AWHONN POSITION STATEMENT

AWHONN
PROMOTING THE HEALTH OF WOMEN AND NEWBORNS
1969-2019 50 YEARS

Elective Induction of Labor

An official position statement of the Association of Women's Health, Obstetric and Neonatal Nurses.

AWHONN 1800 M Street, NW, Suite 740 South, Washington, DC 20036, (800) 673-8499.

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Position

Labor is a complex, physiologic event that involves an intricate interaction of multiple hormones. Women can make fully informed decisions about induction of labor only when they understand the process of induction, potential benefits and risks associated with the pharmacologic and/or mechanical methods used to induce labor, alternatives to induction, and the potential benefits and risks of allowing labor to progress spontaneously. The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) advocates against elective induction of labor before 39 weeks gestation. Induction at or after or 39 weeks gestation is an option that should be carefully weighed against expectant management. Nurses support a woman's choices and provide quality care during the entire perinatal period.

Background

Induction of labor, which can be medically indicated or elective, is defined as the use of pharmacologic and/or mechanical methods to initiate labor (American College of Obstetricians and Gynecologists, 2014). The rate of induction in the United States has more than doubled since 1990 (Osterman & Martin, 2014), and the overall rate in the United States in 2017 was 25.7% (Martin, Hamilton, Osterman, Driscoll, & Drake, 2018). Although limited data are available to distinguish between medically indicated and elective induction of labor, researchers have suggested that the significant increase in the induction rate is not attributable to a similar rise in medical conditions in pregnancy (Moore & Kane Low, 2012). In a recent, federally funded, multicenter, randomized trial, Grobman et al. (2018) found no harm in waiting for spontaneous labor among low-risk, nulliparous women.

Shared Decision Making

Shared decision making, a critical component of patient-centered care, is two-way communication between the provider and patient to ensure the patient's values, goals, and preferences are integrated into the plan of care. This approach engages patients and gives them authority to make informed decisions about their health care (National Quality Forum, 2018). Shared decision making should be central to the discussion about induction of labor between a woman and her maternity care provider. Researchers found that some women who perceived pressure from their maternity care providers were more likely to undergo induction of labor without medical indication (Declercq, Sakala, Corry, Applebaum, Herrlich, 2013; Jou, Kozhimannil, Johnson, & Sakala, 2015; Sakala, Declercq, Turon, & Corry, 2018; Simpson, Newman, & Chirino, 2010).

The Role of the Nurse

The nurse facilitates shared decision making, provides patient education, develops and adheres to standard guidelines for scheduling inductions, tracks and monitors data, and supports public awareness campaigns. To ensure a seamless continuum of reproductive health care, nurses facilitate shared decision making during the following:

- Preconception care
- Prenatal care
- Childbirth education
- Development of a birth plan
- Labor and birth
- Postpartum care
- Well-woman care

Nurses who work in maternity settings should be familiar with evidence-based information about labor induction and spontaneous labor, including risks; benefits; and effects on maternal, fetal, and neonatal well-being. Nurses share current information and advocate for women who have specific requests concerning their birth plans. Before induction, AWHONN (Simpson, 2013), American College of Nurse-Midwives (2016), and American College of Obstetricians and Gynecologists (2009) recommended counseling women about indications, pharmacologic agents and methods, and possible need for repeat induction.

Nurses who plan and evaluate maternity care are advised to monitor all indications for induction, rates of spontaneous labor, and associated outcomes for each (e.g., length of stay, cesarean, success of breastfeeding at discharge, postpartum hemorrhage, and infection). Neonatal outcomes, complication rates, and NICU admissions associated with induced and spontaneous labor should be monitored. This information is valuable when planning and budgeting for resources, including nurse staffing. Patient safety and patient satisfaction are other important variables to consider when evaluating trends in spontaneous and induced labor.

It is important for perinatal nurses to educate families, colleagues, and communities about the benefits of spontaneous labor for women and newborns. Resources are available for nurses to share with women to demonstrate the value of spontaneous labor at 40 weeks gestation (AWHONN, 2014a).

Resources for Induction

Safe induction of labor requires adequate nurse staffing. For women who receive oxytocin, AWHONN (2010) recommended a staffing ratio of one nurse to one woman in labor. The nurse should perform maternal–fetal assessments every 15 minutes during the first stage of labor and every 5 minutes during the second stage of labor (American Academy of Pediatrics & American College of Obstetricians and Gynecologists, 2017; AWHONN, 2018). After birth has occurred, AWHONN (2010) recommended a ratio of one nurse to no more than three mother–newborn couplets. During scheduling at the birth facility, adequate beds and proper staffing should be ensured. Emergent and medically indicated inductions should be given priority over elective inductions.

Greater use of resources during labor induction is thought to affect hospital facility costs, although data are limited (Grobman, 2014). Length of labor is significantly longer with elective induction than with spontaneous labor (Grobman et al., 2018; Tilden, Lee, Allen, Griffen, & Caughey, 2015), which has implications for medication costs, room availability, and nursing hours.

Policy Recommendations

AWHONN supports the following:

- Woman-centered care to help women become educated about and prepared for childbirth and to support their decisions regarding their birth plans;
- Implementation of guidelines, policies, algorithms, and checklists for shared decision making;
- Proactive discussion between maternity care providers and pregnant women about the risks and benefits of induction and spontaneous labor so women are fully informed about related effects and risks;
- Collaboration between nurse leaders and the maternity care team to establish and implement policies and practices that support spontaneous labor, including the use of evidence-based guidelines to define failed induction, management of the active phase of labor, and fetal assessment;
- Adequate nurse staffing to provide safe and optimal care during labor;
- Improved collection of data related to elective induction at 39 weeks gestation and outcomes at the hospital level;
- Reporting of overall induction rates (medically indicated and elective) by hospitals, birth centers, and maternity care providers so women and their families can make informed choices about their maternity care teams and where they give birth;
- Increased representation of nurses and professional colleagues from American College of Nurse-Midwives, American College of Obstetricians and Gynecologists, and Society for Maternal-Fetal Medicine during the development of policy and research priorities;
- Nurse participation in local, statewide, regional, and national perinatal quality care collaborative initiatives and maternal mortality review committees;
- Increased funding for nursing research and education related to spontaneous and induced labor, women's perceptions of and experiences with spontaneous and induced labor, women's decision making about labor induction, and consumer education related to induction and spontaneous labor;
- Maternity care payment models that do not incentivize procedures over expectant management.

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