Induction of labour (with intact membranes)

This leaflet has been written to help you and your partner understand what might happen during an induction of labour.

Date of induction: …….
Please come to Rothschild Ward/DAU* at …….
Please bring your handheld notes with you

What is induction of labour?

Most women will start labour spontaneously by 42 weeks of pregnancy. Induction of labour is the process designed to start labour artificially. On average approximately 1 in 5 labours are induced. At Buckinghamshire Healthcare NHS Trust, this varies between 1 to 1.5 in 5 labours. There are a number of reasons why induction may be offered and recommended. For example, if you have a medical condition in pregnancy such as diabetes or high blood pressure (pre-eclampsia) and there comes a time when it is clinically indicated that giving birth would benefit the health of you or your baby. The most common reason for induction of labour is to avoid the risks associated with a prolonged pregnancy (a pregnancy lasting longer than 42 weeks).

How your body prepares to give birth

During pregnancy your baby is surrounded by water, often called the 'waters' or amniotic fluid. These waters are contained within the sac (the membranes), which protect your baby whilst he/she is developing in the womb (uterus).

As your body gets ready for labour, the neck of the womb softens and shortens. This is sometimes referred to as 'ripening of the cervix' and can sometimes take a few days to occur.

Before or during labour the membranes break (rupture) releasing the fluid. This is often referred to as your 'waters breaking'.

The process of labour involves the cervix opening (dilating) and the uterus contracting to push your baby out.

When is induction recommended?

At the 40 week antenatal visit your Midwife or Obstetrician should offer to talk to you about the induction process and the clinical reasons for induction (eg avoiding a prolonged pregnancy). They should talk to you about the risks and benefits of induction, explain the alternatives and advise you about ways of finding out more information. This gives you time to talk about induction with those close to you and ask any questions, before the possibility of induction of labour is recommended.

If you have had a healthy uncomplicated pregnancy, induction of labour will be offered at 40 weeks plus 12 days. This will give you time to start labour naturally.

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If your pregnancy is more than 41 weeks

Induction of labour is recommended from 40 weeks plus 12 days because the risk of your baby developing health problems begins to increase from 42 weeks. The risk of stillbirth is 2 babies in every 1000 births after 42 weeks compared to 1 baby in every 1000 births at 37 weeks.

If you choose not to be induced at this stage, you and your Doctor will make a plan of care from 42 weeks and this will include:

- Twice weekly checks of your baby's heartbeat using a piece of equipment called an electronic fetal heart rate monitor or cardiotocograph (CTG)
- An ultrasound scan to check the amount of water (amniotic fluid) surrounding your baby

An induction because you are overdue does not increase the likelihood of you needing a Caesarean section but it may increase your chance of needing an assisted (instrumental) vaginal birth.

Induced labour may be more painful than spontaneous labour as contractions can start more suddenly. We will talk to you at your antenatal appointment about how to manage pain. You will be supported with your pain relief choices when you are in labour. You can assist your labour to progress by adopting different positions and trying to remain active during labour.

Membrane Sweeping

Before you are offered an induction you should be offered a membrane sweep. This has been shown to increase your chance of starting labour naturally within 48 hours and can reduce the need for other methods of induction of labour.

Membrane sweeping involves a vaginal examination during which your Midwife or Doctor will place a gloved finger just inside your cervix and make a circular, sweeping movement to separate the membranes from the cervix. It can be carried out at home, at an outpatient appointment or in hospital.

Membrane sweeping may cause some discomfort or light bleeding but will not cause any harm to your baby. If you do experience severe pain or heavy bleeding after a membrane sweep, you should contact the labour ward for advice (01296 316103). You should be offered a membrane sweep at your 40 and 41 week antenatal appointments during your first pregnancy or your 41 week antenatal appointment if you have had a baby before. Membrane sweeps should not be performed if your waters have broken.

How is labour induced?

There are a variety of ways to induce labour. You may be offered one or all of these, depending on your individual circumstances. Once started, the induction process continues until your baby is born and you will need to stay in hospital throughout the whole induction process.

Cervical Balloon (Foley's)

Balloon induction is a mechanical form of induction of labour and is the only method used for outpatient induction of labour at present. This is because mechanical methods of induction of labour have the least chance of over stimulating the uterus and causing too many contractions (uterine tachysystole). If you are having a Foley's induction, you may want to

read this leaflet in conjunction with the leaflet ‘Induction of labour with Cervical Balloon (Foley’s) catheter). This leaflet can be found here:

Prostaglandins

Prostaglandins are drugs that act like natural hormones to start labour. At Buckinghamshire Healthcare NHS Trust, a gel known as Prostin® (dinoprostone 1-2 mg) is used and is inserted into the vagina. This is undertaken in hospital on the antenatal ward or labour ward depending on the reason for your induction.

Before being given any prostaglandins your baby’s heartbeat will be checked for approximately 20—30 minutes using a cardiotocograph monitor (CTG). This will be repeated after the prostaglandin medication has been given. We will also monitor your baby’s heartbeat once contractions start.

If your cervix is not ready for labour and your waters cannot be broken as your cervix is closed, you will be given a Prostin® vaginal gel. However, more than one dose may be needed to induce your labour. A second dose of the Prostin® gel can be given 6—8 hours later if needed. Prostin® can cause vaginal soreness and you will be supported with your pain relief choices when you are having an induction and when your labour starts.

Very occasionally prostaglandins can cause the uterus to contract too much which may affect the pattern of your baby’s heartbeat. If this happens you will be asked to lie on your left side. You may be given other medication to help relax the uterus.

The aim of the prostaglandins is to either start your labour or to dilate the cervix enough so that the waters can be broken (artificial rupture of the membranes). Occasionally, despite being given two Prostin® gels, the cervix does not dilate enough to be able to rupture the membranes. If this is the case, the Doctor will talk through the options with you. This may include offering you another dose of prostaglandins.

Artificial rupture of the membranes (ARM) or amniotomy (breaking of the waters)

If your waters have not broken a procedure called an amniotomy (ARM) will be recommended. This is when your Midwife or Doctor makes a hole in the membrane to release (break) the waters.

This is performed during a vaginal examination using a small plastic disposable instrument, when you are on the labour ward. This will cause no harm to you or your baby, but the vaginal examination needed to perform this procedure may cause you some discomfort.

Oxytocin Intravenous Infusion (hormone drip)

If active labour does not start after the rupture of membranes a drip (or cannula) containing synthetic oxytocin will be given to you through a plastic tube inserted into a vein. Oxytocin in

this form is a drug that mimics the natural hormones that cause contractions and therefore start labour.

The amount of synthetic oxytocin you receive will be increased to ensure you are contracting regularly (approximately 3-4 contractions in 10 minutes). If you start to contract too much the amount can be reduced.

When you are being given intravenous oxytocin your baby's heartbeat will be monitored continuously by a CTG. The oxytocin drip can limit your ability to move around. It may be okay to stand up or sit down, but you won't be able to have a bath, use the birthing pool or move from room to room.

You will be able to continue to drink water or isotonic drinks and to have a light diet, such as toast, rice cakes or non-acidic fruit like bananas. If you are considered to be higher risk, or if the staff have concerns about you or your baby, you will be asked to stop eating but you can still drink.

Women who have intravenous oxytocin are more likely to ask for an epidural in labour due to stronger, more powerful contractions. It is your choice whether you have an epidural or not. An epidural is a form of pain relief provided by an anaesthetist (please talk to your Midwife if you need more information about epidurals).

Steps in the Inpatient induction process (for Foley's induction, please refer to the relevant leaflet)

1. The reason(s) for inducing your labour will have been discussed with you and, with your agreement, a date for induction will be given to you.
2. You will be given a time by your midwife to attend for your induction.
3. You will be welcomed by the ward staff and shown to your bed. Once you have settled in, the ward facilities will be shown to you and you will be given any other information that is relevant to your hospital stay. The Midwife will monitor your baby's heartbeat for 30 minutes and record other observations, e.g. blood pressure, temperature and pulse rate. A member of the maternity team will talk to you and confirm the type of induction that is suitable. This is a good time to ask any questions you or your partner may have. It is important to bear in mind that several women may be admitted for induction of labour on the same day and your induction of labour will be started as soon as possible, but delays can occur.
4. An internal examination will be performed with your consent. If you require prostaglandins a gel (Prostin®) will be inserted into the vagina. This will take place on the Antenatal Ward unless you have been told you will need to have Prostin® on the Labour Ward.
5. After approximately 6 hours you will be assessed again (including an internal examination) and if needed, a second Prostin® gel may be given. If you have not already gone into labour, then 6 hours after your last Prostin® gel, you will be examined to determine if it is possible to rupture your membranes.
6. After you have been given prostaglandins (if needed) you will be encouraged to sleep overnight and stay in hospital. If you are not in active labour at the end of visiting hours

it will be recommended that your partner goes home and will be telephoned when you start to go into established labour. This enables you both to rest.

7. If it is possible to rupture the membranes you will be taken to the Labour Ward as soon as they are able to accept you. If Labour Ward is very busy and are unable to accept you at that time, you should be aware that the next step of your induction process could be delayed for a few hours or even a few days. We will keep you informed of events at all times. Once the induction process has started we would advise you to stay in hospital until your baby has been born. During this time we will continue to regularly monitor you and your baby.
8. Women having their first baby are advised to start intravenous oxytocin immediately after the membranes have been ruptured.
9. Women who have had a baby before are advised to wait for 2 hours after having their waters broken before starting intravenous oxytocin

It is important that you are fully aware that few women give birth on the day of their induction (particularly first time mothers). Induction of labour can take a few days. We would advise you to bring books, magazines etc. to keep you occupied.

Advice for birthing partners

As the induction process can take several days, it is important that you also feel prepared for a potential wait before your wife/partner is transferred to the Labour ward. Many people find it useful to plan music playlists to bring into hospital with them on their mobile phone or MP3 player. Please bring plenty of food and drinks with you to see you through the day and night.

You can support your partner in a variety of ways, including being calm and patient, using gentle massage and encouraging your wife/partner to eat and drink. Assisting your wife/partner to change positions can also help with the induction process.

Further information

For further information about induction of labour and all other aspects of pregnancy and childbirth please talk to your Midwife or Doctor.

- Royal College of Obstetricians and Gynaecologists website at https://www.rcog.org.uk/en/patients/patient-leaflets/induction-of-labour---information-for-people-who-use-nhs-services/ has the full induction of labour guideline including sources of evidence.

Useful numbers

Antenatal Clinic:	01296 316227 (Stoke)	01494 425569 (Wycombe)
Labour Ward:	01296 316103 (Stoke)	

This leaflet explains some of the most common side-effects that some people may experience. However, it is not an exhaustive list. If you experience other side-effects and want to ask anything else related to your treatment please contact your community midwife or Stoke Mandeville Hospital Labour Ward: **01296 316103** or Wycombe Hospital Birth Centre: **01494 425513.**

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