are concerned that the movements have slowed down compared with normal, you should telephone Labour Ward immediately. The midwife will ask you to come in to monitor the baby to check that all is well.

Further information
Your midwife or obstetrician will be happy to discuss the contents of this leaflet and answer any questions you might have at any time.

If you would like to receive this leaflet in a language or format of your choice please contact pals.service@wmuh.nhs.uk or 020 8321 6261

Useful telephone numbers

Helpline	020 8321 5608
Antenatal Clinic:	020 8321 5007
Antenatal Ward:	020 8321 5950
Labour Ward:	020 8321 5946/5947
Reception:	020 8321 5952
Head of Midwifery:	020 8321 5022
NHS Smoking Helpline:	0800 169 0 169
Main switchboard	020 8560 2121

West Middlesex University Hospital
Twickenham Road
Isleworth
Middlesex TW7 6AF

www.westmidmaternity.org.uk

March 2017

CSP068597 CSP Ltd. 02/18

West Middlesex University Hospital

NHS
Chelsea and Westminster Hospital
NHS Foundation Trust

MATERNITY SERVICES

INDUCTION OF LABOUR

Date of admission.....

Time of admission.....

WHAT IS INDUCTION?

Induction of Labour (IOL) means that labour is started off artificially rather than waiting for it to happen spontaneously. Induction frequently results in a normal birth.
Induction for women who have had a previous Caesarean section follows a different pathway – please see separate leaflet.

WHY MAY INDUCTION OF LABOUR BE NECESSARY?

Problems that arise during pregnancy sometimes cause increased risk to the baby or the mother.
If it is suggested that your labour is induced, you should make sure that you understand why induction is thought to be necessary before making a decision. If you choose not to be induced you will be offered twice weekly monitoring in the Day Assessment Unit.

The most common reasons for induction are:

Prolonged pregnancy

Your estimated due date (EDD) is calculated at your dating ultrasound as this is the most accurate way to predict when you baby might be born. Normally labour starts spontaneously any time from three weeks before to two weeks after your due date, i.e. 37-42 weeks. Pregnancy is only thought of as being prolonged if it extends beyond 42 weeks, after which there is an increased risk that the placenta may become progressively less efficient, providing the baby with less nourishment and oxygen.
We consider induction when women are approaching 42 weeks although the actual timing may vary from one woman to another depending upon whether the cervix has started to soften and dilate.

Pre-eclampsia

Pre-eclampsia is a potentially serious condition which causes raised blood pressure, protein in the urine and fluid retention. The only cure for pre-eclampsia is to deliver the baby, so induction may be recommended to prevent worsening of the condition.

Step 3 Breaking your waters (ARM, or artificial rupture of the membranes)

Once the cervix is 'ripe' and there is availability on the Labour Ward, you will be transferred there for an ARM to further stimulate labour. This may not happen immediately and will depend on available space on Labour Ward. **You may have to wait for several hours**.

An ARM is when the membranes enclosing the amniotic fluid (the waters round the baby) are broken using a small hook inserted through the cervix, which is no more uncomfortable than a vaginal examination.
Walking around can be very helpful after ARM to stimulate the contractions. You will now remain on the Labour Ward.

Step 4 Oxytocin Drip

If labour has not started within two hours of your ARM you will be started on an oxytocin drip. Oxytocin is similar to the hormone that stimulates contractions in a spontaneous labour.
When labour is being stimulated artificially with oxytocin, we monitor your contractions and the baby's heart beat continuously to make sure that contractions do not occur more frequently than in normal labour and cause the baby to become distressed. Continuous monitoring may limit your range of mobility but does not confine you to bed.

Pain relief

The options for pain relief are the same as for spontaneous labour, with the exception of labour and delivery in water which is not usually possible if you have an oxytocin drip. Walking about helps to stimulate strong, effective contractions. Your midwife will explain the different ways of dealing with pain so that you can choose which suits you best.

BABY'S MOVEMENTS

Throughout your pregnancy, but particularly towards term, you should pay close attention to your baby's movements. If you experience less than 10 movements in any 12 hour period, or you

It is common to feel some tightenings after insertion of the Propess, however, the Propess can soften the cervix without you feeling any contractions, or alternatively the Propess may be sufficient to send you into normal labour. However, the primary aim is to prepare the cervix and it is unlikely that your labour will start at this point. You should inform the midwife if your contractions start or your waters break so that she can monitor you and the baby more closely.

The Propess will be removed after 24 hours or when you go into labour, whichever is sooner.

Step 2 Reassessment
When the Propess is removed, your cervix will be reassessed to see if it is now possible to break your waters. If it is, you will move to step 3. If it is not, we may proceed to step 2a or 2b.

Step 2a Balloon catheter
We may insert a balloon catheter (a small tube) into the cervix and inflate the balloon with water to the size of an egg. By pressing on the cervix it encourages the cervix to 'ripen' and start to dilate. The balloon catheter will remain in place for 24 hours. When the catheter is removed, you will be re-examined to determine whether it is now possible to break your waters

Step 2b Prostin gel
Alternatively, 6 hours after removal of the pessary you may be given up to 3 doses of vaginal prostin gel at 6 hourly intervals to continue the ripening process. If at any point the cervix is ripe, you will move to step 3.

Very occasionally, there is still little progress. The doctor will review the urgency for delivery and may suggest waiting a few days and re-starting the induction process or in rare cases a Caesarean section may be appropriate.

Fetal growth restriction (FGR)
In some pregnancies the baby's growth does not proceed as it should due to the blood supply not providing the baby with enough oxygen or nourishment. It is safer for the baby to be born early.

Complicated pregnancy
Sometimes women whose pregnancies are complicated, for example by diabetes, obstetric cholestasis or twins, may need to have labour induced. This is not always the case and many women with these conditions go into labour spontaneously.

Pre-labour rupture of membranes
If your waters break but your labour does not start spontaneously within 24 hours, we recommend that labour is induced to reduce the risk of infection to the baby.

RISKS AND BENEFITS OF INDUCTION OF LABOUR
Induction of labour will only be suggested if the risk of continuing the pregnancy is thought to be greater to mother and/or baby than the risks incurred by induction. Occasionally the induction process is not successful in starting labour. In this case the risks of continuing the pregnancy will be re-evaluated and the decision that is made will depend on how urgently the baby needs to be born.
There are usually three stages to starting labour artificially. First the cervix is softened by inserting a prostaglandin 'Propess' pessary into the vagina. When the cervix is sufficiently soft or 'ripened' the waters surrounding the baby are broken, then an intravenous drip containing oxytocin is started and continued throughout the labour. Oxytocin is the synthetic form of a hormone which your body produces to make the uterus contract regularly.
Women may experience niggling contractions after the insertion of the pessary. Rarely the pessary causes the uterus to contract too much, in which case it can be removed and medication can be given to reverse its effect.
The oxytocin drip, if set at too high a dose, can cause contractions which are too frequent for the baby to tolerate safely. The drip is therefore carefully controlled and its effects monitored. For this

reason induction of labour can only be offered in the Labour Ward, not the Natural Birth Centre.
Many women find that in an induced labour the contractions are more painful than in spontaneous labour. Continuous monitoring which restricts freedom of movement can also make the contractions harder to cope with. All methods of pain relief are available, though more women are likely to choose an epidural for pain relief for an induced labour than for spontaneous labour.

WHAT HAPPENS WHEN LABOUR IS TO BE INDUCED?

Complementary therapies
You may be offered a complementary therapy session to stimulate the spontaneous onset of labour if this is appropriate for you. Complementary therapies have a good induction success rate.

Sweeping the membranes
Separating the membranes from the cervix has been shown to increase the chances of labour starting naturally, so you may be offered a membrane sweep at your complementary therapy session or at your regular 40 or 41 week appointment, or earlier for other complications. A sweep involves the midwife or doctor carrying out a vaginal examination and sweeping a finger round the inside of the cervix. This may cause some discomfort or bleeding but will not harm you or the baby, and may result in spontaneous labour.

Coming into hospital
Once the decision for induction has been agreed a date will be set for you to come to the Maternity Unit, though you may start labour on your own before that date.
Please come to the antenatal ward on the Ground Floor of the Maternity Unit on the date and time given to you. The midwife will monitor the baby's heart beat and start the induction process.

When you come in, please bring everything you need for labour and for the baby but do not bring a car seat at this stage. Your birthing partner is welcome to accompany you, and may remain overnight in a reclining bedside chair once contractions start.

Please note that this arrangement is dependent on the agreement of the other mothers in a four bedded bay. Male visitors are requested to remain fully dressed at all times. Visiting hours for all other relatives and friends is 3-8pm. Once you have moved to Labour Ward, you may have additional people to accompany you.

When labour is being induced it is important for your safety that there are midwives available to look after you. We try to ensure that your labour proceeds as smoothly as possible, but there are occasions where the Labour Ward is extremely busy and it may be safer to delay your induction. We do our best to keep delays to a minimum as we appreciate how frustrating this can be.

HOW IS LABOUR STARTED?

Step 1 Using prostaglandins
In a natural labour the pregnancy hormone prostaglandin prepares the cervix for labour by making it softer and more open. The Propess pessary has a similar effect. Propess contains a slow release tablet and has a tape attached for easy removal.

Your midwife will perform a vaginal examination to assess the 'ripeness' of your cervix, which is an indication of how ready your cervix is for labour. She will insert the Propess into the vagina, which is no more uncomfortable than the vaginal examination itself. Your baby's heart beat will be monitored for about 20 minutes before, and for one hour after giving you the Propess, during which time you should remain in bed.

After that you can be up and about, but make sure that you do not pull on the tape. Pat, don't wipe, yourself after passing urine or washing, and take care when moving up and down the bed that the tape doesn't snag.

The midwife will check on you and the baby every 4 hours whilst the Propess is in place but we encourage you to remain in your day clothes and to walk around within the hospital grounds. It is important to carry on eating and drinking as normal.