Outpatient induction of labour in low risk women: *A best practice toolkit*

London Strategic Clinical Networks

Aim

To optimise understanding and uptake of outpatient induction of labour (IOL) for low risk women.

This toolkit has been produced as part of the London Maternity Strategic Clinical Network's strategy to identify areas of good practice for implementation across all maternity units in the capital, thus ensuring equally good outcomes for all pregnant women and their babies.

The remit for the toolkit is to present the principles underlying the practice of outpatient induction of labour rather than it being an exhaustive guideline. It is envisaged that all units across London will develop guidelines in line with these principles.

The toolkit is intended to cover women with uncomplicated pregnancies and at low risk of developing intrapartum complications.

Background and rationale

Induction of labour (IOL) is a relatively common procedure with approximately 20-25 per cent of deliveries in the UK being induced. The induction rate in England continues on an upward trend as more women undergo induction of labour on a yearly basis. As a result there is more strain on maternity resources with often a deterioration in patient experience.

Although the majority of London's hospitals are still new to the outpatient IOL procedure, the uptake is increasing. Twelve per cent of London hospitals have implemented the procedure for more than two years; 64 per cent of London hospitals have started the practice in the last two years, and 36 per cent plan to start using IOL in 2015.

A small number of audits conducted by London hospitals have concluded that the practice is safe and effective when compared to inductions in inpatient settings and there is no significant difference in fetal or maternal outcome. The audits also show that there is no significant difference between the outpatient and inpatient groups[1] for caesarean section, admission to neonatal intensive care or maternal postpartum haemorrhage.

One London audit shows a small decrease in emergency caesarean section rates for the outpatient group and concluded that the only adverse outcome in the outpatient induction group was the higher rate of hyperstimulation [2].

Although studies of outpatient induction of labour are still limited, comparative studies to date show that the procedure carries a number of benefits for healthcare providers and women including

- Reduction in length of antenatal stay in hospital[2]
- Less strain on antenatal unit/resources
- Potential reduced financial costs[2]
- Higher maternal satisfaction
- Avoidance of unnecessary hospital admission

IOL definition

There are many obstetric indicators for IOL but the most common reasons are for postdates pregnancies. [>42/40 occurs in between 5 and 10 per cent of all pregnancies] where there may be an increased risk of stillbirth[4]. The procedure is routinely offered between 41^{+0} and 42^{+0} weeks.

Outpatient induction is the process of induction that starts as an inpatient or outpatient procedure for women who are then discharged either to home or to a setting where they do not have immediate access to the hospital, such as an outreach antenatal clinic or a birthing centre. Women then return to the hospital for the birth of their baby[5].

It is essential that induction of labour in an outpatient setting is only carried out with safety and support procedures in place and in low risk women[4].

Guidelines for IOL in outpatient settings

Criteria for outpatient IOL

It is essential that there is a careful risk profiling of women eligible for outpatient Induction of labour and it is offered to low risk women who meet the following criteria:

- Uncomplicated pregnancy requiring induction for prevention of prolonged pregnancy (between 41^{+0} and 42^{+0} weeks).

- Woman has transport available and lives within 30 minutes of the hospital.
- Patient has a functional home telephone.
- Ability to communicate with labour ward staff.
- Number of previous births less than or equal to four.
- Reassuring pre and post prostaglandin fetal heart rate monitoring.

Information given to patients

Women should be given clear verbal and written information on outpatient induction of labour containing[4]:

- The reasons for induction being offered.
- When, where and how induction could be carried out.
- The arrangements for support and pain relief.
- The alternative options if the woman chooses not to have induction of labour.
- The risks and benefits of outpatient IOL in specific circumstances and the proposed induction.
- That induction may not be successful and what options are available to the woman.

Recommended pharmacological methods of IOL

Vaginal PGE_2 is the preferred method of induction of labour, unless there are specific reasons for not using it (in particular the risk of uterine hyperstimulation). It should be administered as a gel, tablet or controlled-release pessary. Costs may vary over time, and trusts/units should take this into consideration when prescribing PGE_2. The recommended regimens are[4]:

- One cycle of vaginal PGE_2 tablets or gel: one dose, followed by a second dose a minimum of after six hours if the labour is not established (up to a maximum of two doses).
- One cycle of vaginal PGE_2 controlled-release pessary: one dose over 24 hours.

Misoprostol should only be offered as method of induction of labour to women who have intrauterine fetal death or in the context of a clinical trial[4].

Mifepristone should only be offered as a method of induction of labour to women who have intrauterine fetal death[4].

Most of maternity units use vaginal PGE_2 controlled-release pessary (Propess) for outpatient induction of labour as it has number of advantages. However, units might use tablets and gels.

Clear information must be given to women leaving the hospital regarding what to expect after the procedure, what to look for and when to return or contact the labour ward. The information should be given verbally and in writing. An information leaflet should be provided with a clearly marked 24 hour contact number included. (See appendix 2 and 3 as examples of best practice information leaflets.)

Staff skills and competencies

Staff performing an outpatient induction of labour must be able to demonstrate key skills. It is paramount that only staff trained in an outpatient induction procedure carry out the procedure and they must have attended appropriate annual mandatory education in the subject.

Staff providing the outpatient IOL service must also be competent in abdominal palpation and cervical assessment as well as having completed annual cardiotography training.

Auditable standards

Each unit as a minimum should audit against the following standards:

- Percentage of eligible women induced in an outpatient setting.
- Percentage of women given written and verbal information prior to and following the outpatient induction of labour procedure.
- Re-presentation before the planned 24 hour review and reason for this.
- Place of birth.
- Induction to delivery time interval.
- Unexpected admission to neonatal unit (no >comparable inpatient induction group).
- Unplanned delivery at home.
- Delivery method after the induction of labour:
  - Percentage of normal vaginal delivery.
  - Percentage of caesarean sections.
  - Percentage of instrumental delivery.
- Number of failed inductions.

An example audit tool is attached in appendix 1.

Appendices: Examples of good practice

- **Appendix 1** – South West London Maternity Network suggested audit tool for outpatient induction of labour
- **Appendix 2** – Barking Havering and Redbridge University Hospitals NHS Trust induction of labour information leaflet
- **Appendix 3** – Imperial College Healthcare NHS Trust – Induction of labour, information for women and their families
- **Appendix 4** – South West London Maternity Network patient information leaflet
- **Appendix 5** – South West London Maternity Network patient satisfaction survey for outpatient induction

References

- 1.) Propess Abstract, North Middlesex Hospital audit.
- 2.) Akmal S, Nightingale P, Dana S, Loudon J, Bennett P. Outpatient induction of labour in low risk primigravidae by slow release Dinoprostone.
- 3.) Kelly AJ Alfirevic Z Dowswell T Outpatient versus inpatient induction of labour for improving birth outcomes: Cochrane Database of Systematic reviews 2009.
- 4.) NICE clinical guideline CG70; Induction of labour.
- 5.) NICE support for commissioning for induction of labour.
- 6.) Henry A, Outpatient Foley catheter versus inpatient prostaglandin E2 gel for induction of labour: a randomised trial.
- 7.) Biem SR, Turnell RW, Olatunbosun A randomized controlled trial of outpatient versus inpatient labour induction with vaginal controlled-release prostaglandin-E2: effectiveness and satisfaction. Journal of Obstetrics and Gynaecology Canada: JOGC. 2003;25(1):23–31.

Appendix 1
South West London Maternity Network:
Suggested audit tool for outpatient induction of labour

NHS
London
Strategic Clinical Networks

1. Does this woman meet the inclusion criteria for SWL guidelines? Yes ☐ No ☐
   If not, please record why: _____
   _____
2. Place of birth
3. Provision of information leaflet Yes ☐ No ☐
4. Documentation of consent Yes ☐ No ☐
5. Documentation of vaginal assessment prior to IOL Yes ☐ No ☐
6. Offered a membrane sweep Yes ☐ No ☐
7. Documentation of satisfactory maternal and fetal observations prior to discharge home
   Maternal observations Yes ☐ No ☐
   Electronic fetal monitoring Yes ☐ No ☐
8. Documentation of discharge advice given Yes ☐ No ☐
9. Parity _____
10. Prostaglandin used ☐ Propess ☐ Prostin ☐ Tablet ☐ Gel ☐ Dose___ml
11. Dilation of cervix when readmitted at 24 hours?_____cm
12. Additional prostaglandins required on re-admission Yes ☐ No ☐
13. Method of membrane rupture ☐ ARM ☐ SROM
14. Syntocinon required Yes ☐ No ☐
15. Analgesia _____
16. Mode of delivery
    ☐ Spontaneous vaginal birth
    ☐ Assisted delivery with forceps ☐ ventouse
    ☐ Caesarean section, urgent ☐ emergency
17. APGAR score 1 minute 5 minutes 10 minutes
18. Time interval from induction of labour to delivery _____ (time)
19. Admission to neonatal unit? Yes ☐ No ☐
20. Risk incident Yes ☐ No ☐
    If yes, please detail
    _____
21. Patient satisfaction
    Was a patient questionnaire completed? Yes ☐ No ☐
    Would she recommend outpatient induction to friends/family? Yes ☐ No ☐

What is induction of labour?

Induction of labour (IOL) is the process of starting labour artificially. Nearly 20 per cent of births in the UK are induced, mainly when pregnancy has gone past the due date but also for various other reasons. At Queen's Hospital, we offer induction of labour either in hospital or as an outpatient. This leaflet gives you information about outpatient induction of labour.

Outpatient induction of labour will only be offered to you if you have had a normal 'low-risk' pregnancy this time. You will normally be offered induction of labour if your pregnancy is 10 days past your due date. If you wish to have detailed information about induction of labour, please ask your midwife, who can also give you the leaflet called *Induction of labour*.

Why have an outpatient induction of labour?

An outpatient induction of labour:

- Reduces the amount of time you will need to stay in hospital before your labour begins.
- Allows you to stay at home and wait for labour to start.
- Makes the process of induction more normal.

Who can have outpatient induction of labour?

You may be offered an outpatient induction of labour if:

- Your pregnancy is 'low risk'.
- You have no medical or obstetric problems.
- You have not had any gynaecological surgery.
- You have a good understanding of English or you can speak English fluently.
- You have a relative who will stay with you at home on that day.
- You have transport to bring you to the hospital.
- You live within 30 minutes (driving distance) from Queen's Hospital

Your midwife will have a discussion with you about the outpatient induction of labour process and if you meet all the criteria you will be offered this method of induction.

What happens on the day?

Your midwife or doctor will book an appointment for you to attend the Obstetric Assessment Unit at Queen's Hospital for your induction of labour.

Please remember to bring your hand-held notes with you and an overnight bag just in case you need to stay in hospital.

Step 1

When you arrive in the Obstetric Assessment Unit you will have your pulse, blood pressure, temperature and urine checked. The midwife will also read your notes and make sure that the outpatient induction of labour checklist is completed.

The midwife will discuss the process of induction of labour with you and answer any questions you may have. The midwife will also examine and measure your tummy to check your baby's size and the way your baby is lying. The midwife will also check that your baby is ok by monitoring the baby's heart beat on a CTG machine for about 30 minutes. The machine also monitors contractions.

Step 2

When the midwife is happy with the observations and CTG monitoring she will ask if it is ok to perform an internal examination (vaginal examination) to check the neck of the womb (cervix).

If the neck of the womb is closed, then the inducing drug Propess will be inserted into the vagina. Propess is a very small flat tampon containing inducing drugs which will remain inside your body for 24 hours. The tape from the tampon will be kept fixed on your thigh. After the Propess tampon is inserted you will need to lie down for about 30 minutes. The Propess tampon will absorb the moisture from your vagina which makes the tampon swell and settle into place. This reduces the chance of it falling out.

The Propess tampon string will lie just outside the vagina and it is important that you take care not to pull or drag on it. You also need to take care when:

- Wiping yourself after going to the toilet.
- After washing.
- Getting on and off the bed.

Step 3

When the Propess has been given, your baby's heart rate will be monitored again for 30 minutes. When this has been completed and the midwife is happy with your observations you will be encouraged to walk around the hospital or go for a snack for the next two hours.

If your water breaks, you experience any tightenings, bleeding or if you have any concern you should return to the Obstetric Assessment Unit immediately.

Step 4

After two hours you should return to the Obstetric Assessment Unit (OAU) and the midwife will check baby's heart beat. You will be given the opportunity to ask the midwife any questions and if everything is ok you will be able to go home. You will be given the option to either come back to OAU at 4 pm for a further check-up of baby and yourself or ring the OAU for a telephone assessment (Tel: 01708435000 ext 2596).

Step 5

You can continue with your day to day activities and eat and drink as normal. Following your assessment at 4 pm, either on OAU or by telephone, there are no concerns or signs of labour, you can stay at home and return the following morning to the antenatal ward for admission.

You should contact the helpline immediately 01708503742 if you experience any of the following:

- Your tummy starts to tighten every 5 minutes (contractions).
- You have any vaginal bleeding.
- You think your waters have broken.
- The Propess falls out.
- You are worried.

What happens when I go home?

The Propess you have been given works by 'ripening' your cervix – this means the cervix softens, shortens and begins to open up. You will commonly feel a period-like ache while this happens, but sometimes tightening of the womb can occur and even labour can start. It is ok to stay at home during this time, but if the contractions become distressing or come every 5 minutes you should phone up and come in to Triage.

Are there any side effects?

Propess can occasionally produce some side effects which are usually mild and include: nausea, vomiting, dizziness, palpitations and fever. If any of these occur to a distressing level you should phone up and come in to hospital (see below)

There is a rare chance you may be very sensitive to the Propess and start contracting very frequently and strongly:

- More than five times in 10 minutes.
- A run of contractions each lasting more than two minutes.
- Severe abdominal pain.

If this happens you must contact the number below and make your way immediately to hospital (You should remove the Propess tampon using the tape).

Helpful telephone numbers

Helpline number 01708503742
Triage number 01708435000 Ext 2704

For a translated, large print or audio tape version of this document please contact the Patient Advice and Liaison Service (PALS) on 0800 389 8324.

References

- Dowswell T, Kelly AJ, Livio S, Norman JE, Alfirevic Z. Different methods for the induction of labour in outpatient settings. Cochrane Database of Systematic Reviews 2010, Issue 8. Art. No.: CD007701. DOI: 10.1002/14651858.CD007701.pub2.
- Kelly AJ, Alfirevic Z, Dowswell T. Outpatient versus inpatient induction of labour for improving birth outcomes. Cochrane Database of Systematic Reviews 2009, Issue 2 Art. No.: CD007372. DOI: 10.1002/14651858.CD007372.pub2
- Induction of labour. An update of NICE inherited clinical guideline D. July 2008. National Institute for Health and Clinical Excellence.

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Introduction

This leaflet has been provided to help answer some of the questions you and your family may have about induction of labour (IOL) and to help you make an informed decision about your IOL.

This information is based on a national evidence-based clinical guideline on induction of labour (National Institute for Clinical Excellence [NICE] guidelines 2008). It does not specifically look at the care of women who are pregnant and have diabetes, women who are giving birth to more than one baby, or women who are already in labour.

What is induction of labour?

Labour is a natural process that usually starts on its own, however, sometimes labour needs to be started artificially and this is called **induction of labour**. About 20 percent of pregnant women are currently induced in the UK.

Why might I be offered an induction?

An obstetrician (doctor) or midwife will only recommend an induction if it benefits you and your baby. There are several reasons why you might be offered induction when your waters are intact:

1) **To avoid prolonged pregnancy**, which is when the pregnancy lasts 42 weeks or longer (14 days or longer than your expected date of delivery). This is the most common reason for induction.

The placenta is where the oxygen is transferred from the mother's blood to the baby's blood and where the food passes from mother's blood to the baby's blood during pregnancy. This may become less efficient with prolonged pregnancy and result in stillbirth, although the overall risk of stillbirth remains low. Therefore, IOL is recommended routinely to all women between 40 weeks + 10 to 13 days, if their labour has not started naturally.

The risk of stillbirth increases from:
0.9 in 1000 pregnancies by 40 weeks of pregnancy
1.3 in 1000 pregnancies by 41 weeks of pregnancy
1.6 in 1000 pregnancies by 42 weeks of pregnancy
2.1 in 1000 pregnancies by 43 weeks of pregnancy

Because there is no precise way to identify those pregnancies at risk of stillbirth, induction of labour is currently recommended to all such women by 42 weeks.

2) **Advanced maternal age** - There is some evidence (references are given at the end) that the stillbirth rate increases with advanced maternal age. If you are 40 years or older, the risk of still birth increases as follows:

1.8 in 1000 pregnancies by 40 weeks of pregnancy
2.6 in 1000 pregnancies by 41 weeks of pregnancy
3.2 in 1000 pregnancies by 42 weeks of pregnancy
4.2 in 1000 pregnancies by 43 weeks of pregnancy

For this reason, you may be offered IOL if you are 40 years old or older at around 40 weeks in your pregnancy (gestation). We will discuss this with you in detail in the antenatal clinic.

3) **If you or your baby's wellbeing is causing concern** - You will be offered IOL in circumstances when delivering your baby would be beneficial to the health of baby or mother, such as the presence of diabetes, high blood pressure, growth problems of the baby, and other such conditions. Please note that if your baby is larger than expected, you should not routinely be offered induction for this reason alone.

What is membrane sweeping?

You will be offered a membrane sweep to help you go into labour naturally before 42 weeks. This involves your obstetrician or midwife placing a finger into your cervix and making a circular, sweeping movement to separate the membranes that surround your baby, or massaging your cervix if this is not possible.

Membrane sweeping does not cause any harm to you or your baby although it may cause some discomfort, pain or bleeding. It may stimulate the natural production of prostaglandins (hormones), which might promote softening of the cervix and in time trigger active labour.

You will be offered a membrane sweep between 40 and 41 weeks at your antenatal appointments to reduce the need for induction of labour. If labour does not start after this, you can ask for additional membrane sweeps especially if you have had a baby before.

What are the risks or disadvantages of IOL?

Induction promotes birth before your body is ready for labour, so compared to natural labour, some interventions are more common. When reviewing the figures quoted below, remember that you have not gone into spontaneous labour and are being induced to avoid problems.

Compared to spontaneous labour without complications, induction of labour[1]:

- Is a longer process.
- Increases the need for an epidural for pain relief (currently about 80 per cent of our women (delivered at QCCH and St Mary's) who are induced have regional analgesia).
- May provoke too many or prolonged contractions, which can diminish your baby's oxygen supply and lower your baby's heart rate - very rare (less than 1 per cent).
- Increases the need for an instrumental birth (10 per cent for spontaneous labour versus 15 per cent for induced labour nationwide but slightly higher in our maternity units as more women choose to use epidurals for pain relief).
- Increases the need for caesarean section delivery but this is very dependent on the reason for the induction, rather than the induction itself.

If the process of IOL does not work, we will discuss other options with you, one of which is a caesarean section delivery. Therefore, IOL is only recommended if the benefits outweigh the risks.

What happens if I need to be induced?

Your midwife or obstetrician will explain in detail the reasons why they recommend induction of labour. It is important that you understand the IOL process and ask any questions you might have.

Your assessment will include examination of your belly (abdomen) to see how your baby is lying in your womb, and listening to your baby's heart beat. Following this, you will most likely be offered an internal examination to assess your cervix (neck of the womb), and a **membrane sweep**. We will then arrange a date of IOL for you at the reception desk in the antenatal clinic.

How long should IOL last?

It is different for each pregnant woman and depends on how ready the neck of your womb and your baby are for birth. In general, if this is your first pregnancy (you have not given birth before) and the neck of your womb is not ready (cervix is closed and hard), it may take up to two to three days from the start of the IOL to the birth of your baby.

1 Figures are taken from the Hospital Episode Statistics for Maternitys.net.

How will I be induced?

IOL is carried using the following methods:
1) **Softening and shortening of your cervix** (neck of the womb) called cervical ripening. This is usually achieved by inserting prostaglandins (hormones) into the vagina.
2) **Breaking the waters around your baby in the womb** (if they have not broken already during ripening). This is called artificial rupture of membranes (ARM).
3) **Using an oxytocin infusion drip** to enhance the contractions to widen your cervix. This is called cervical dilatation.

Your labour might start after cervical ripening by the prostaglandins and you may not need the following two steps. However, if this is your first pregnancy or the neck of your womb is not ready at all, you are more likely to go through all steps as above.

Prostaglandins

We use two types of prostaglandins: **pessary and gel**. We prefer to use a prostaglandin pessary, especially if this is your first pregnancy or the neck of the womb is not ready at all.

Pessary is a slow release prostaglandin which is inserted into your vagina once and works over 24 hours. It prepares the neck of the womb for labour. You may also get contractions during this process. We will advise you to keep the pessary in for 24 hours. The pessary may need to be removed if:

- You are in real labour (which is when you have regular, three or four contractions every ten minutes and the neck of your womb is opened 3 cm or more).
- You are having too many contractions (five or more contractions every ten minutes).
- You are having too long contractions (one contraction lasting about two minutes).
- Your baby's heart beat is no longer normal.
- You start bleeding. It is normal to get a tiny amount of blood with some mucousy discharge after an internal examination.

The possibilities of what might happen once prostaglandin pessary is inserted:

- You may go into labour and the neck of your womb may start opening. If this happens, we will remove the pessary.
- Your waters may break without you being in labour. If this happens, you will need an oxytocin infusion drip to start the contractions. The prostaglandin pessary may be left inside while you are waiting for the drip.
- The neck of your womb will soften and shorten but you may not have gone into labour. If this happens, your waters will need to be broken and then you will need an oxytocin infusion drip to start the contractions.

If an oxytocin infusion drip is planned for your induction, you may choose to have an epidural anaesthesia before the drip. Epidural anaesthesia will not make the oxytocin drip less effective.

Prostin E2 ® (Dinoprostone) gel is also effective in preparing the neck of the womb for labour. However, if one gel does not make the neck of the womb ready, you may need another gel. Some women need a third application of gel but this is very rare. There has to be at least a six-hour period in between the prostin gels. This period may be longer if you are having contractions or if the labour ward is very busy. It works the same way as prostaglandin pessary.

Artificial rupture of the membranes (ARM)

This is also known as **breaking the waters** and can be used if the cervix has started to ripen. A small hole is made in the membranes using a slim sterile plastic instrument (single use) during an internal examination performed by the midwife or obstetrician. Having your membranes broken should encourage more effective contractions.

Use of oxytocin

Sometimes prostaglandins or breaking the waters is sufficient to start a labour, but many women require oxytocin. This drug is given using a drip into a vein in the arm. It causes the womb to contract, and is usually used after the membranes have broken either naturally or artificially. The dose can be adjusted according to how your labour is progressing. The aim is for the womb to contract regularly until you give birth.

When using this method of induction, it is advisable to have your baby's heart rate monitored continuously using a cardiotocogragh machine (CTG). The contractions can feel quite strong with this type of induction – the midwife will ask you how you are coping and tell you about different methods of pain management. However, we will offer you an epidural for pain relief before starting an oxytocin drip.

Can I be induced and still have a home birth or go to the birth centre?

If your labour is induced, you will not be able to have your baby at home or in the birth centre. This is because your baby's heart beat and the frequency of your contractions will need to be monitored continuously after having prostaglandin and/or oxytocin drip.

What happens if induction does not work?

If you do not go into labour after induction, your midwife and obstetrician will discuss your options with you and check you and your baby thoroughly. This happens in about five to ten percent of women having IOL. Depending on your wishes and circumstances, we may offer you:

- Another method of IOL.
- Defer the IOL for a later date if circumstances allow.
- Caesarean section delivery.

Can I choose not to be induced?

Your obstetrician will explain in detail the reasons why they recommend IOL. However, if you do not wish to be induced at this time, you should tell your midwife or obstetrician. We will then ask you to come to the hospital for monitoring so that we can check how you and your baby are. We will test your baby's heart beat using a CTG and you will have a scan to check the water around your baby.

Please note that these methods are not very reliable to show us which pregnancies are at high risk for stillbirth. Because of these limitations, we offer IOL to all pregnancies before 42 weeks gestation (two weeks after your expected date of delivery).

How often you come to the hospital for monitoring depends on your situation, and the midwife and obstetrician will discuss this with you.

Why might my induction be delayed?

We understand that when your induction is delayed, this can make you feel distressed and upset. However, the midwife or obstetrician will give you reassurance and try to keep you informed about arrangements for your induction. The arrangements are dependent on your individual circumstances and those of the labour ward.

Your IOL may be delayed if all midwives are busy caring for other patients at that time and/or there is no bed available. Birth is unpredictable and we have women arriving as emergencies 24 hours a day. We, as midwives and obstetricians, have a responsibility to care for mothers and babies on our unit and ensure safe deliveries. This may impact on the plan for your IOL, either delaying the start of your induction or delaying the process of your induction if it has already started. If you are unhappy at any time, please ask to speak to the senior midwife on duty.

What are the arrangements for induction of labour at Queen Charlotte's and Chelsea Hospital?

We will give you a date and time to come to the hospital. You do not need to phone us to confirm.

- On the day of admission for your induction, please come to the Lewis Suite (day assessment unit) at 08.00am.
- If all is well and you are living close to the hospital, you may be allowed to go home. We will ask you to come back for assessment 12 hours later if this is your first pregnancy, OR four to six hours later if you had a vaginal birth before. We will give you detailed instructions on what to expect and what to do if you go home.
- If you stay in hospital, you will be admitted to the Edith Dare Ward after prostaglandin insertion.

The Lewis Suite is located on the first floor of Hammersmith Hospital (opposite the birth centre). The telephone number is 020 3313 3349.

What are the arrangements for induction of labour at St Mary's Hospital?

We will give a date and time to come to the hospital. There is no need to phone to confirm.

- On the day of the admission for your induction, please come to Day Assessment on the labour ward at 08.00am.
- Following the insertion of the prostaglandin pessary you will then stay in hospital, and be admitted to the Alec Bourne Ward.

Occasionally on admission to Day Assessment you may be transferred to Alec Bourne Ward for the insertion of the prostaglandin pessary.

How do I make a comment about my treatment?

We aim to provide the best possible service and staff will be happy to answer any of the questions you may have. If you have any suggestions or comments about your visit (either positive or negative), please speak to a member of staff, email our patient complaint coordinators at complaints@imperial.nhs.uk or contact our patient advice and liaison service (PALS) who will listen to your concerns and queries and are often able to help sort out problems on your behalf. You can phone the PALS team on 020 3312 7777 (St Mary's Hospital) or 020 3313 0088 (Queen Charlotte's and Chelsea Hospital), email them at pals@imperial.nhs.uk or visit www.imperial.nhs.uk/pals).

Alternatively, you may wish to express your concerns in writing to:
Chief executive's office, Imperial College Healthcare NHS Trust, Trust Headquarters
The Bays, South Wharf Road, London W2 1NY

If you have any further questions about induction of labour or about information in this information sheet, please contact the antenatal clinic:

Queen Charlotte's and Chelsea Hospital 020 3313 3926
St Mary's Hospital 020 3312 1443
Maternity Helpline 020 3313 1888

References

http://guidance.nice.org.uk/CG70/PublicInfo/pdf/English)
http://www.nice.org.uk/nicemedia/pdf/CG070FullGuideline.pdf
http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=1475

Advanced maternal age

Joseph KS, Allen AC, Dodds L, et al. The perinatal effects of delayed childbearing. Obstet Gynecol 2005; 105:1410–1418.
Jacobsson B, Ladfors L, Milsom I. Advanced maternal age and adverse perinatal outcome. Obstet Gynecol 2004; 104:727–733.
Bahtiyar MO et al Stillbirth at Term in Women of Advanced Maternal Age in the United States: When could the antenatal testing be initiated? Amer J Perinatol 2008; 25(5): 301-304.

Being induced with Propess – going home during the process (outpatient induction)

Having a baby is a very special time in the life of a woman and her family, and we want to make sure that if is a positive and safe experience. In most pregnancies the labour starts naturally between 27 to 42 weeks, Here at (insert name) Hospital, low-risk women who have chosen to be induced when their labour has not started by (insert gestation) to 42 weeks, are able to go home during the induction process. (This is known as *outpatient induction*).

If you have chosen not to be induced, this process is not relevant to you. Please talk to your midwife or doctor about other ways to manage your pregnancy until the birth of your baby.

If you have had a healthy straightforward pregnancy (and do not suffer from any medical conditions) and you have chosen to be induced because your pregnancy has continued at least 10 days beyond your estimated due date, we will offer you an outpatient induction.

Going home during an induction is not recommended for some women, for example, if you are over 40 years old, overweight (with a BMI over 30), over 42 weeks pregnant, have had a previous Caesarean birth, this is not your first pregnancy, or your waters have already broken.

Inducing labour usually takes time, sometimes several days, and may follow a number of steps. These could include softening (or ripening) your cervix (the neck of the womb), breaking your waters and giving you a hormone drip through your vein to make your contractions start. You may not need all of these steps, and this information leaflet is about the process of softening your cervix using a drug called Propess.

We understand that you may be disappointed about being induced, so it is important that you feel it is the right thing for you and your baby. If you do choose to go ahead with the induction, we will do all we can to meet your birth plan wishes as closely as possible.
Please ask us if you have any questions.

Common questions

Why is my labour being induced?

About one in five women have their labour started artificially by induction. In most cases this is done because their labour has not begun by ……weeks. The main reason that induction is recommended is because some studies have shown that babies are at slightly more risk of developing problems during pregnancy and labour if they remain in the uterus after 41 weeks and five days [reference].

Can I avoid having my labour induced?

Having your labour induced is your choice. Some women would like to avoid being induced with drugs (due to the disadvantages – see below) and choose to have a membrane sweep (which may help the cervix to soften without any further intervention) or do nothing and wait for their labour to start naturally.

Membrane sweep ('stretch and sweep')

This involves a midwife or doctor placing a finger inside your cervix and making a circular sweeping movement to separate the membranes from the cervix. It can be carried out at home or at an outpatient appointment.

A stretch and sweep:

- Increases the chance of labour starting naturally within the next 48 hours and can reduce the need for further induction of labour.
- May be uncomfortable and cause a small amount of bleeding.
- Is not recommended if your membranes have ruptured (waters broken).
- Does not increase the risk of infection to you or your baby.

What happens in hospital?

You will be asked to come to [insert ward and time] on the day your labour is to be induced. A midwife will check your vital signs (your temperature, pulse, blood pressure and breathing rate) and record your baby's heartbeat (CTG). The midwife will then carry out a vaginal examination to assess your cervix before inserting a vaginal pessary, called Propess.

How will I be induced?

Your labour will be induced with a vaginal pessary, called *Propess*. The pessary can stay in your vagina for 24 hours.

What is Propess?

Propess pessary contains an active ingredient (dinoprostone) which is a natural hormone also known as prostaglandin. The pessary looks like a very small tampon and is inserted into the vagina.
What are the benefits of going home after having a Propess pessary inserted?
Going home means that you can return to a comfortable and familiar environment. Research shows that women are more likely to go into labour if they are relaxed within their own surroundings.

Who can have an outpatient induction?

We recommend an outpatient induction if:

- Your pregnancy has been straightforward.
- You live within 30 minutes of the hospital.
- You have access to a telephone.
- You understand the process.

What you need to be aware of once the pessary is in place

If the string from the pessary moves to the outside of your vagina, you should be careful not to pull or drag on it as this may cause the pessary to come out. South West London Maternity Network

Please take special care:

- When wiping yourself after using the toilet.
- While or after washing yourself.
- When getting on or off a bed.

It is very unlikely that the pessary will come out, but if it does it will need to be put back in. If it has fallen onto a clean surface you can replace it yourself. Otherwise, you should come to (insert ward) to have it put back in.

Tell the midwife if:

- Your waters break.
- You don't feel your baby moving as much as usual.
- Your contractions are coming more than once every five minutes.
- You are worried.
- The pessary falls out.

If any of the above happens, please call our midwifery team on [insert telephone number] and come into the labour ward.

Suggestions to help yourself at home

- Carry on as usual. Try to do things to take your mind off wondering when your labour will start.
- Go for a walk if you feel like it.
- Make sure you eat and drink as usual.
- Rest and sleep as much as possible − induction can be a slow process.
- Arrange to have an adult with you.

Suggestions for coping with contractions at home

- Have a warm bath.
- Take long, deep breaths through your contractions – focus particularly on breathing out.
- Keep mobile and try different positions to get more comfortable.
- Try sitting or leaning on a birth ball.
- Emotional and physical support from your birth partner can help.
- Ask someone to give you a massage.
- Aromatherapy can help (on the recommendation of a qualified aromatherapist).
- Listen to music or relaxation downloads.

Once your contractions start, there is no need to come to hospital straight away unless:

- The contractions are every two minutes or very strong.
- You have continuous pain in your stomach.
- Your waters break.
- You have vaginal bleeding.
- Your baby is not moving as usual.

If you are concerned about anything while you are at home, please call our midwifery team in the labour ward on (insert number).

After 12 hours

You should call the midwife on (provide ward and telephone number) between (insert times) to discuss your progress and receive advice.

What happens 24 hours after the pessary is inserted?

After the Propess is inserted you will be asked to return the following day to (insert ward) at (insert time) to have it removed and have a vaginal examination. If your cervix is ready, your waters will be broken. If the cervix is not ready, the midwives will discuss a further plan with you. South West London Maternity Network

Artificial rupture of the membranes (ARM)

ARM, or breaking your waters (amniotic fluid), is part of the induction process. It needs to be carried out before the hormone drip can be used.

- It is done during an internal examination so may be uncomfortable.
- It may increase the strength and frequency of contractions quite significantly, which can be more difficult to cope with.
- It does not hurt your baby, but your baby may become distressed due to an increase in the strength of contractions.
- The midwives can see the colour of the amniotic fluid which can help them assess your baby's well-being.
- You will need to keep a maternity pad on afterwards until your baby is born.
- You are still encouraged to keep moving about.

Syntocinon hormone drip

Syntocinon is an artificial hormone which is used to represent the natural hormone oxytocin. It can be given on the labour ward, after your waters are broken, as part of the induction process. The drip increases the strength and frequency of your contractions and can cause too many contractions or very strong contractions. If that happens, the drip will be slowed down or turned off. Your baby's heartbeat will need to be monitored continuously to check that he or she is coping with the effects of the syntocinon.
You do not have to be in bed when you are being induced − it is still possible to be out of bed with a monitor and drip attached.

Advantages of having your labour induced

- It can benefit the health of your baby as the placenta may not work as well once you go two weeks beyond your due date.
- It is a planned date (but you could go into labour naturally before then).
- If you are being induced after your due date, you are no more likely to need a Caesarean section than if you go into labour naturally.

Disadvantages of having your labour induced

- Syntocinon-induced contractions are stronger than natural contractions and you are more likely to need an epidural to be able to cope with the pain.
- Syntocinon-induced contractions may distress your baby.
- Breaking your waters may distress your baby.
- Synthetic oxytocin can interfere with the release of natural oxytocin during labour and early breastfeeding, so you and your baby may need extra support with getting breastfeeding started.
- Induction may not always be successful and you will need a Caeasarean section if this is the case. Your care will be reviewed by a senior doctor and a plan will be discussed with you.
- You will need more internal examinations to assess your progress and plan your treatment. You may find this uncomfortable.
- You may spend some of the time on an antenatal ward with other women who are in labour.
- Your partner may be sent home while you are on an antenatal ward.
- There can be a delay between the induction starting and your labour becoming established. Your labour may take up to three days.
- Occasionally there may be a delay with your induction due to other cases on the labour ward. You will be kept informed.

Information and communication

You will be kept fully informed about what is happening at all stages, and your wishes will be taken into account. Please do ask if you do not understand anything or you want us to explain anything.

Appendix 5
South West London Maternity Network
Patient satisfaction survey for outpatient induction

NHS
London
Strategic Clinical Networks

We value your comments and suggestions so please complete this questionnaire by ticking the boxes that apply. It will help us to improve our service.

1. Were you satisfied with the explanation given to you about outpatient induction of labour?
☐ Yes ☐ No

2. Was it more convenient to return home rather than stay in the hospital?
☐ Yes ☐ No

3. Did you have any problems following the instructions?
☐ Yes ☐ No

4. Were you comfortable having your induction done as an outpatient?
☐ Yes ☐ No

5. Overall how satisfied were you with the treatment?
☐ Very satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very dissatisfied

6. Would you be recommending this process to your friend/family?
☐ Yes ☐ No

Please provide any comments or suggestions you feel may be of help to us.

Thank you for your response.
Kindly return the completed form to your midwife.