

Medically Indicated Inductions Guidance

Indiana Perinatal Quality Improvement Collaborative



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I. OVERVIEW

In 2014, the Quality Improvement Committee of the Indiana Perinatal Quality Improvement Collaborative (IPQIC) was charged to develop guidelines that would support efforts in Indiana to reduce the number of non-medically indicated early term deliveries (37 0/7 through 38 6/7 weeks of gestation) to a rate of 3% or less. Research shows that early term elective deliveries without medical or obstetrical indication is linked to neonatal morbidities with no benefit to the mother or infant. Neonatal morbidities include increased adverse outcomes and death, NICU admissions, adverse respiratory outcome, transient tachypnea of the newborn, newborn sepsis, treated hypoglycemia, CPR or ventilation and extended length of stay.

In 2021, the Reproductive Health Planning Task Force was asked to review the original guidelines and to make necessary revisions based on updated knowledge and guidance from relevant professional organizations.

II. PURPOSE OF THIS DOCUMENT:

To establish guidelines to allow for safe delivery of obstetric care and prevent iatrogenic early elective and preterm birth.

Note: The following guidelines are intended only as a general resource for hospitals and are not intended to reflect or establish a standard of care or to replace individual clinician judgments and medical decision making for specific healthcare organization and patient situations.

III. POLICY STATEMENT:

- I. Medically indicated induction of labor or cesarean delivery before 39 0/7 weeks of gestation should occur when the evidence outweighs continuation of the pregnancy.
- II. Nonmedically indicated deliveries before 39 0/7 weeks gestation have been shown to have immediate and long term adverse neonatal outcomes.
- III. Elective deliveries that are performed early term (37 0/7 through 38 6/7 weeks of gestation) without medical indication should be reviewed by the department in the quality review process. Cases that are unjustified based upon documentation should be forwarded for Peer Review.
- IV. Shared decision making with the physician and patient should occur when planning elective induction of labor at 39 weeks gestation.

IV. DEFINITIONS:

- A. **Elective Cesarean Section:** Refers to a primary or repeat Cesarean Section (CS) that is performed on a pregnant woman per request of the physician on behalf of the patient.
- B. **Elective Induction:** An elective induction is defined as a pharmacological or mechanical initiation of labor in a woman who has no known medical conditions or complications.
- C. **Late preterm:** Refers to 34 0/7 weeks through 36 6/7 weeks of gestation.
- D. **Early term:** Refers to 37 0/7 weeks through 38 6/7 weeks of gestation.
- E. **Full term:** Refers to 39 0/7 weeks through 40 6/7 weeks of gestation.
- F. **Late term:** Refers to 41 0/7 weeks through 41 6/7 weeks of gestation.

G. Post term: Refers to 42 0/7 weeks of gestation and beyond

V. REQUIREMENTS:

The Committee on Obstetric Practice of the Society for Maternal-Fetal Medicine has issued a new ACOG Committee Opinion regarding Medically Indicated Late-Preterm and Early Term Deliveries (Committee Opinion Number 831). If there is a medical indication for early induction of labor that is not included in the current opinion document, the primary OB provider will consult the OB Department Chair or Maternal Fetal Medicine for documentation that there is medical benefit to the mother or infant to be delivered prior to 39 weeks.

<https://www.smfm.org/publications/387-acog-committee-opinion-831-medically-indicated-late-preterm-and-early-term-deliveries>

VI. RECOMMENDED CRITERIA FOR INITIATING A MEDICALLY INDICATED INDUCTION

- A. Prior to initiating a medically indicated late-term or early-term induction, *full term* gestational age should be confirmed and documented by one of the following:
 - 1. It has been 36 weeks since a positive serum or urine human chorionic gonadotropin pregnancy test result.
 - 2. Fetal heart tones have been documented as present for 30 weeks by Doppler ultrasonography.
 - 3. Ultrasound measurement at less than 20 weeks of gestation supports *full term*
- B. A mature fetal lung maturity test result before *full term* (39 0/7 weeks of gestation through 40 6/7 weeks of gestation), in the absence of appropriate clinical circumstances, is not an indication for early elective delivery.
- C. Prior to a medically indicated induction, a Bishop score should be calculated.
 - 1. A high bishop score (defined as greater than 5 for multiparous patients or greater than or equal to 8 for nulliparous patients) indicates a similar likelihood of vaginal birth whether labor is spontaneous or induced. A Bishop score less than 6 is associated with a higher rate of failed induction of labor, particularly in nulliparous women.
 - 2. 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 less than 6, the cesarean section rate approaches 50%.

VII. SCHEDULING PROCEDURE:

The physician should utilize a formal system when scheduling a late preterm/ early term delivery.

A. Physician Responsibility:

- 1. The delivering physician or designee will contact the OB Department to schedule the induction or cesarean section. The following will be provided either on a scheduling form or electronic entry order with supporting documents:
 - a. Indication for the procedure.

- b. Gestational age on the day of the scheduled procedure.
 - c. Consent for induction of labor (or complete on day of procedure)Prenatal records including first ultrasound report
- B. Nursing Responsibility:
- 1. The Charge Nurse will review the information provided and compare it with the above stated ACOG guidelines for medically indicated late-preterm and early-term deliveries
 - 2. The Charge Nurse or designee will review the department calendar for scheduled inductions and cesarean sections daily.
 - a. Scheduling priority will be given to the patients with medical indications for delivery.
 - b. Elective induction of labor at 39 weeks of gestation will be scheduled on a first come, first serve basis.
 - 3. Any request that does not meet category criteria as defined above will be referred to the OB Department Nurse Manager or designee for review at that time. The OB Department Nurse Manager or designee will initiate the chain of command.

Note: During times of high acuity or high census, patient prioritization will be determined by utilizing the following guidelines:

- 1. Priority will be given to patients in active labor.
- 2. Scheduled deliveries will be prioritized according to their indication for delivery.

REFERENCES:

- American College of Obstetricians and Gynecologists, Society of Maternal-Fetal Medicine. (2013). Definition of Term Pregnancy (Committee Opinion No. 579). Washington, DC: Author
- American College of Obstetricians and Gynecologists. (2009). Induction of Labor (Practice Bulletin No. 107). Washington, DC: Author
- American College of Obstetricians and Gynecologists. (2008). Fetal Lung Maturity (Practice Bulletin No. 97). Washington, DC: Author
- American Academy of Pediatrics & American College of Obstetricians and Gynecologists. (2012). Guidelines for Perinatal Care (7th Ed, pp 180-181,193.). Elk Grove, IL; Washington, DC: Authors
- American College of Obstetrics and Gynecologists. (2013, Reaffirmed 2017). Definition of Term Pregnancy (Committee Opinion 579). Washington, DC: Author
- American College of Obstetrics and Gynecologists. (2019). Avoidance of Nonmedically Indicated Early-term Deliveries and Associated Neonatal Morbidities (Committee Opinion 765). Washington, DC: Author
- American College of Obstetrics and Gynecologists. (2021). Medically Indicated Late-Preterm and Early-Term Deliveries (Committee Opinion 818). Washington, DC: Author
- American College of Obstetrics and Gynecologists. (2021). Medically Indicated Late-Preterm and Early-Term Deliveries (Committee Opinion 831, replaces Committee Opinion 818, February 2021). Washington, DC: Author
- Northern New England Perinatal Quality Improvement Network. (2011). Guidelines for Medically Indicated Induction of Labor.
- Simpson, K.R., (2009) Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN) Cervical Ripening and Induction and Augmentation of Labor, 3rd Edition. Washington, DC.
- Spong, C. (2013). Defining “Term” Pregnancy Recommendations from the Defining “Term” Pregnancy Workgroup. *JAMA* published online May 3, 2013. Retrieved from <http://jama.jamanetwork.com>.
- American College of Obstetrics and Gynecologists. (2019). Avoidance of Nonmedically Indicated Early-term Deliveries and Associated Neonatal Morbidities (Committee Opinion 765). Washington, DC: Author
- American College of Obstetrics and Gynecologists. (2021). Medically Indicated Late-Preterm and Early-Term Deliveries (Committee Opinion 831). Washington, DC: Author

Sample Documents

Insert Hospital Name
CONSENT FOR INDUCTION OF LABOR

If you are considering an elective induction of labor, please read the information provided. The risks associated with an elective induction may outweigh the possible benefits, especially if this is a first-time labor. You should also discuss this with your physician.

YOUR LABOR INDUCTION

Labor induction is usually done with a medication such as Pitocin, Misoprostol and Cervidil . With your practitioner’s order, our staff will start the medication at a standard dose and increase it over time to achieve labor progress. While you are getting the medication, we will closely monitor the baby’s heart rate and your contractions. The length of labor depends on how dilated or “ripe” your cervix is at the start of the induction. In general the more dilated you are, the quicker your labor will progress. Also, if this not your first birth, labor may progress faster.

If your cervix is already fairly dilated, your practitioner may start your induction by breaking the bag of water. We may schedule a cervical ripening the day before your induction, if your cervix is closed and not shortening. This procedure may soften your cervix and cause it to begin to dilate. Ripening your cervix may make the Oxytocin more effective when it is begun. Additionally, ripening your cervix may trigger the onset of your labor.

WHY ARE LABOR INDUCTIONS PERFORMED?

Labor inductions are performed for many reasons. Clearly, some reasons are more urgent than others. Here are just a few examples:

- A woman is past her due date.
- A woman is experiencing medical problems that place her or her baby at risk, such as high blood pressure, diabetes, rupture of the bag of water, etc.
- The baby or babies may be small or the amniotic fluid too low.

WHAT ARE THE POTENTIAL RISKS AND BENEFITS OF LABOR INDUCTION?

It is always important to consider the potential benefits and risks of any procedure. The risks include, but are not limited to the following:

- A greater risk of cesarean birth delivery, especially with an “unripe” cervix.
- Longer labors
- Higher chance of a vacuum or forceps delivery.
- Side effects associated with medications or unintended adverse reactions. For example, it is possible to cause contractions that are too frequent and may affect the baby’s heart rate. This is why careful monitoring of your baby’s heart rate is necessary during labor induction.

If you are considering an elective induction, the risks may outweigh the possible benefits, especially if this is a first time labor.

CONSENT FOR INDUCTIONS OF LABOR

Indications for Induction: _____

I have read the above information and I have had the chance to ask my practitioner questions. All of my questions have been answered to my satisfaction. I wish to proceed with the induction.

Patient Signature

Date

Provider Signature

Date

(Patient Sticker)

Delivery Analysis and Scheduling Form

Patient Name: _____ DOB: _____ G ___ P ___ EDC: _____

Requested Date of Procedure: _____ Gestational Age on Date of Procedure: _____

Desired Method of Delivery: Induction of Labor Cesarean

Reason for Induction:

******Include first ultrasound report and Updated H&P which includes documentation of indication for delivery**

Fetal maturity confirmation was confirmed by the following method:

- Based on assisted reproductive technologies dating
- Ultrasound measurement at less than 20 weeks of gestation supports full term (39 0/7 weeks of gestation through 40 6/7 weeks of gestation)
- Fetal heart tones have been documented as present for 30 weeks by Doppler ultrasonography.
- It has been 36 weeks since a positive serum or urine human chorionic gonadotropin pregnancy test result.

Bishop Score: Circle factors that are present at start of induction.

Non-applicable (Scheduled C-section, medically indicated delivery)

Factor	0	1	2	3
Dilation (cm)	Closed	1 - 2	3 - 4	Greater Than or Equal to 5
Effacement (%)	0 - 30%	40 - 50%	60 - 70%	Greater Than or Equal to 80%
Station	-3	-2	-1 / 0	+1 / +2
Consistency	Firm	Medium	Soft	-----
Cervical Position	Posterior	Mid-Position	Anterior	-----

Bishop Score Total: _____

- A high bishop score (defined as greater than 5 for multiparous patients or greater than or equal to 8 for nulliparous patients) indicates a similar likelihood of vaginal birth whether labor is spontaneous or induced.
- A bishop score less than 6 is associated with a higher rate of failed induction of labor, particularly in nulliparous women. 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 less than 6, the cesarean section rate approaches 50%.

Other Factors: Yes/No Adequate Pelvis _____ EFW < 4500 grams _____ EFW > 4500 grams

Patient Education: Patient reviewed risk and benefits Patient signed Consent for Induction of Labor Form

Physician Signature Time Date