Inducing labour

All stages

Provide information and support, invite questions, and allow women time for discussion with partners and families before they make their decision.

Before induction

Uncomplicated pregnancy

- Explain to women that labour usually starts naturally before 42 weeks.

Discuss with women the options of:

- membrane sweeping at antenatal visits after 39 weeks
- additional membrane sweeping if labour does not start after the first sweep
- induction from 41+0 weeks
- pain relief (see **box 1**).

Induction may be offered if there is:

- Breech presentation: only if caesarean declined, and external cephalic version unsuccessful, declined or contraindicated. Fully discuss risks.
- Previous caesarean birth: offer induction, caesarean birth or expectant management on individual basis. Explain increased risk of caesarean birth and uterine rupture with induction.
- Intrauterine fetal death.
- Maternal request: discuss the benefits and risks with the mother.
- Suspected fetal macrosomia: offer induction, caesarean birth or expectant management. Fully discuss risks.

Discuss pain relief (see **box 1**).

Induction may be offered if there is prelabour rupture of membranes:

- Before 34 weeks: only if there are other obstetric indications.
- Between 34 and 37 weeks: discuss with the woman the risks to her and her baby, and the availability of neonatal intensive care.
- At or over 37 weeks: choice of induction or expectant management (induction appropriate after 24 hours).

Discuss pain relief (see **box 1**).

Avoid induction:

- If there is fetal growth restriction with confirmed fetal compromise.
- To avoid unattended birth if there is a history of precipitate labour.

If induction is declined:

- Respect the woman's decision and discuss further care with her.
- Offer increased antenatal monitoring but advise that adverse effects on the baby (including stillbirth) cannot be prevented even with monitoring.
- Advise women to contact their maternity unit as soon as possible if they have concerns about their baby.

Induction chosen by woman

Ask for consent and offer membrane sweep (check for low-lying placenta first).

If labour does not start

Induction chosen by woman

Confirm presentation of the baby, uterine activity, assess Bishop score and confirm normal fetal heart rate pattern with cardiotocography using antenatal interpretation.

Abnormal fetal heart rate → See the NICE guideline on fetal monitoring.

Normal fetal heart rate

Bishop score 6 or less:

- Discuss the risks of uterine hyperstimulation.
- Check for low-lying placenta before induction.
- Offer vaginal dinoprostone as tablet, gel or controlled-release pessary, or low dose oral misoprostol (follow the manufacturer's guidance on the use of dinoprostone and misoprostol).
- Consider a mechanical method to induce labour (for example, a balloon catheter or osmotic cervical dilator) if pharmacological methods are not suitable, or the woman chooses to use a mechanical method.

Bishop score more than 6:

- Offer induction of labour with amniotomy and an intravenous oxytocin infusion.

Contractions begin

- Confirm fetal wellbeing and uterine contractions with cardiotocography using intrapartum interpretation.
- Intermittent auscultation should then be used unless there are indications for continuous monitoring.
- 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 intrapartum care.
- When labour is established, monitor according to the NICE guideline on fetal monitoring.
- Reassess the Bishop score to monitor progress.
- For pain relief, see **box 1**.

If unsuccessful

To reduce the adverse effects of cord prolapse:

- Assess the level and stability of the fetal head.
- Palpate for umbilical cord presentation during preliminary vaginal examination (avoid dislodging baby's head).
- Carry out continuous cardiotocography during induction if the presenting part is not stable and not well applied to the cervix.
- If necessary, consider caesarean birth.

Unsuccessful induction

- Reassess woman's condition and pregnancy in general.
- Assess fetal wellbeing with cardiotocography.
- Provide support, and make decisions in accordance with woman's wishes and clinical circumstances.
- Management options include:
  - a rest period, if clinically appropriate, and then re-assessment
  - expectant management
  - a further attempt to induce labour (timing to depend on clinical situation and woman's wishes)
  - caesarean birth.

Box 1: Pain relief

- Explain:
  - that induced labour may be more painful than spontaneous labour
  - pain relief options.
- Provide support and pain relief appropriate for the woman and her pain, as needed. This can include simple analgesia, labour in water and epidural analgesia.

Outpatient induction:

- Consider outpatient induction in low-risk women with vaginal dinoprostone or mechanical methods after full clinical assessment of the woman and fetus.
- Agree a review plan with the woman before they return home.
- Ask the woman to contact her obstetrician/midwife or maternity unit:
  - when contractions begin, or
  - if her membranes rupture, or
  - if she develops bleeding, or
  - she has any other concerns, such as reduced fetal movements.

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