



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 for Non-Medically Indicated Delivery (NMID)

Approved 5/1/2015

(Replaces Elective Labor Induction)

Please note NNEPQIN has separately published “Guideline for Medically Indicated Delivery and Induction of Labor”.

Scope: Women undergoing non-medically indicated delivery (NMID). This guideline does not apply to women presenting with spontaneous rupture of membranes or spontaneous onset of labor.

Definitions:

Non-Medically Indicated Delivery (NMID): Delivery, by either planned cesarean section or 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.

Early NMID: NMID at less than 39 weeks.

Medically Indicated Delivery: Delivery when there is clear medical benefit gained by either mother or child from ending the pregnancy compared to continuing the pregnancy. See NNEPQIN’s Guideline for Medically Indicated Induction of Labor for a list of medical indications for delivery.

Labor: Painful and regular contractions with progressive cervical change.

Term Gestation: (ACOG Practice Bull #107 Induction of Labor; August 2009/2013) (1)

- Ultrasound measurement at less than 20 weeks of gestation supports gestational age of 39 weeks or greater
- 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.

Guideline:

- Elective delivery prior to 39 0/7 weeks should not be performed. The best obstetric estimate should be used to determine the gestational age in concordance with ACOG criteria (2,3, 18) (Level B)
- Labor augmentation for prolonged latent phase is rarely appropriate in women with intact membranes at less than 39 weeks gestation with a category I fetal heart rate tracing. Therapeutic rest is typically more appropriate (4)
- Elective deliveries after 39 weeks should meet ACOG criteria for confirmation of term gestation. The best obstetric estimate should be used
- Medically Indicated deliveries should always take precedent over elective deliveries when resources on the labor unit become scarce. Patient’s undergoing NMID should be informed that their delivery may be delayed to accommodate a medically indicated delivery. (5) (Level B)

- All delivery units should have clear policies and procedures relating to indicated and NMID which collectively include the following elements: (6) (Level C)
 - Criteria for establishing gestational age.
 - Appropriate medical indications for delivery at less than 39 weeks (7) (Level C)
 - Commonly perceived indications for delivery, which are not medical indications and cannot be used to justify delivery at less than 39 weeks.
 - A defined process for scheduling deliveries which includes collecting the indication for delivery, gestational and how it was established, and the bishop score (for elective labor induction). (Level C)
 - A defined chain of command for labor and delivery staff to access if they believe an early NMID has been scheduled. (9, 18) (Level B)
 - Process for reviewing all scheduled deliveries at less than 39 weeks, to determine if an appropriate medical indication was present, and a means of providing feedback to providers who perform early elective deliveries. (9, 18) (Level B)
 - Process for obtaining a second opinion if there is concern that there is not a true medical indication for delivery.

The following commonly used indications for delivery ARE NOT medical indications for delivery. Delivery for any of the indications below is an NMID. (2,10,11)

- Post maturity (gestational age <41 weeks)
- Macrosomia or impending macrosomia
- Amniotic Fluid Index (AFI) >5
- Opiate Dependence
- Pain
- 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

Additional criteria and considerations for elective labor induction:

- Bishop score: In the setting of elective IOL, the Bishop Score should be > 8 nulliparous, > 6 multiparous (12,13) (Level B, Level C)
 - In certain rare social situations, 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.
- Nulliparity: The increased risk of cesarean delivery secondary to labor induction is almost entirely confined to nulliparous women and especially those with an unfavorable cervix. For nulliparous women with a Bishop score of < 6, the cesarean section rate approaches 50%. If elective labor induction is chosen in this setting, the provider should document that the patient and her family were informed of the significantly increased risk of cesarean delivery.

- Discharge Undelivered: Prior to commencing an elective labor induction, the potential for discharge home undelivered if labor is not established within 12-24 hours should be discussed with the patient and documented in the medical record.
- Cervical Ripening: Cervical ripening should not be used or necessary in women undergoing elective labor induction if they are appropriately chosen. (14,15) (Level B)
- Amniotomy: Amniotomy should only be used for labor induction in multiparous women with a Bishop score > 6 as it is otherwise not highly effective and it precludes the patient's discharge to home if labor is not established. (16)
- Non-medically Indicated Cesarean Section: 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. (17)
- Scheduling: Elective labor induction should generally not be scheduled more than seven days in advance and ideally no more than 1 day in advance. This practice helps ensure that there are adequate unit resources for indicated deliveries. (9)

Auditing:

- Periodic audits of scheduled deliveries should be performed to ascertain the following: (7)
 - The reported medical indication is supported in the medical record documentation.
 - Bishop scores reported at the time of scheduling an elective labor induction are consistent with or less than the admitting cervical exam.
- The cesarean section rate in women undergoing elective labor induction should be followed and evaluated at least annually.
- The rate of Early NMID is <3% of all deliveries between 37 and 39 weeks.

References:

1. ACOG Practice Bulletin #107 Induction of Labor, August 2009/2013
2. Clark SL, et al, Oversight of elective early term delivery: avoiding unintended consequences. *Am J Obstet Gynecol* 2012;206:387-9
3. Morrison JJ, et al, Neonatal respiratory morbidity and mode of delivery at term: influencing of timing of elective cesarean delivery. *Br J Obstet Gynaecol* 1995;102:101
4. Clark SL, Miller DD, Belfort MA, et al. Neonatal and maternal outcomes associated with elective term delivery. *Am J Obstet Gynecol.* 2009;200:156.e1-156.e4.
5. Reddy UM, et al, Term pregnancy: A period of heterogenous risk of infant mortality. *Obstet Gynecol* 2011;117:1279-87
6. National Quality Forum Publication August 2014, Early Elective Delivery Play Book-Maternity Action Team
7. Clark SL, et al, Validation of the Joint Commission Exclusion Criteria for Elective Early-Term Delivery. *Obstet Gynecol*;123:29-33
8. ACOG Patient Safety Checklist, Number 5 December 2011
9. Clark SL, et al. Reduction in Elective Delivery prior to 39 weeks gestation: Comparative Effectiveness of Three Approaches to Change and the Impact on Neonatal Outcome and Stillbirth. *Am J Obstet Gynecol.* 2010; 203: 449.e1-449.e6
10. The Joint Commission. Specifications manual for Joint Commission national quality core measures (v2012A1). Available at <https://manual.jointcommission.org/releases/TJC2013A/MIF0166.html>.
11. Milton CG, The Joint Commission's Perinatal care measure set overview. *Breastfeed Med* 2010;5:257-8
12. Vahratian A, et al. Labor Progression and Risk of Cesarean Delivery in Electively Induced Nulliparas. *Obstet Gynecol* 2005;105:698

13. Bishop E, Pelvic Scoring for Elective Induction. *Obstet Gynecol* 1964;24:266.
14. Johnson, D.P., Davis, N.R., and Brown, A.J. Risk of cesarean delivery after induction at term in nulliparous women with an unfavorable cervix. *Am J Obstet Gynecol*. 2003; 188: 1565–1572
15. Maslow, A.S. and Sweeny, A.L. Elective induction of labor as a risk factor for cesarean delivery among low-risk women at term. *Obstet Gynecol*. 2000; 95: 917–922
16. Bricker L, Luckas M, Amniotomy Alone for induction of labor. Cochrane Database System Review 2000;CD002862
17. Agency for Healthcare Research and Quality. Maternal and neonatal outcomes of elective induction of labor. AHRQ Evidence Report/Technology Assessment No. 176. Rockville (MD): AHRQ; 2009. (Systematic review)
18. ACOG Committee Opinion No. 561. Nonmedically indicated early-term deliveries. Committee Opinion No. 561. *Obstet Gynecol* 2013;121:911–5.
19. ACOG Committee Opinion No. 611. Method for Estimating Due Date. *Obstet Gynecol* 2014; 124:863-6.

General References:

1. Creasy and Resnik: 5th Edition (references they refer to: Keetel 1968m Cole 1975, Tylleskar 1979) Dublin 2000, Henberg 2002
2. 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
3. Guidelines for Perinatal Care, October 2007, American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. — 6th ed.
4. ACOG Practice Bulletin 97. Fetal Lung Maturity. *Obstet Gynecol*. 2008: Sep;112(3):717-26.
5. LAUREL DURHAM, MPH, RN, MCN 2008 May/June. St. Vincent's Hospital Portland Oregon. Courtesy of Paula Nelson Portsmouth NH.