OB / MATERNAL HEALTH

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Bishop Score & Cervical Ripening

A pre-induction cervical assessment tool that predicts the likelihood of successful labor induction — and the nursing interventions that follow when the score is unfavorable.

MATERNAL/OB | PRIORITY: SAFETY | NCJMM 6-STEP | HIGH-YIELD

📚 **SOURCE TRANSPARENCY:** Bishop Score / cervical ripening content is not present in Diane's uploaded personal notes. Material below is synthesized from standard NCLEX references: *Saunders Comprehensive Review for the NCLEX-RN Examination (2026)*, *ATI Maternal Newborn Nursing*, *Lippincott Manual of Nursing Practice*, *AWHONN Perinatal Nursing (5th ed.)*, and *ACOG Practice Bulletin No. 107: Induction of Labor*.

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Definition & Overview

WHAT IT IS · WHY IT MATTERS

📋

WHAT

A 0–13 point scoring system that assesses cervical readiness for labor induction using 5 components: **dilation, effacement, station, consistency, and position**.

🎯

WHY

Predicts whether induction will likely succeed. A higher score = cervix is "favorable" (ripe) and induction is likely to mimic spontaneous labor.

⏰

WHEN

Performed before any planned induction of labor — typically for post-term pregnancy, PROM, preeclampsia, gestational diabetes, or IUGR.

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Pathophysiology of Cervical Ripening

HOW THE CERVIX BECOMES LABOR-READY

STEP 1
Prostaglandins released (PGE2, PGF2α) → break down cervical collagen

→

STEP 2
Cervix **softens** (firm → medium → soft)

→

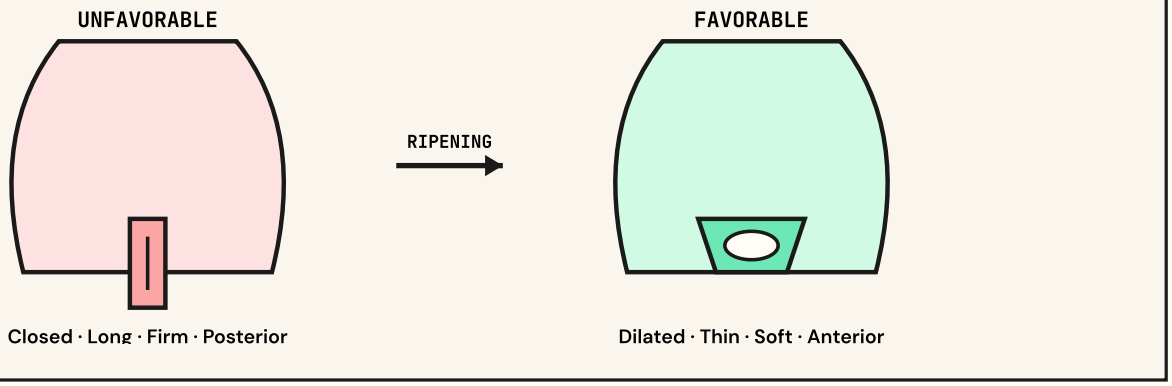
STEP 3
Cervix **shortens & thins** (effacement)

→

STEP 4
Cervix moves **posterior → anterior**

→

STEP 5
Dilates + fetal head descends → induction succeeds



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The Bishop Scoring Table

5 PARAMETERS · 0–3 POINTS EACH · MAX 13

PARAMETER	0 POINTS	1 POINT	2 POINTS	3 POINTS
Dilation (cm)	Closed	1–2	3–4	5–6
Effacement (%)	0–30	40–50	60–70	≥ 80
Station	-3	-2	-1 / 0	+1 / +2
Consistency	Firm	Medium	Soft	—
Position	Posterior	Mid-position	Anterior	—

≤ 6
UNFAVORABLE
Cervical ripening agent **required** before oxytocin. Higher failure rate.

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EQUIVOCAL
Borderline. Clinical judgment required — may attempt induction with caution.

≥ 8
FAVORABLE
Induction success likely. Cervix mimics spontaneous labor readiness.

🔧 MODIFIED BISHOP (BUMP UP / DROP DOWN): `+1` for each: preeclampsia, each prior vaginal delivery. `-1` for each: postdates pregnancy, nulliparity, PROM (premature rupture of membranes).

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Assessment Findings

UNFAVORABLE VS FAVORABLE CERVIX · RED FLAG FINDINGS

🔴 Unfavorable Cervix

- Cervix **closed or < 2 cm** dilated
- Effacement < 50%
- Fetal head **high** (station -3 to -2)
- Firm consistency (feels like the tip of your nose)
- Posterior position — difficult to reach on exam
- Patient often **nulliparous, postdates**, or has PROM
- 🚨 RISK failed induction → C-section

🟢 Favorable Cervix

- Cervix **3+ cm** dilated
- Effacement **≥ 60–80%**
- Fetal head engaged (station 0 or below)
- Soft consistency (feels like lips/earlobe)
- Anterior position — easily palpated
- Multiparous, term gestation
- ✅ Induction success rate approaches spontaneous labor

🚨 **RED FLAG SIGNS DURING INDUCTION:** Tachysystole (> 5 contractions in 10 min averaged over 30 min), late or variable decelerations, fetal bradycardia < 110 bpm, hypertonic uterus (no rest between contractions), maternal hypotension, sudden severe abdominal pain (`uterine rupture`), bright red bleeding.

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Priority Nursing Interventions

ABC FRAMEWORK · SAFETY FIRST

A · AIRWAY/FETAL

Continuous Fetal Monitoring

- **Continuous EFM** during all cervical ripening & induction
- Baseline FHR 110–160 bpm; assess variability
- **STOP** ripening agent for non-reassuring FHR (late decels, prolonged decels, bradycardia)
- Position client **left lateral** if decels occur — improves uteroplacental perfusion

B · BREATHING/CONTRACTIONS

Monitor Uterine Activity

- Assess **frequency, duration, intensity**, resting tone q15min
- **Tachysystole** = > 5 contractions in 10 min → STOP agent / decrease Pitocin / give terbutaline as ordered
- Ensure resting tone < 20 mmHg with IUPC
- Contractions should not exceed 90 seconds in duration

C · CIRCULATION

Maternal Hemodynamics

- Baseline VS, then q15–30min during induction
- IV access (18 g) — large bore for emergent blood/fluids
- Monitor for **water intoxication** with oxytocin (HA, N/V, confusion, ↓Na)
- Strict I&O — output < 30 mL/hr is a red flag

S · SAFETY

Pre-Induction Verification

- **Confirm Bishop score** documented before agent given
- Verify **no contraindications**: prior classical C/S, transverse lie, placenta previa, active herpes, vasa previa
- Informed consent on chart
- Bed rest 30–60 min after vaginal prostaglandin insertion
- Have **terbutaline** readily available (tocolytic rescue)

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Pharmacology — Ripening & Induction Agents

DRUG · MECHANISM · KEY NURSING CONSIDERATIONS

DRUG / CLASS	MECHANISM & USE	KEY SIDE EFFECTS	NURSING CONSIDERATIONS
Dinoprostone Vaginal Insert (Cervidil) *Prostaglandin E2*	Ripens unfavorable cervix. Vaginal insert with retrieval string.	Tachysystole, fetal distress, N/V, diarrhea, fever, chills	Continuous EFM; bed rest 2 hr; **REMOVE by pulling string** if tachysystole or non-reassuring FHR; wait 30–60 min before oxytocin
Dinoprostone Gel (Prepidil) *Prostaglandin E2*	Endocervical gel for ripening. Single-dose syringe.	Same as above — but not removable once given	Bed rest 30 min; cannot retrieve — give cautiously; wait 6–12 hr before oxytocin
Misoprostol (Cytotec) *Prostaglandin E1*	Off-label cervical ripening. PO or vaginal (25–50 mcg).	Tachysystole (higher risk), N/V, diarrhea, fever, **uterine rupture**	⚠ **CONTRAINDICATED in prior C-section or uterine surgery — uterine rupture risk. Wait 4 hr before oxytocin.**
Oxytocin (Pitocin) *Synthetic posterior pituitary hormone*	Stimulates uterine contractions for induction/augmentation. **Titrated** IV piggyback.	Tachysystole, fetal distress, **water intoxication** (antidiuretic effect), hypotension, uterine rupture	IV pump **mandatory**; piggyback to mainline at port closest to insertion; titrate per protocol; monitor I&O, Na+; **STOP** for tachysystole or non-reassuring FHR
Terbutaline *Beta-2 agonist (tocolytic)*	Emergency reversal of tachysystole / hypertonic uterus. SubQ 0.25 mg.	Maternal tachycardia, tremor, palpitations, hyperglycemia, pulmonary edema	Rescue drug — keep at bedside during induction; monitor maternal HR (hold if > 120); reassess FHR for recovery
Mechanical: Foley Balloon / Laminaria	Mechanical dilation of unfavorable cervix without prostaglandins. Safe with prior C/S.	Discomfort, infection risk, bleeding	Document insertion; expect spontaneous expulsion when ~3 cm dilated; sterile insertion technique

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NCLEX Test Traps ⚠️

WHAT STUDENTS GET WRONG · WHAT'S ACTUALLY RIGHT

❌ WRONG	✅ RIGHT
Start oxytocin immediately because the patient is postdates.	Calculate Bishop score first. If ≤ 6 → ripening agent *before* oxytocin. Pitocin on an unfavorable cervix = failed induction.
Give misoprostol (Cytotec) to ripen the cervix for a VBAC client.	Cytotec is `contraindicated` with prior C-section — risk of uterine rupture. Use mechanical methods (Foley) instead.
"Tachysystole means more progress" — keep the agent in place.	Tachysystole (> 5 contractions/10 min) impairs uteroplacental perfusion. `STOP/REMOVE` the agent, reposition left lateral, give O2, notify provider.
Increase the oxytocin rate because contractions are mild and patient is uncomfortable.	Titrate per protocol, not by patient comfort. Assess `FHR & resting tone` first — uncomfortable ≠ ready to increase.
Position the patient supine after vaginal Cervidil insertion.	Supine → vena cava compression → ↓BP, ↓placental perfusion. Use `side-lying or HOB elevated 30°` for 2 hours post-insertion.
A Bishop score of 7 means induction will definitely succeed.	Score of 7 is `equivocal`. ≥ 8 is favorable. NCLEX may test the exact cutoffs — memorize ≤ 6, 7, ≥ 8.

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Patient & Family Education

TEACH BEFORE · DURING · AFTER INDUCTION

BEFORE INDUCTION

Explain what the Bishop score measures and why ripening may be needed first. Set realistic expectations: **induction can take 24+ hours**, especially with an unfavorable cervix. Empty bladder before insertion. Bed rest is required for 2 hours after Cervidil.

REPORT IMMEDIATELY

Severe abdominal pain, contractions closer than 2 minutes apart, sudden gush of fluid, bright red bleeding, decreased fetal movement, severe headache, visual changes. Teach the patient to **call the nurse**, not Google.

HYDRATION & NUTRITION

Clear liquids only during active induction in many facilities. Ice chips for comfort. Monitor I&O — oxytocin's antidiuretic effect can cause water intoxication if IV fluids are excessive.

SUPPORT & COMFORT

Encourage support person presence. Discuss pain management options early (IV opioids, epidural). Position changes (side-lying, rocking) promote labor progress. Avoid supine.

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Memory Boosters & Mnemonics

PATTERN RECOGNITION FOR FAST RECALL

DESCP

- **D** **Dilation** (cm)
- **E** **Effacement** (%)
- **S** **Station** of fetal head
- **C** **Consistency** of cervix
- **P** **Position** of cervix

The 5 components of the Bishop score.

8 = GO

Score **≥ 8** = **G**reen light, induction l**O**oks good (favorable).

Score **≤ 6** = **S**top & **S**often → needs ripening.

Quick decision rule for any vignette.

SCAR = NO CYTOTEC

Any uterine **SCAR** (prior C/S, myomectomy, classical incision) = **NO misoprostol/Cytotec**. Risk = uterine rupture.

Use **Foley balloon** instead — mechanical, safe.

STOP & PULL

If tachysystole or non-reassuring FHR during Cervidil: **S**top the agent · **T**urn left lateral · **O**2 by mask · **P**ull the string (remove Cervidil) · notify provider

NCJMM 6-Step Clinical Judgment Scenario

NEXT-GENERATION NCLEX 2026 THINKING FRAMEWORK

📖 **CASE:** *A 28-year-old G2P1 at 41+3 weeks gestation is admitted for induction of labor. Vital signs: BP 118/72, HR 88, T 98.6°F, FHR 142 with moderate variability. Cervical exam: 1 cm dilated, 30% effaced, station -2, firm, posterior. The provider orders Cervidil 10 mg vaginal insert.*

STEP 1

Recognize Cues

Postdates (41+3 wks), **Bishop score = 1+0+1+0+0 = 2**. Cervix is highly unfavorable. FHR reassuring. G2P1 → 1 prior vaginal delivery (Modified Bishop +1 = 3).

STEP 2

Analyze Cues

Score < 6 = cervical ripening needed BEFORE oxytocin. Cervidil (PGE2) is appropriate because no contraindications (no prior C/S, no active herpes, FHR reassuring).

STEP 3

Prioritize Hypotheses

Highest priority risk: **tachysystole** with fetal compromise after PGE2 insertion. Secondary: maternal N/V, fever. Must have terbutaline available.

STEP 4

Generate Solutions

Continuous EFM, side-lying or HOB 30°, bed rest × 2 hr, VS q15min × 1 hr then q30min, IV access (18 g), withhold oxytocin × 30–60 min after removal.

STEP 5

Take Action

Verify consent, baseline EFM 20 min, insert Cervidil per protocol, secure string, position side-lying, document time of insertion, educate patient on what to report.

STEP 6

Evaluate Outcomes

Goals met: FHR remains 110–160 with moderate variability; contractions ≤ 5/10 min; no maternal hypotension; cervix progresses to Bishop ≥ 8 within 12 hr → ready for oxytocin.