## **Inducing labour**

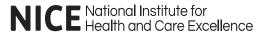
## All stages Provide information and support, invite questions, and allow women time for discussion with partners and families before making decisions. Before induction Induction may be offered if there is: Induction may be offered if there is Avoid induction: Uncomplicated pregnancy Induction declined prelabour rupture of membranes: • Breech presentation: only if caesarean declined, and • If there is fetal growth • Explain to women that labour usually starts • Respect the woman's decision and external cephalic version unsuccessful, declined or Before 34 weeks: only if there are other restriction with confirmed naturally by 42 weeks. discuss further care with her. • Offer membrane sweeps at antenatal visits contraindicated. Fully discuss risks. obstetric indications. fetal compromise. • Offer increased antenatal • Previous caesarean birth: offer induction, caesarean • Between 34 and 37 weeks: discuss with • To avoid unattended birth if from 39+0 weeks. monitoring but advise that adverse birth or expectant management on individual basis. the woman the risks to her and her baby. there is a history of precipitate • Offer additional membrane sweeps if labour effects on the baby (including Explain increased risk of caesarean birth and uterine and the availability of neonatal intensive labour. does not start naturally. stillbirth) cannot be prevented • Offer induction at 41+0 weeks, to take place rupture with induction. even with monitoring. · Intrauterine fetal death. • At or over 37 weeks: choice of induction then or as soon as possible afterwards. Advise women to contact their Maternal request: discuss the benefits and risks with or expectant management (induction Discuss pain relief (see box 1). maternity unit as soon as possible the mother. appropriate after 24 hours). if they have concerns about their • Suspected fetal macrosomia: offer choice of induction Discuss pain relief (see box 1). baby. or expectant management. Fully discuss risks. Discuss pain relief (see box 1). Induction chosen Induction chosen Obtain consent and offer membrane sweep (check for low-lying placenta first). Box 1: Pain relief If labour does not start Abnormal fetal • Explain: heart rate Confirm presentation of the baby, uterine activity, assess Bishop score and confirm normal fetal heart rate - that induced labour is likely to be more → See the NICE guideline on intrapartum care. pattern with cardiotocography using antenatal interpretation. painful than spontaneous labour - pain relief options. ♦ Normal fetal heart rate To reduce the likelihood of cord prolapse: • Provide support and pain relief appropriate for Bishop score 6 or less: the woman and her pain, as needed. This can • Assess the level and stability of the fetal head. include simple analgesia, labour in water and • Discuss the risks of uterine hyperstimulation. Palpate for umbilical cord presentation during preliminary vaginal epidural analgesia. • Check for low-lying placenta before induction. examination (avoid dislodging baby's head). • Offer vaginal dinoprostone as tablet, gel or controlled-release pessary: Carry out continuous cardiotocography during induction if the • Consider low-dose oral misoprostol (25 microgram). presenting part is not stable and not well applied to the cervix. Consider a mechanical method to induce labour (for example, a balloon catheter) if pharmacological If unsuccessful Outpatient induction: methods are not suitable, or it is the woman's choice to use a mechanical method. Offer outpatient induction to low-risk women Bishop score more than 6: with vaginal dinoprostone or mechanical Offer induction of labour with amniotomy and an intravenous oxytocin infusion. Unsuccessful induction methods after full clinical assessment of the woman and fetus. • Reassess woman's condition and pregnancy in general. Contractions begin • Agree a review plan with the woman before • Assess fetal wellbeing with cardiotocography. they return home. • Provide support, and make decisions in accordance with woman's • Confirm fetal wellbeing and uterine contractions with cardiotocography using intrapartum interpretation. • Ask the woman to contact her obstetrician/ wishes and clinical circumstances. • Intermittent auscultation should then be used unless there are indications for continuous monitoring. midwife: • Management options include: • If fetal heart rate is abnormal after administration of dinoprostone or misoprostol, do not administer

any more doses and remove any vaginal delivery systems if necessary. Refer to the NICE guideline on

When labour is established, monitor according to the NICE guideline on intrapartum care.

• Reassess the Bishop score to monitor progress.

• For pain relief, see box 1.



- she has any other concerns, such as reduced

- when contractions begin, or

- if her membranes rupture, or

- if she develops bleeding, or

fetal movements.

- a rest period, if clinically appropriate, and then re-assessment

situation and woman's wishes)

- caesarean birth.

- a further attempt to induce labour (timing to depend on clinical