The goal of any labour induction is a vaginal birth that is as natural as possible [2]. To determine the likelihood of induction success and the appropriate method of induction, the Society of Obstetricians and Gynecologists of Canada (SOGC) Clinical Practice Guideline (CPG) recommends that the most responsible practitioner (MRP) should assess the cervix using the Bishop score assessment tool and factor the score into decision making [2].

Originally created by Dr. E. Bishop in the 1960s, the Bishop score is a cost-effective, reliable method to assess cervical status [3-5]. A composite score is calculated based on the vaginal examination of the cervical dilation, effacement, cervical consistency, cervical position, and fetal station. Each component is given a score of 0 to 2 or 0 to 3 and totaled to a highest possible score of 13. Dilation is the most important criteria for predicting a successful induction, followed by effacement, station, and position, with cervical consistency being the least predictive component [5]. A pre-induction Bishop Score of >6 is considered favourable and is predictive of a successful vaginal delivery [5]. To increase the success of an induction with an unfavourable cervix (Bishop Score ≤6), SOGC guidelines recommend methods of cervical ripening that include mechanical and pharmacological options [2].

**Documentation:** The SOGC Labour Induction CPG stipulates the following must be documented prior to commencing an induction: the reason for induction, Bishop score, method of induction, and risks. Documentation should be thorough and unambiguous. In addition, three induction checklists have been created to support SOGC guideline adherence: 1) a pre-induction checklist completed by an RN or the MRP prior to the start of ANY induction intervention, 2) a pre-oxytocin checklist to be completed by both the MRP and RN prior to commencement of any oxytocin induction, and 3) an inflight oxytocin checklist to facilitate RN/MRP communication during an oxytocin induction of labour. Medical checklists, such as the aforementioned induction checklists, serve as important tools that facilitate interdisciplinary communication and enhance patient safety [8].

To calculate the Bishop score, each component measurement is compared with the Bishop Score Grading Card (*Figure 1*). Each component is given a score of 0 to 2 or 0 to 3 and totaled to a highest possible score of 13.

![Bishop Score Table](image)

*Figure 1: Bishop Score*
Technique: A thorough examination includes five components: dilation, effacement, station, consistency, and position.

Dilation
- A measure of the diameter of the cervical opening expressed in centimeters (cm) translated to a score of 0 to 3.

Effacement
- A measure of the thinning of the cervix expressed in percentage.
- An uneffaced cervix (0%) is >3cm in length
- A fully effaced cervix (100%) is as thin as the adjacent lower uterine segment, sometimes described as paper-thin [6].

Station
- Measures the degree of descent of the fetal presenting part
- Is the distance, in centimetres, of the fetal presenting part above or below the ischial spines from -3 to +2. (Figure 2)
- **Note:** the fetal distance from the introitus **cannot** be used to measure station.

Cervical Consistency
- Refers to the perceived pliability of the cervix
- Ranges subjectively from firm (like a tennis ball) to soft (like gelatin).
- Reflects changes in cervical microstructure and is an early sign of cervical ripening [7].

Cervical Position
- Categorized as anterior, mid, and posterior, with a favourable cervix situated more anteriorly (Figure 3).

1. Figures used with express permission of Rachel Bensler, 2015, Calgary, Alberta.