Clinical Guideline for Induction of Labour (includes Pre Labour Rupture of Membranes)

Approval date:	**13/10/2021**
Version number:	**1.0**
Author:	**Joanna Inkster and Dr Andrene Hamilton**
Review date:	**13/10/2022**
Security classification:	**Official – Green: unclassified information**

If you would like this document in an alternative language or format, please contact Corporate Services on 01595 743069.

Document reference number: NAGUI005

NHS Shetland Document Development Coversheet*

Name of document	Clinical Guideline for Induction of Labour		
Document reference number	NAGU1005	**New or Review?**	**New**
Author	Joanna Inkster and Dr Andrene Hamilton		
Executive lead	Kathleen Carolan		
Review date	13/10/2022		
Security classification	Official – Green: unclassified information		

Proposed groups to present document to:		
ANMAC		
Maternity Policy Development Group		

Date	Version	Group	Reason	Outcome
21/02/2021	0.10	Maternity Guideline Development Group	For professional opinion	Approved
13/03/2021	0.10	ANMAC	For professional opinion	Advised to take to Information Governance
13/10/2021	0.11	ANMAC	For professional opinion	Approved

Examples of reasons for presenting to the group	**Examples of outcomes following meeting**
• Professional input required re: content (PI)	• Significant changes to content required – refer to Executive Lead for guidance (SC)
• Professional opinion on content (PO)	• To amend content & re-submit to group (AC&R)
• General comments/suggestions (C/S)	• For minor revisions (e.g. format/layout) – no need to re-submit to group (MR)

• For information only (FIO)	• Recommend proceeding to next stage (PRO)
• For proofing/formatting (PF)	• For upload to Intranet (INT)
• Final Approval (FA)	• Approved (A) or Not Approved, revisions required (NARR)

***To be attached to the document under development/review and presented to the relevant group**

Please record details of any changes made to the document in the table below

Date	Record of changes made to document
04/11/2020	Daily CTG if prolonged pregnancy after 42 weeks added in
11/12/2020	Bishop score and position of fetal head added to inclusion criteria for IOL in Shetland
11/12/2020	Statement added – timing of induction may be influenced by workload in the Maternity Department
11/12/2020	Appendix 5 – Oxytocin regime added
27/1/2021	Review by Dr Hamilton, change to wording about criteria for staying in Shetland – women outwith criteria should all be aware that Aberdeen is the recommended and safest place of birth
28/1/2021	No epidural service in Shetland added to points to discuss with women prior to IOL
28/1/2021	In the case of expectant management and liqour and dopplers on scan are not normal, immediate IOL in Aberdeen should be offered
28/1/2021	Pre labour rupture of membranes at term – if women choose to wait more than 24 hours for IOL, Aberdeen should be advised as safest place of birth as per NICE. IOL should be started at 8am
28/1/2020	Fetal head not engaged in maternal pelvis added to list for immediate review after pre labour SRM
28/1/2020	Consider place of birth after pre labour SRM if GBS positive added
24/03/2021	Transferred onto correct NHS Shetland template and formatting issues fixed Neonatal observations changed as discussed at Maternity Guidelines Group 25/02/2021

Contents

1. Introduction

Induction of Labour (IOL) is a procedure experienced by approximately 20% of pregnant women in the UK. Whilst induction of labour is a relatively common procedure it has an impact on the birth experience of women. IOL is recommended when birth confers benefit to the woman or the baby greater than if the pregnancy continues. It is defined as an intervention designed to artificially initiate uterine contractions leading to progressive dilatation and effacement of the cervix and birth of the baby. This guideline reflects evidence-based recommendations and has been adapted from NHS Grampian Clinical Guidelines for Induction of Labour for use in NHS Shetland.

2. Indications for Induction of Labour

Induction of labour for:

- Prolonged pregnancy
- Bishop Score ≥ 5
- Fetal head fixed in maternal pelvis
- Prelabour rupture of membranes at term

can be booked by a midwife without consultant review (unless there are additional risk factors).

Any woman being considered for induction of labour in Shetland out with these criteria, should be discussed with the multi-disciplinary team, taking into account maternal and neonatal risks. These women should always be made aware that Aberdeen is the recommended and safest place for birth. This should include as a minimum the Consultant Obstetrician, Named Midwife, Senior Clinical Midwife and Consultant Anaesthetist.

All decisions about induction of labour should be made in partnership with women and their families and sufficient time should be given for decision making whenever possible.

Women should be informed that timing of induction may be influenced by workload in the maternity department.

3. Prolonged Pregnancy

Induction of labour for prolonged pregnancy can be offered for between 41-42 weeks pregnant. All women should be offered a discussion and written information about induction of labour for prolonged pregnancy at 34 weeks (as appropriate).

This discussion may include:

- Most women will go into labour spontaneously by 42 weeks
- Induction of labour at or beyond 37 weeks gestation may reduce the already small risk of stillbirths in comparison to expectant management (0.4 per 1000 compared with expectant management 3 per 1000) The optimum timing for offering induction of labour needs further research (Middleton et al 2020)
- There is moderate evidence of a reduced risk of a caesarean birth with IOL at around 41 weeks compared to expectant management (Middleton et al 2020)

- There is a slightly increased risk of an operative vaginal delivery from IOL at around 41 weeks (Middleton et al 2020)
- Induction of labour may be associated with a more painful labour and may impact on the birth experience of a woman. There is no epidural service in Shetland.
- Differences between Gilbert Bain Hospital and Aberdeen Maternity Hospital
- The alternative options if the woman chooses not to have IOL
- IOL may not be successful and the subsequent options that would be available to the woman at that point.

3.1. **Membrane Sweeping**

Membrane sweeping is an evidence-based intervention which can reduce the need for formal induction. Nuliparous women should be offered a membrane sweep at 40 and 41 weeks and multi parous women at 41 weeks. Additional membrane sweeping may be offered if labour does not start spontaneously (RCM 2019). Membrane sweeps should be discussed at an antenatal appointment prior to 40 weeks and the discussion should include the following:

- Women are more likely to go into spontaneous labour if they have a membrane sweep after 40 weeks.
- Side effects may include pain during the procedure, light vaginal bleeding and cramps afterwards.

(RCM 2019)

3.2. **Procedure for Membrane Sweeping**

Abdominal palpation and auscultation of fetal heart

- Cervical assessment by vaginal examination. If internal os is open, gentle circular movement with either one or two fingers, depending on dilatation, around the internal os to strip the membranes from the lower segment.
- Throughout procedure, observe verbal and non-verbal indications of distress, and respect any request for the procedure to be discontinued
- Auscultate fetal heart after procedure.
- Cervical findings including the Bishop's score should be documented in the Badgernet maternity record.

3.3. **Expectant Management**

If the woman wishes to wait for labour to commence spontaneously beyond T+7, then she should be supported in her decision making and offered an ultrasound scan by 41 weeks to determine liquor volume and Doppler:

- If the liquor volume, dopplers and fetal movements are reassuring, and there are no other concerns, it is reasonable to delay IOL for up to a further week from the date of the scan. IOL should then be offered for birth to occur within 1 week of the scan.

- If any of the above are non-reassuring, transfer to Aberdeen for immediate IOL should be offered.

In the event that the woman chooses to decline IOL by T+14 she should be referred for consultant review and offered a further scan for liquor volume and Doppler and daily CTG. Aberdeen would be the recommended and safest place for birth after 42 weeks.

4. Pre-labour Rupture of Membranes at Term (PROM)

Women with PROM at term should be advised that:

- The risk of serious neonatal infection is 1%, rather than 0.5% for women with intact membranes
- 60-95% of women with PROM will go into labour within 24 hours
- Induction of labour is appropriate approximately 24 hours after rupture of membranes (women should be admitted at 8am)
- If labour has not started 24 hours after rupture of the membranes, to stay in hospital for at least 12 hours after the birth for neonatal observations
- Bathing or showering is not associated with an increase in infection, but that having sexual intercourse may be.

4.1. Initial assessment

On initial telephone contact with the woman a history should be taken, including the date and time of SRM. The woman should be advised to attend the maternity department for review immediately if she reports any of the following:

- Vaginal bleeding
- Liqour is green or offensive smell
- She feels unwell or has a raised temperature (over 37.4 °c)
- Reduced fetal movements
- History of Group B Strep
- Additional risk factors in pregnancy
- Contractions have established
- Fetal head not engaged in maternal pelvis at last antenatal assessment

4.2. Ongoing management without risk factors

The woman should be reviewed by a midwife within 12 hours and then every 24 hours as required. The following assessment should take place:

- Confirm PROM (woman's description and visualisation of the liqour, confirm diagnosis with a sterile speculum examination if necessary)
- Avoid digital vaginal examination in the absence of good contractions
- Auscultate the fetal heart and ask about fetal movements

- Maternal observations including temperature, pulse rate and respiratory rate
- Recommend the women takes her temperature four hourly during waking hours
- Offer lower vaginal swab
- Discuss options for induction of labour
- Recommend consultant review if induction of labour is not requested by 24 hours for ongoing management plan

Infection Risk

- If there are no signs of infection in the woman, antibiotics should not be given to the woman, even if the membranes have been ruptured for over 24 hours.
- If there is a history of GBS, women should be referred for consultant review. Place of birth should be decided by individual risk assessment considering bishop score, women's preference and transfer conditions. IV antibiotics should be commenced immediately.
- If there are signs of infection, advise admission to hospital for consultant review and immediate induction of labour. A high vaginal swab should be taken and commence broad spectrum antibiotics.

4.3. Babies born to women with pre labour rupture of the membranes at term

Closely observe any baby born to a woman with pre labour rupture of the membranes (more than 24 hours before the onset of established labour) at term for the first 24 hours of life.

Observations should be taken at

- 1 hour
- 2 hours then 2 hourly for 12 hours
- 4 hourly from 12 – 24 hours

Babies with symptom of possible sepsis, or born to a woman who has evidence of chorioamnionitis, should be referred to the consultant obstetrician and discussed with Scotstar as required.

Advise women to inform staff immediately of any concerns they have about their baby's wellbeing in the first 5 days following birth, particularly in the first 12 hours when risk is greatest. Provide written information about signs of an unwell baby.

5. Methods of IOL and assessment:

5.1. Initial Assessment prior to each stage of Induction of Labour

1. Ensure the process and the options are explained to the woman and consent is documented.
2. Maternal observations on admission, commence MOEWS and document in the Badgernet maternal record

3. Abdominal palpation to confirm the fetal lie and presentation are longitudinal and cephalic.
4. Confirm the woman has no regular, painful uterine activity or history of spontaneous rupture of membranes.
5. If an intravenous cannula is required for intravenous syntocinon, a Full Blood Count and Group & Save samples should be taken
6. CTG for a minimum of 20 minutes which must be classified as normal
7. Obtain verbal consent for vaginal examination to undertake cervical assessment. The consultant will decide which method of induction is the most suitable, taking into account the patient's preferences
8. Record all findings in Badgernet maternal record

5.2. **Cervical Assessment**

Cervical assessment is undertaken using a BISHOP score, to assess favorability of the cervix prior to induction. This can be undertaken by a trained midwife or obstetrician. Findings must be documented clearly in the maternity records following the procedure (refer to Table 1).

Table 1: Bishop Score of cervical favourability

Cervix	**0**	**1**	**2**	**3**
Dilatation	<1	1-2	2-4	>4
Length (cm)	>4	2-4	1-2	<1
Consistency	Firm	Average	Soft	
Position	Posterior	Central	Anterior	
Station	S-3	S-2	S-1/0	Below spines

5.3. **Methods of Induction at GBH**

- Propess vaginal pessary
- Prostin gel vaginal pessary (2mg or 1mg doses)
- Cook Balloon Intrauterine Catheter
- Artificial Rupture of Membranes (ARM) with or without oxytocin infusion

5.4. **Induction with Propess®**

Propess® is a slow release prostaglandin (Dinoprostone, prostaglandin E2) delivery system used for induction of labour. It is inserted vaginally into the posterior fornix and remains insitu for up to 24 hours.

- Insert Propess using ONLY water based lubricant gel for lubrication. Once the cervix is located and assessed insert the Propess® pessary in-between fingers and slide pessary into the posterior fornix.

- Turn pessary into transverse position in the posterior fornix and withdraw fingers carefully. No attempt should be made to tuck the remaining tape into the vagina as this may make retrieval more difficult.
- The woman should stay on the bed for 30 minutes following insertion and have assessment by CTG for at least 30 minutes
- Advise the woman to take care when visiting the toilet not to pull on the tape and to inform a midwife if pessary falls out or she is concerned about anything.
- If pessary falls out, replace with fresh one and leave for the remainder of the 24 hours.

  If SROM occurs but labour is not established do NOT remove pessary
- If cervical dilation >3cm with no regular contractions the pessary can be left in situ for maximum time of 24 hours.
- If cervix is < 3cm but contractions are regular the pessary MAY be left in situ but there must be CEFM and reassessment of the cervical dilatation in 4 hours
- (N.B vaginal assessment is only necessary after SRM if regular contractions or concerns)
- If analgesia is required perform antenatal assessment and VE prior to IM analgesia. The propess pessary should be removed if cervix >3cm dilated and analgesia is required.

The propess should be removed in the following instances;

- Fetal compromise
- Adverse maternal reaction
- Vaginal bleeding (not show)
- Regular contractions are established i.e. 2-3:10 A CTG and vaginal assessment should be undertaken, and the propess removed if the cervix is dilated >3cm
- Uterine Hyperstimulation (contracting>5:10 minutes)- Commence CTG, due to the short half life of propess this should resolve within 15-20 minutes where there is any additional concern consideration should be given to administering terbutaline 250mcg subcutaneously.
- After 24 hours to review progress

To remove propess, apply gentle traction on the retrieval tape (the insert will have swollen to 2-3 times its original size and be pliable). Cervical assessment should be done to guide the next step of induction.

** Oxytocin can be administered 30 minutes after removal of Propess® **

5.5. **Induction with Prostin E2 vaginal gel**

Prostin E2 vaginal gel contains dinoprostone and comes in two preparations of 1mg and 2mg. The 2mg dose is recommended mostly for primigravida with unfavourable cervical assessment. If labour has not commenced after 6 hours of insertion, further doses can be given up to a maximum dose of 3mg in 24 hours.

- Insert the gel high into the posterior fornix (not the cervical canal) using the applicator
- Instruct the woman to stay on the bed for 30 minutes following insertion and perform a CTG for at least 30 minutes
- A CTG needs to be performed for at least 30 minutes before and after each prostin gel insertion

5.6. Selection Criteria for Outpatient Management

- Low risk pregnancy
- No ruptured membranes
- Fetal head fixed in pelvis

To progress with outpatient IOL women should:

- Have access to a telephone
- Have a good understanding of English or someone who is able to interpret with them at all times
- Have someone who will be at home with them
- Have ready access to transport
- Be staying on the Shetland mainland

5.7. Process

Vaginal examination undertaken by the consultant obstetrician or a midwife competent in balloon insertion.

- If not favourable (BS 8 or less), for balloon insertion.
- Following procedure women should have continuous CTG monitoring for at least 30 minutes.
- Women can then go home, with a planned consultant review at 08:30 the following morning.

Women should be given information leaflet and advised to call for advice if:

- Rupture of membranes
- Uterine activity
- Vaginal bleeding
- Concerns about fetal movement
- If balloon falls out

When the woman returns for assessment, the midwife or consultant should remove the balloon and assess if favourable for amniotomy (ARM). If not favourable for ARM, discuss subsequent management with Consultant Obstetrician.

If membranes ruptured, remove balloon, IOL as per current guidance.

5.8. Potential Problems

If balloon falls out:

- Assessment by consultant obstetrician
- If technical reason for failure, consider re-inserting after discussing with the woman
- If re-insertion not an option, follow local guidelines for routine IOL

If unable to insert the catheter

- Consider Propess or PGE2 gel

If cervix remains unfavourable after the balloon insertion

- Consider IOL by PGE2 gel or Caesearan Section depending on womans' preference
- Repeat induction with balloon catheter should not be offered

Unintended amniotomy

•Proceed with alternative IOL policy

PV Bleeding

- Reassessed by consultant and consider removing or continue depending on amount of bleeding

Balloon rupture

- Consider alternative IOL

See appendix 1 for procedure

6. Induction with ARM

The consultant may decide to provide directly to induction of labour by ARM, or may proceed with this method following earlier steps by other induction methods. ARM should only be performed by a midwife after confirming the fetal head to be engaged within the pelvis. If the head is felt to be high, ARM should be performed by the consultant and may need to be performed in theatre.

- If the patient is primigravid without significant contractions, oxytocin should be started promptly following the ARM, alongside continuous CTG monitoring of labour
- If the patient is multiparous or has some uterine activity, a CTG should be performed for 30 minutes. If labour progresses following ARM alone, intermittent auscultation can be used for fetal monitoring unless there are other factors requiring continuous monitoring. The time interval before starting oxytocin will be determined by the consultant taking into account uterine activity, parity, unit workload, and patient preference

- 3. Oxytocin should be administered as per oxytocin guideline with continuous CTG monitoring. See appendix 5 for oxytocin regime

7. Induction of Labour management

For women who report **no uterine activity**: assess for labour, PV loss, blood pressure, pulse, temperature, RR and fetal heart every 6 hours, except when the woman is sleeping, until labour establishes.

If there is **uterine activity**: assess for labour. If labour not yet established: assess for PV loss, blood pressure, pulse, RR and fetal heart rate every hour and perform CTG if indicated.

- Try to encourage methods other than opiates e.g. warm baths, TENS, birthing balls, mobilisation.
- If pharmacological methods of pain relief required vaginal examination may be indicated.
- Vaginal examination to assess progess every 4 hours is advised.

If at any point in the induction process a woman complains of abdominal pain, tightenings or contractions, assessment of uterine activity should be made. If palpable uterine activity, pains are considered severe or there are other concerns, a CTG should be commenced to assess fetal wellbeing for at least twenty minutes

7.1. Reactions

The midwife should inform the consultant obstetrician if any maternal reaction is suspected.

For example:

- Nausea
- Vomiting
- Diarrhoea
- Hypotension
- Maternal tachycardia
- Genital oedema
- Uterine hyper stimulation

7.2. Uterine Hyperstimulation following the administration of Prostaglandins

- Tachysystole is defined as >5 contractions in 10 minutes.
- Hypertonic uterine contraction is defined as painful sustained uterine contraction for >90 seconds
- Hyperstimulation = tachysystole or hypertonic uterine contraction PLUS evidence of fetal compromise (i.e. a suspicious or pathological fetal heart rate pattern)
- If tachysystole or hypertonic uterine contraction is suspected, commence a CTG immediately and inform consultant

- If Propess is in situ with any CTG abnormalities, remove Propess. Consider giving terbutaline depending on severity of CTG changes, remembering that the CTG may improve within 15-20 mins of Propess removal.
- Tocolysis: Terbutaline 250mcg by subcutaneous injection may be required. Have a very low threshold for giving tocolysis with hyperstimulation in a woman with a previous scarred uterus or in a multiparous patient (especially Para 4 or more)

8. Documentation

All documentation should be recorded in the Badgernet Maternity Record in accordance with NMC Recordkeeping: guidance for Nurses and midwives.

Appendix 1 – Cook Balloon Insertion Procedure

Equipment

- Bed/examination couch with lithotomy poles
- Sterile Vaginal Pack
- Cusco speculum
- Rampley's sponge holder
- Balloon catheter
- Entonox

Procedure

An assistant must be present to help with the procedure. This can be a HCSW.

- Give full explanation of procedure
- Ensure the woman's privacy and dignity at all times
- Lithotomy position may be used

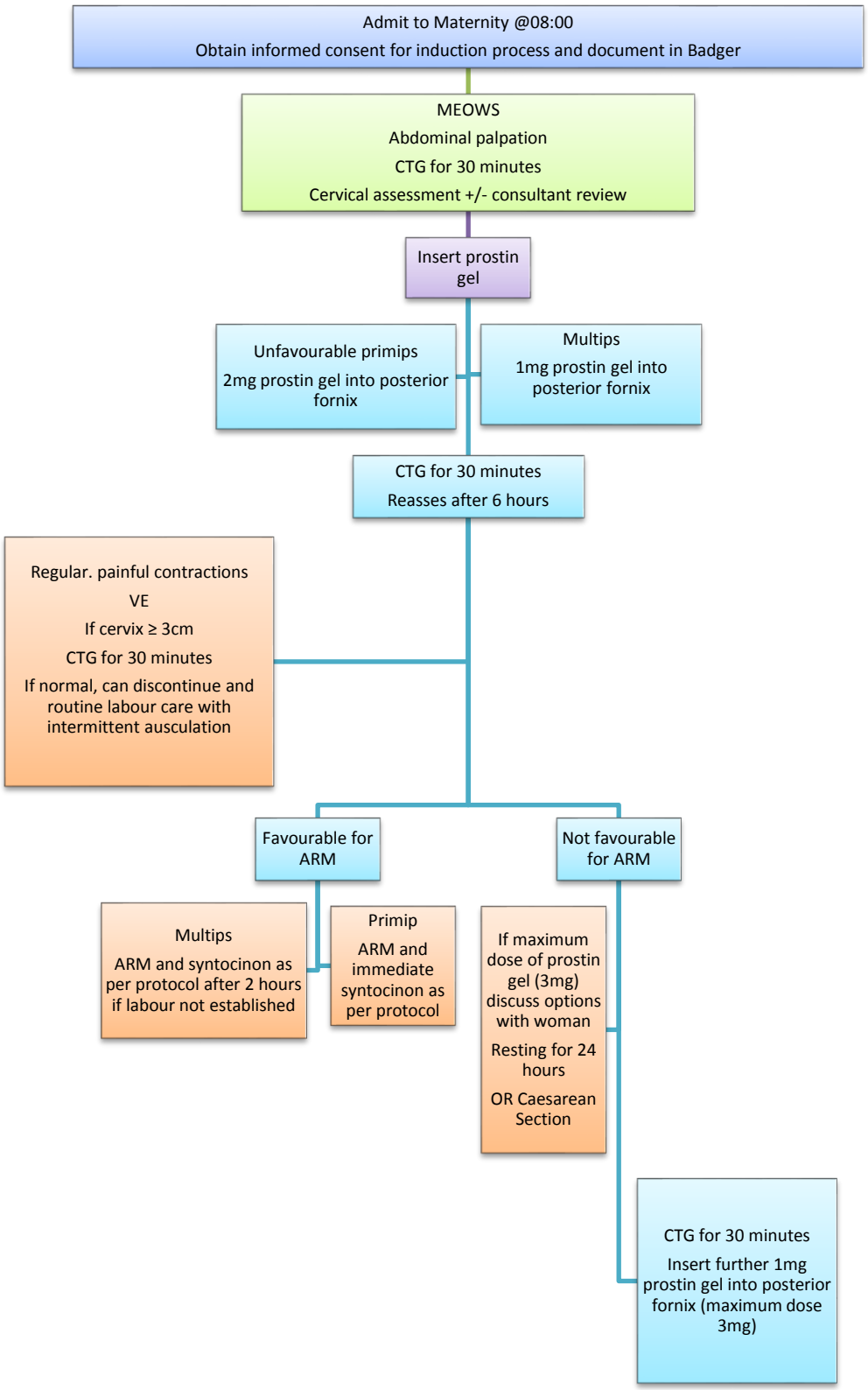
This procedure may be done using a speculum and sponge holder or may be done digitally. There is limited evidence that women find the digital procedure more comfortable. The most appropriate procedure should be used.

- Using a Cusco speculum, visualise the cervix
- Using a Rampley's sponge holder advance the catheter through the cervix until both the balloons have entered the cervical canal and passed the internal os.
- Inflate the uterine balloon with 40mls of fluid (0.9% sodium cholride or sterile water) through the red Check-Flo valve (marked U) using a standard 20ml luer- lock syringe.
- Once the uterine balloon is inflated, pull back until the balloon is against the internal os.
- The vaginal balloon should now be felt outside the external cervical os.
- Inflate the vaginal balloon with 20mls of fluid through the Check-Flo valve (marked V).
- Once the balloons are situated on each side of the cervix, add more fluid (slowly in 20mls increments) until each balloon contains 80mls maximum) – this is to ensure that the balloons are placed correctly and to ensure the woman's comfort.

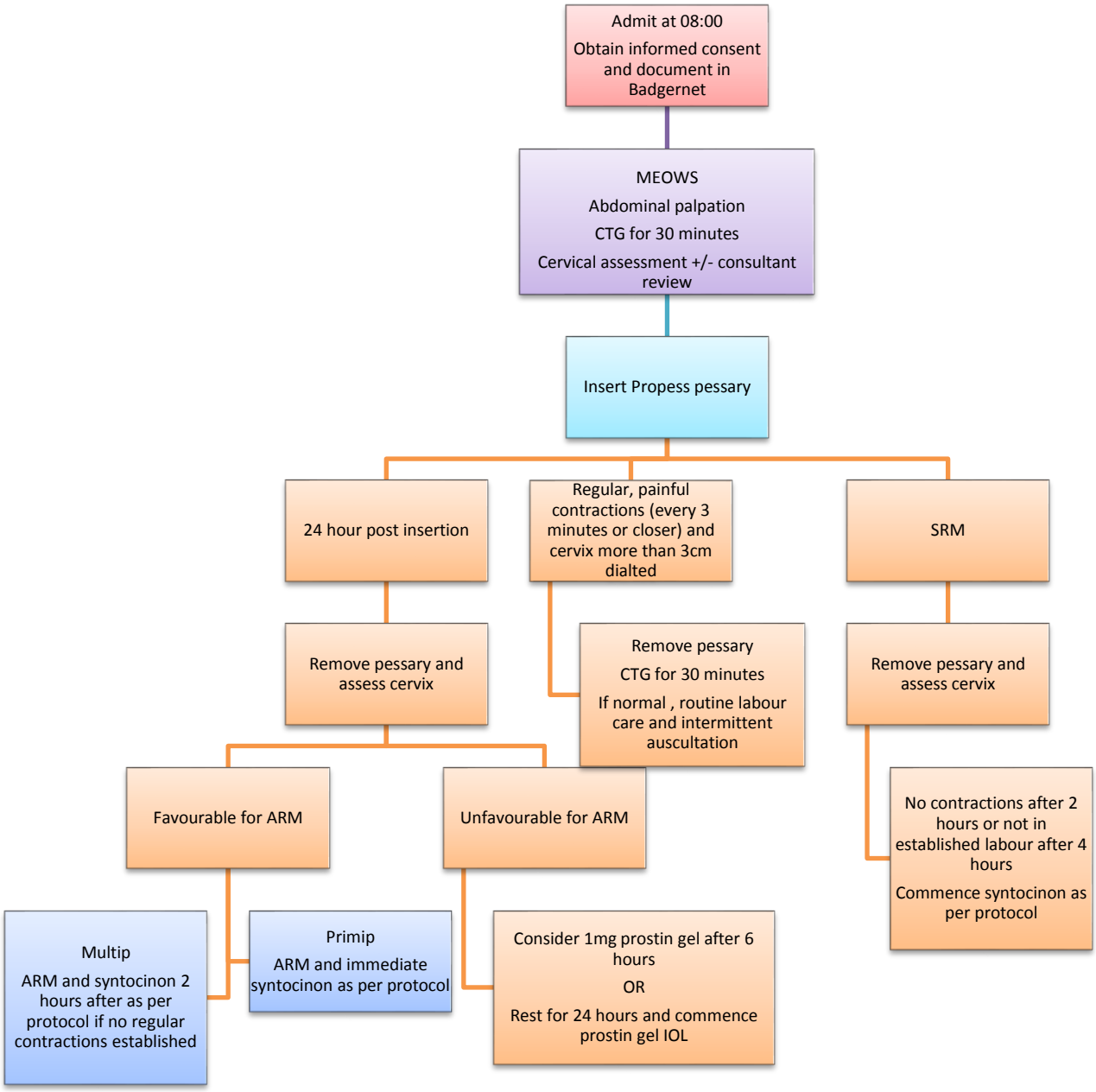
In all cases, the volume of fluid is dependent on the woman's comfort.

Document the procedure in Induction of Labour section of the Badgernet Matenrity Record.

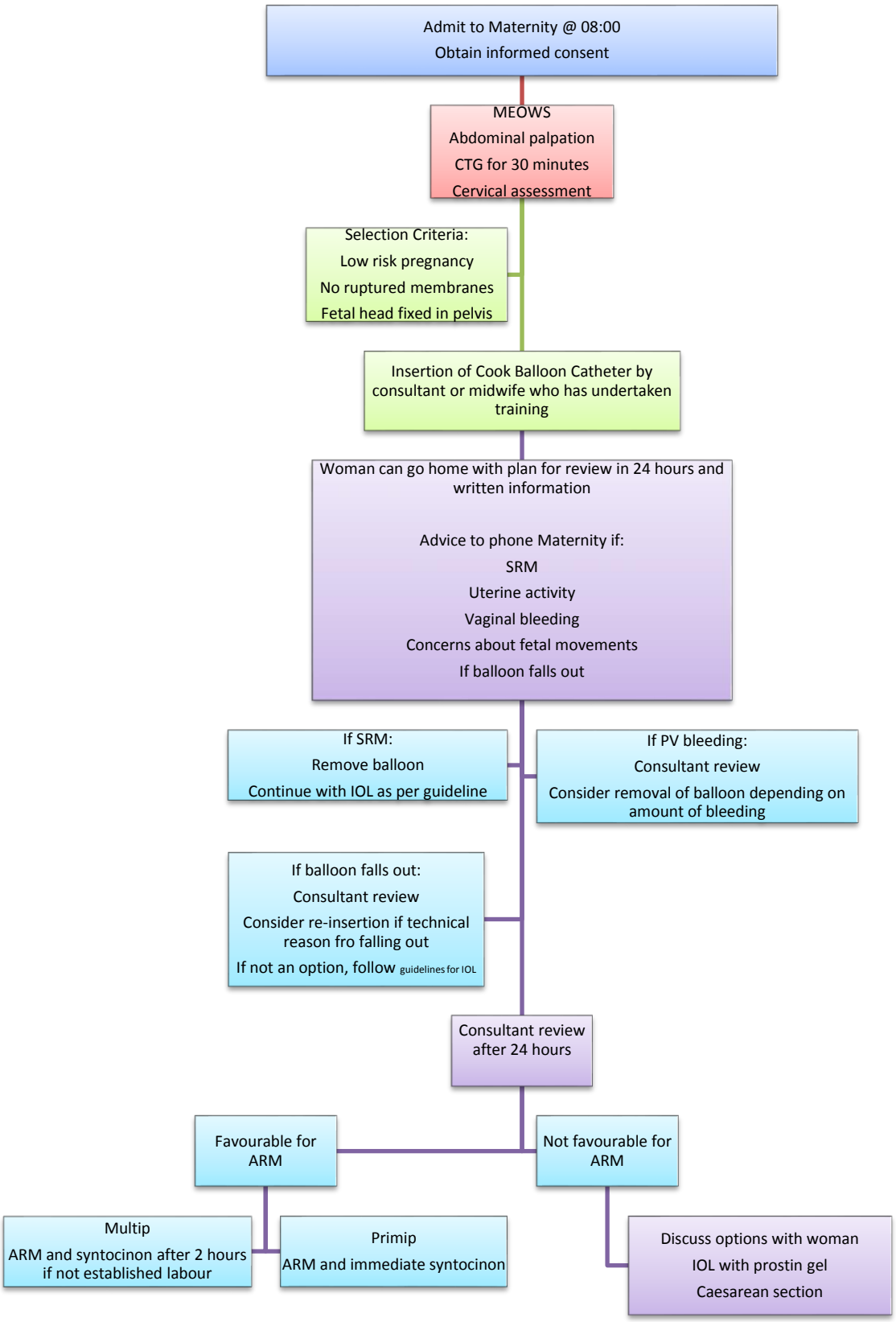
Appendix 2 Prostin Gel



Appendix 3 Propess Pessary



Appendix 4 Cook Balloon



Appendix 5 - Oxytocin

Women should be informed that the use of oxytocin following spontaneous or artificial rupture of membranes (ARM) will advance the birth but will not influence the mode of birth or other outcomes.

Indications for oxytocin use

- Delay in the onset of contractions following spontaneous rupture of membranes (SRM) at term
- Following artificial rupture of membranes (ARM) during the induction process
- Prolonged latent phase or delayed progress in 1st stage of labour. This could be inadequate progress (<1/2cm/hr) or inadequate uterine activity (contracting < 4:10)
- Delay in second stage of labour following Review/VE by Senior Obstetrician

Prior to commencing oxytocin

Prior to commencing an oxytocin intravenous infusion a full assessment should be carried out by the Midwife and/or Obstetrician. Including:

- Abdominal palpation
- Vaginal examination
- Assessment of maternal and fetal wellbeing
- Pain relief wishes
- History (parity, previous mode of birth, previous obstetric history, gestation, uterine contractions/progress)
- Membranes should be ruptured
- Documented discussion review by Consultant
- Oxytocin infusion to be prescribed on the Prescription and Administration Record and syringe / volumetric pump prescription sheet
- Commence continuous electronic fetal monitoring (CEFM)

This assessment should be clearly documented within the woman's electronic record.

Fetal monitoring

Continuous Electronic Fetal Monitoring (CEFM) is recommended due to the risks of hypoxia and should be started prior to commencing oxytocin as per NICE Guidelines (2014).

Fetal Scalp Electrode (FSE) should be considered if there is difficulty in maintaining a continuous CTG trace abdominally (if no contraindications to FSE present).

Oxytocin intravenous infusion

30 units of oxytocin (3x10unit vials) stored in the fridge

Added to:

500mls sodium chloride 0.9%

To be checked by 2 trained members of staff. A drug additive label to be completed with patient details, drug, dose, route and signed.

Consent must be obtained and documented and risks explained; including fetal distress, uterine rupture and hyperstimulation (contacting >5:10)

Woman's identification must be checked (checked verbally and name band)

Oxytocin intravenous infusion rate

Commence at 1ml/hr in 1st stage (8ml/hr in 2nd stage). Increasing according to the increments below every 30 mins if required/indicated to a MAXIMUM of 12 ml/hr. Any deviations from this should be discussed with SCM/Obstetrician.

- 1ml/hr
- 2ml/hr
- 4ml/hr
- 8ml/hr
- 12ml/hr

Documentation

- The IV oxytocin infusion rate must be documented on the volumetric pump prescription chart and in the labour assessment of Badger. The rate should be documented every 30 mins or when altered.
- The strength, tone and frequency of contractions should be palpated every 30 mins and documented in the partogram or sooner if hyper stimulation is suspected.
- All adjustments to oxytocin should also be documented on the electronic CTG tracing under add comments. Aim for 3-5 contractions every 10mins.

Uterine hyperstimulation

- Oxytocin should be reduced/discontinued if uterine hyperstimulation (tachysysole), this is defined as contracting >5 contractions in 10 mins or any fetal concerns on the CTG tracing. This should be in discussion with the Senior Charge Midwife (SCM) and or medical staff.
- Terbutaline 250micrograms can also be given by subcutaneous injection to reduce uterine activity due to uterine hyperstimulation and/or concerns with CTG tracing. Terbutaline use should be documented on Badger, CTG and on the Prescription and Administration Record. An obstetric review should be carried out and plan made prior to recommencing oxytocin. Terbutaline should not be used if abruption suspected.

Observations in labour

- Routine maternal observations to be documented on partogram as per first stage labour guideline.

- Accurate fluid balance/prescription recording
- Fetal Heart Rate (FHR) documented on partogram every 15 minutes during the 1st stage of labour and documented on Badger at least every 5 minutes in the 2nd stage of labour

Progress in Labour

Induction of labour: it is recommended that a vaginal examination (VE) is carried out 6 hours from commencing oxytocin and then 4-hourly thereafter unless indicated otherwise

Augmentation: it is recommended that a vaginal examination (VE) is carried out 4-hourly unless indicated otherwise.

Post birth

Post Birth the oxytocin infusion can be discontinued unless at increased risk of PPH risk score is less than 6