

Safe Deliveries Roadmap

Advancing Safety for Mothers and Babies
A Roadmap from Pre-pregnancy to Postpartum

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Washington State
Hospital Association

Frequently Asked Questions

Induction of Labor Algorithm and Checklist:

- 1) **What is the definition for a medically indicated induction at 39 – 40 6/7 weeks gestation?** Anything on the ACOG labor induction criteria list and cases that fall outside of the Safe Deliveries Roadmap guidelines for non-medically indicated inductions (see Safe Deliveries Roadmap obstetric definitions).
- 2) **How should we determine induction vs. augmentation if the contraction pattern is not clear on admission?** Augmentation is stimulation of labor. Labor is contractions resulting in cervical change. Significant cervical effacement and evidence of cervical dilation in nulliparous women with spontaneous onset of contractions is evidence of labor and therefore, if intervened, it is considered augmentation. In multiparous women the determination is more difficult and requires clinical judgment.
- 3) **Do we use the induction checklist for AROM?** If AROM is done prior to labor it is considered an induction so you can use the induction checklist. If AROM is done during labor it would be an augmentation and you would not use the induction checklist.
- 4) **What is the expectation/recommendation for patients with ruptured membranes?** Patients with ruptured membranes are either contracting and considered “in labor,” or they are not contracting and are candidates for expectant management or induction. Bishop score requirement DOES NOT apply to these patients. They should have visual inspection of the cervix but not a digital exam.
- 5) **What is the distinction between induction and augmentation for patients with ruptured membranes?** Administration of Oxytocin to patients with ruptured membranes with regular existing contractions is augmentation. Administration of Oxytocin to patients with ruptured membranes without contractions is induction (see Safe Deliveries Roadmap obstetric definitions document).

- 6) **If I review a case for data submission and based on the Safe Deliveries Roadmap definitions it is an augmentation, can I call it that even if a provider wrote “Oxytocin induction” in the note?** This is a common situation and can be frustrating. If the clinical documentation fits the definition of induction of labor or augmentation but is identified differently in the notes, it is appropriate to reclassify the procedure for data collection purposes. Care providers need to be educated to carefully consider whether they are augmenting or inducing the patient and then stick with consistent terminology for the entire delivery episode.

Spontaneous/Active Labor Checklist and Algorithm:

- 7) **How do you define adequate progress and inadequate progress?** You can use the Partogram based on Zhang labor curves. They represent 95% confidence intervals of thousands of labors resulting in normal newborn outcomes. If a patient approaches the limits of the curve, interventions should be considered to enhance the progress (e.g. AROM, Oxytocin, position change, analgesia etc.) In the active phase (≥ 6 cm) normal progress to complete is expected within 4-5 hours at the most. The guideline to allow 4 hours (6 hours without adequate contractions) before calling labor arrest does not mean the clock should be reset if for instance the patient makes one centimeter progress to 7 cm in 4 hours. Expert clinical judgment is required to be sure the active phase is not severely prolonged with resultant increased risks for mother and baby from Chorioamnionitis. This will mean that sometimes patients who have poor progress in the active phase could have cesarean section recommended without having absolute arrest of dilation if they exceed the 4-5 hour limit from 6 cm. The Zhang article can be found at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3660040/>
- 8) **What do we do with TOLAC patients?** Use the same practices outlined in the checklist and algorithm as your guide and use your clinical judgment as you would with all patients.
- 9) **How do we utilize the checklists for patients that are sent home for delayed admission and then come back?** Some hospitals are putting the patient label on the back of the checklists and then linking the forms when the patient comes back so they can track the whole patient experience. Another way to handle this is to consider each form as one encounter without linking.
- 10) **In triage, what do we do with a patient who is having painful contractions and it is not clear whether she is in labor?** A period of observation (1 – 2 hours) can be offered to determine whether the patient meets criteria for admission. If the cervix is less than 4, the mother and fetus are stable, and pain control is adequate, patients can often go home, or can walk and be re-evaluated. However, if pain control is inadequate, the patient can be admitted.
- 11) **Is assessment of “adequate pain control” from the perspective of the nurse, MD or patient?** If a patient does not feel that pain control is adequate enough to go home, it is the care provider’s responsibility to address this concern before discharging the patient or denying admission. Many approaches are available to address pain and we are currently gathering resources to offer to the collaborative.