be appropriate. In this setting, it is particularly important to consider stopping the procedure if labor is not begun in 12- 24 hours.
 - The increased risk of cesarean delivery secondary to labor induction is almost entirely confined to nulliparous women with an unfavorable cervix. For nulliparous women with a Bishop score of < 6, the cesarean section rate approaches 50%.

Additional Criteria to Consider:

- Documented understanding between patient and provider that if labor does not commence within 12-24 hours of starting the procedure, the attempt will be abandoned.
- Cervical ripening should not be used or necessary if it is favorable.
- Amniotomy alone should be reserved for multiparous women a Bishop score > 6. This permits the patient to be sent home if induction is not successful. In this group of women, amniotomy is highly effective as the sole agent required.
- Some institutions with very high rates of EIOl may want to require approval by a department/unit director or other senior member for a period of time. If the person requesting the induction is a director, then approval by the same level nursing director should be considered.
- Should elective induction be unsuccessful and the patient requests an elective cesarean section, the cesarean section should be scheduled using the routine procedures of the hospital.

Implementation Suggestions

- Have a senior L&D nurse (i.e. charge nurse of that day) be responsible for scheduling EIOl.
- The evening charge nurse triages all patients scheduled for IOl the night before in order to prioritize the indicated inductions over the elective inductions.
 - Patients call the night before or morning of induction prior to coming in
- EIOl must be scheduled no more than 7 days in advance, and ideally no more than 1 day in advance.
- EIOl can only be scheduled during business hours.
- Volume of inductions
 - Some institutions have unlimited scheduling, but have triage the night before or morning of in order to prioritize indicated inductions, with the elective inductions waiting at home as necessary.
 - Some institutions limit the number of inductions that can be scheduled on a given day
 - i.e. FAHC schedules 2 medically indicated labor inductions and 1 elective labor induction for Mon-Fri. The physician running the floor on the day in question prioritizes the inductions and the nurse calls them in. There are no scheduled inductions on the weekend, allowing the schedule to catch up as needed.
 - Some institutions limit the number of women that can be undergoing induction on a given day. So, if there is a hold over from the day before, it limits what can happen the next day.
 - Some institutions do not permit any elective labor inductions.

Auditing:

- Periodic audits of all inductions should be performed to ascertain the following:
 - Do “indicated inductions” actually meet institution criteria
 - Are Bishop scores reported from the office and used for scheduling the same as the Bishop score found on presentation to labor and delivery
 - What percent of elective inductions fail, and what happens in these situations.
- A formal audit tool should be used. Fletcher Allen Health Care has one.

References:

LAUREL DURHAM, MPH, RN, MCN 2008 May/June. St. Vincent's Hospital Portland Oregon. Courtesy of Paula Nelson Portsmouth
Creasy and Resnik: 5th Edition (references they refer to: Keetel 1968m Cole 1975, Tylleskar 1979) Dublin 2000, Henberg 2002 (risk of c/s confined).

ACOG Practice Bulletin 10, November 1999

ACOG Practice Bulletin 97; August 2008

Dale P. Reisner, MD; Terri K. Wallin, RN, MHA; Rosalee W. Zingheim, RN, MN; David A. Luthy, MD. Reduction of elective inductions in a large community hospital Am J Obstet Gynecol 2009;200:674.e1-674.e7

FAHC independent review of EIOl (private communication): No patients required C/S, only a rare patient is nulliparous, and they all delivered within 24 hours with about half delivering the day of induction.