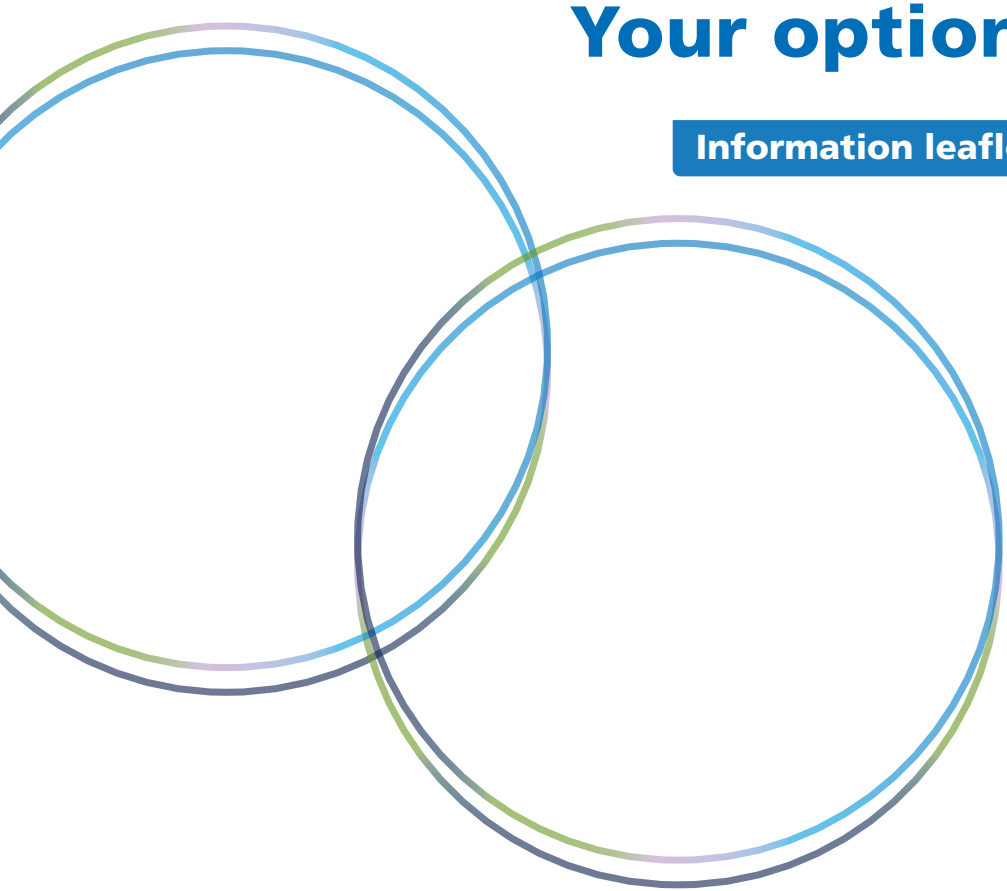
Oxford University Hospitals
NHS Foundation Trust

The induction of labour journey: Your options

Information leaflet



Name:.....

MRN number:.....

Birth Partner(s):.....

Gender inclusive language in OUH Maternity and Perinatal Services:

This leaflet uses the terms woman, women and mother throughout. These terms should be taken to include people who do not identify as women but who are pregnant. Similarly, where the term parent(s) is used, this should be taken to include anyone who has main responsibility for caring for a baby.

The term partner refers to the woman's chosen supporter. This could be the baby's father, the woman's partner, a family member or friend, or anyone who the woman feels supported by and wishes to involve in their care.

Why am I being given this leaflet?

You are being given this leaflet as you may be offered an Induction of Labour (IOL) at some point during your pregnancy, and it is important that you have all the information needed to make decisions that you feel are right for you. It is also a space for you to write down your thoughts, questions, and feelings, if you decide to proceed with an IOL. You can also use it to record the journey to welcoming your baby.

You may be offered an induction for a number of reasons such as having high blood pressure or diabetes or for simply going overdue (also known as being postdates). A postdates pregnancy is one that progresses to more than 41 weeks of pregnancy. IOL may also be offered if continuing a pregnancy may be a risk to a mother or baby's health and wellbeing.

Decision making – using the BRAIN acronym – how can this help?

The BRAIN acronym is a decision-making tool that will help you gather the information you need to make informed decisions about your and your baby's health. We will include the BRAIN acronym throughout this leaflet to help you consider some of the decisions you may need to make about your care options later in your pregnancy.

B – Benefits

What is the benefit of having this procedure/intervention?

R – Risks (or disadvantages)

What are the risks of this process for me and my baby?

A – Alternatives

What is the alternative to this procedure – is there a different care pathway?

I – Instinct

What do you feel is right for you, what feels safest, what does your gut instinct tell you?

N – Nothing

What happens if I do nothing or if I need more time to decide?

What do I need to know about Induction of Labour (IOL)?

IOL is the process of starting labour artificially. Most people will start to labour spontaneously (naturally/by themselves) between 37 and 42 weeks of pregnancy. Recent guidance by the National Institute of Health Care Excellence (NICE) recommends offering IOL from 41 weeks of pregnancy. You may hear the time after 41 weeks of pregnancy described as postdates or going overdue. The information in this leaflet is mainly concerned with IOL that is being offered due to a pregnancy being postdates/going overdue. If you are being offered IOL for other medical reasons, and have questions, please talk to your obstetrician (hospital doctor).

The following information shows how using the **BRAIN** decision making tool may help you consider the **pros and cons of IOL** and what feels right for you.

Benefits

IOL is when labour is started off artificially to reduce length of pregnancy. In some circumstances the chance of stillbirth and other complications can increase the longer a pregnancy continues. Stillbirth (the death of a baby from 24 weeks of pregnancy) does not happen often. However, we do know that IOL at 41 weeks of pregnancy may reduce the chance of your baby bring stillborn or being born in poor condition and needing admission to the Neonatal Unit.

The chance of stillbirth can be reduced by bringing the birth forwards. The recommended timing of an IOL will depend on your individual situation/clinical condition and preferences.

Across the general population the following numbers of stillbirths may occur;

- about 7 in every 10,000 babies will be still born between 40 weeks and 0 days to 40 weeks and 6 days
- about 17 in every 10,000 babies will be stillborn between 41 weeks and 0 days to 41 weeks and 6 days
- about 32 in every 10,000 babies will be stillborn between 42 weeks and 0 days to 42 weeks and 6 days

It is important to understand that the chance of stillbirth will vary depending on individual circumstances.

By offering postdates IOL from 41 weeks of pregnancy we are aiming to reduce the chance of stillbirth happening.

IOL can be associated with a lower chance of third or fourth degree perineal tears (tears into the rectal muscle in the area between the vagina and anus).

For second/subsequent labours, there is a lower chance of needing a caesarean birth if you choose to have an IOL because your pregnancy has gone overdue. About 5 in every 100 people having their second/subsequent baby, who choose to have an IOL for a postdates pregnancy will need a caesarean birth, compared to about 6 in every 100 people who choose not to have an IOL.

Risks (or disadvantages)

IOL may lead to higher intervention rates. This means where a doctor or midwife needs to help in the birthing process. It also carries the chance of hyperstimulation, which is when the uterus (womb) is contracting too frequently (often). The level of chance of hyperstimulation depends on the induction method used. Hyperstimulation may cause the baby to become distressed, which may mean the IOL has to be stopped.

The table below shows how often intervention or complications arise in induced labours compared to natural onset labours. The percentages represent the number of people per 100 (so for example 28% = 28 people out of every 100 people):

		IOL	Natural Labour
Instrumental Birth (e.g. forceps, ventouse)	First birth	28%	23.9%
	Second/subsequent births	7.6%	4.6%
Caesarean Section	First birth	29.3%	13.8%
	Second/subsequent births	5.3%	6.2%
Epidural	First birth	71%	41.3%
	Second/subsequent births	41%	18.1%
Episiotomy	First birth	41.2%	30.5%
	Second/subsequent births	11.9%	7.7%
Post-partum haemorrhage	First birth	41.2%	30.5%
	Second/subsequent births	11.9%	7.7%
Need for perineal repair	In all births	89.3%	84.3%

Other risks for newborns (of women undergoing IOL) include slightly higher chances of neonatal birth trauma, resuscitation (where the baby needs help with breathing etc after birth), respiratory disorders (for example if the baby needs ongoing help with breathing), and later admissions to hospital due to infection.

These risks do not apply to those who go into labour naturally after a Stretch and Sweep.

Induction of labour (IOL) pathway

The most common IOL pathway offered is as follows:

Up to 3 **Stretch and Sweeps** in the community (if you choose this and if the cervix is in a position and condition that makes this possible) *(see page 10)*

If you do not go into labour following this, we then offer:

1 to 2 **Prostin gels** given on Level 6 at the Womens Centre in the John Radcliffe Hospital *(see page 14)*

OR

Dilapan-S Rods method of induction *(see page 17)*

An **ARM** (artificial rupture of membranes – known as breaking the waters). This is performed either on Level 6 or Delivery Suite *(see page 20)*

If you do not go into labour following this, we then offer:

An **oxytocin Infusion** (artificial hormone drip) up to 4 hours after an ARM *(see page 23)*

(The IOL methods described above will be explained in the next section of the leaflet)

This is a typical pathway from the start of an IOL through to giving birth to the baby. We do not recommend requesting an ARM if you are going to decline oxytocin for example, because this would not be a safe thing to do and would increase your chance of infection without reducing the time before baby is born.

The steps in combination lead to the birth of your baby. If you feel that you may want to decline one of the steps, for example the oxytocin drip, it is important that you discuss these preferences with your midwife or doctor before you start on the IOL pathway.

Induction Methods

At the Oxford University Hospitals Womens Centre, we offer five different methods of induction which are outlined below.

Community Based IOL:

- Stretch and Sweep

Hospital Based IOL:

- Artificial Rupture of Membranes
- Prostaglandin Gel
- Dilapan-S Rods
- Oxytocin Infusion

It may be that a particular method is not recommended for you due to your medical or birthing history (for example if you have had a previous caesarean birth). Your midwife or doctor will talk to you about what they would recommend and why.

Note: if you wish to discuss alternatives to an IOL please speak to your community midwife who can refer you to an obstetrician if needed.

Stretch and Sweep

This is a procedure offered to try to encourage labour to start spontaneously (naturally/on its own). It is carried out by a midwife or doctor as part of an internal vaginal examination. It involves inserting two lubricated, gloved fingers into your vagina to locate your cervix (neck of the womb). During the membrane sweep, the index finger is gently inserted into the opening of the cervix.

A circular, sweeping movement is used to try to separate the membranes of the amniotic sac (that surround the baby), from your cervix. This action, releases hormones called prostaglandins that soften the cervix and may help initiate (start) labour. If your cervix has not started to soften and open, it would not be possible to perform a Stretch and Sweep.

The Stretch and Sweep will allow the midwife to work out how dialated (open) the cervix is, this is know as **Cervical Dilation** (see page 12).

The Stretch and Sweep will also allow the midwife to work out the **Bishop's Score** (see page 13).

B – Benefits

- Sweeping of the membranes at 41 weeks of pregnancy greatly reduces the number of people who give birth beyond 41 weeks. It may be offered as an alternative to inducing birth through medication or by artificially breaking the waters.
- The procedure is safe in a low-risk pregnancy.

R – Risks (or disadvantages)

- There is a small chance the membranes may unintentionally break during the procedure. If this happens, there is a slightly increased chance of infection. If the membranes do unintentionally break during a Stretch and Sweep, a more immediate form of induction may be recommended.

- Some people find the procedure uncomfortable, and a few are unable to tolerate it at all.
- It may not be successful at inducing (starting) labour.

A – Alternatives

- Using other natural methods of induction of labour e.g. exercise, acupuncture or nipple stimulation (please be aware there is no evidence to support or disprove these methods).
- Consider behaviours that promote natural levels of oxytocin levels in your body. Oxytocin is also known as the 'love hormone'- it is released by the body most effectively when you are relaxed and feel safe and happy. Having higher levels of oxytocin can help prepare your body for labour. Oxytocin is the hormone that also causes the uterus to contract during labour.
- Discussing the option of a caesarean birth.

I – Instinct

What do you feel is right for you, what feels safest, what does your gut instinct tell you?

N – Nothing

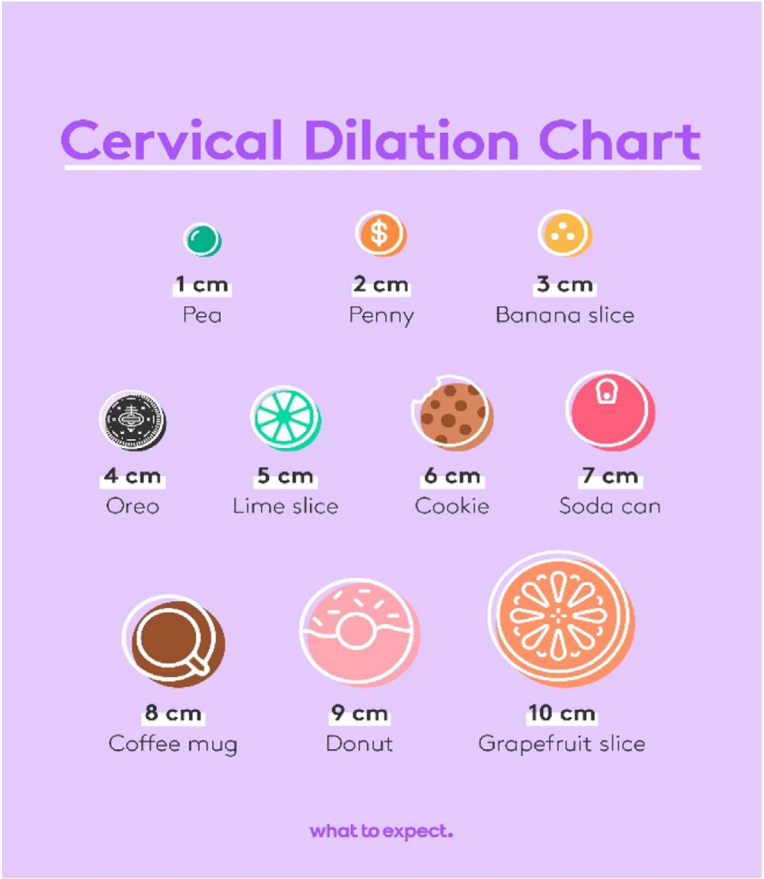
If you do nothing you may go into natural labour at a later date. You may also choose or need to have an IOL at a later time.

If you do nothing, your pregnancy will become prolonged (overdue), and this may be harmful to you and your baby. Depending on individual clinical circumstances this could also increase the chance of stillbirth.

If you decide not to have IOL, extra monitoring may be offered to check the wellbeing of the baby and to check to see if the placenta still appears to be working normally (this is known as expectant management). However, it is important to understand these checks may not be able to identify problems before they occur or prevent them from happening.

Cervical Dilation

Cervical dilation is only one part of the whole picture when the progress of labour and/or the induction of labour (IOL) is assessed, but is often something that people focus quite heavily on. It is important for you not to feel disappointed if your cervix is not dilating quickly, as there are lots of other signs that show positive progress during labour. During an IOL, these other factors are considered as part of an assessment called the Bishops Score. Cervical dilation (how open the cervix is) is one part of a Bishop Score assessment. Below is a visual guide to what cervical dilation looks like in terms of how open your cervix is during labour (not to scale):



www.whattoexpect.com/pregnancy/symptoms-and-solutions/dilation-and-effacement.aspx

A Bishop's Score – what does this mean?

When your midwife or doctor completes a vaginal examination during a Stretch and Sweep or as part of an IOL assessment. They will be checking the position of your cervix, the consistency/how it feels, how long it is and how dilated it is. They will also be checking the station (how high or low) the baby's head is in the pelvis. All these findings when considered together will create a Bishop's Score. This score is then used to help guide you and your midwife/doctor in the decision making around the most appropriate IOL options for you. For example, if a Bishop's Score is 7 or more, we wouldn't recommend a Prostin Gel for induction.

We will fully explain your individual situation and discuss your options with you at the time of the induction of labour.

There is an additional information sheet about the Bishop's Score that you can have a look at and discuss with your midwife in more detail. Please ask your midwife at the time of your induction if you would like further information on this.

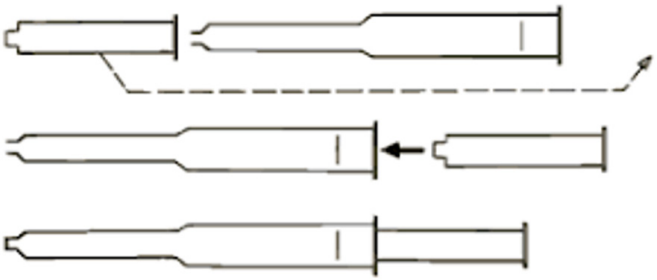
Prostaglandin Gel

Prostaglandin gel is used to soften (ripen) and dilate (open) the cervix. The insertion of the prostaglandin gel is a procedure that is carried out by a midwife or doctor as part of an internal vaginal examination. It involves two lubricated, gloved fingers being inserted into your vagina to locate the cervix (neck of your womb).

The applicator containing the prostaglandin gel is then introduced until it reaches behind the cervix. Using the applicator, the prostaglandin gel is then administered behind the cervix. The prostaglandin gel acts on the cervix, preparing it for birth by making it thinner, softer and more stretchy.

Sometimes (not often) labour contractions start after the first gel is inserted. Most people require two doses of prostaglandin gel, which are given 6 hours apart. For some people, a third prostaglandin gel may be offered, but this will depend on individual circumstances.

This method can take up to 24 hours to take effect.



This is a picture of what a prostaglandin gel applicator looks like and how it works.

B – Benefits

- Prostaglandin gel helps to soften and dilate your cervix to enable the induction process to continue.
- The procedure is safe in low-risk pregnancy
- It may help to start the childbirth journey and increases the chance of a vaginal birth within 24 hours of the prostaglandin gel being given.

R – Risks (or disadvantages)

- Some people develop 'prostin' contractions, which can feel painful but are not established labour contractions. You can try mobilising (moving around/changing position), sitting/rocking on a birthing ball and/or a TENS machine (Trans-Electrical Nerve Stimulation) to help relieve the early labour type contractions that will probably develop after a prostaglandin gel is given.
- Side effects (not common) can include nausea, vomiting, dizziness, palpitations and fever. The midwife on the IOL bay will be available during this time, checking your observations and listening to the baby's heartbeat every 4 hours.
- Occasionally some people develop a prolonged (extra-long) contraction or start to experience contractions that are coming too frequently (often). This is known as hyperstimulation. If this happens, the baby may become distressed. Hyperstimulation occurs in approximately 5 in every 100 people who have a prostaglandin gel. This may result in you being offered an emergency caesarean section.
- Medication can be given to reduce the frequency of contractions happening if needed.
- Having the prostaglandin gel may not be successful at inducing labour.
- This method of induction is not recommended for people who have had a previous caesarean section.

A – Alternatives

- Using other methods of IOL such as exercise, acupuncture or nipple stimulation may help you go into labour. Please be aware there is no evidence to support or disprove these methods.
- Consider behaviours that promote natural levels of oxytocin levels in your body. Oxytocin is also known as the 'love hormone'- it is released by the body most effectively when you are relaxed and feel safe and happy. Having higher levels of oxytocin can help prepare your body for labour. Oxytocin is the hormone that also causes the uterus to contract during labour.
- Discussing the option of a caesarean birth.

I – Instinct

What do you feel is right for you, what feels safest, what does your gut instinct tell you?

N – Nothing

If you do nothing you may go into natural labour at a later date. You may also choose or need to have an IOL at a later time.

If you do nothing, your pregnancy will become prolonged (overdue), and this may be harmful to you and your baby. Depending on individual clinical circumstances, this could also increase the chance of stillbirth.

If you decide to decline IOL, extra monitoring may be offered to check the wellbeing of the baby and to check to see if the placenta still appears to be working normally (this is known as expectant management). However, it is important to understand these checks may not be able to identify problems before they occur or prevent them from happening.

Dilapan

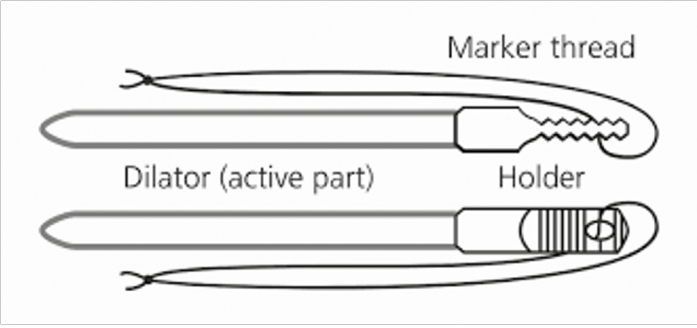
Mechanical Method of IOL

Dilapan is a small blunt ended rod, a little larger than a matchstick, that is used as a non-hormonal way of opening the cervix. The rod is made of a hydrogel aquacryl inert (harmless) substance that when inserted into the neck of the cervix, absorbs secretions from the vagina and cervix. This causes the rods to slowly increase in diameter and the pressure created helps to gradually stretch open the cervix over 12 to 15 hours. Between 3 to 5 Dilapan rods can be inserted at one time.

This procedure is carried out by a midwife or doctor as part of an internal vaginal examination. Two lubricated, gloved fingers are inserted into the vagina to locate the opening of the cervix (neck of your womb).

A long grasper is then used to pick up the Dilapan rod and guide it into the cervix. This is repeated until 3 to 5 rods have been inserted. The number of rods inserted will vary from person to person. These rods expand to approximately 1cm each and help to gently open the cervix in preparation for labour and birth.

This method can take up to 24 hours to take effect.



This is a picture of what a Dilapan rod looks like.

B – Benefits

- This is a non-hormonal method of induction.
- Sometimes you can return home for 12 to 15 hours and then return to Level 6 to have the Dilapan rods removed.
- The procedure is safe in a low-risk pregnancy.
- It begins the labour and childbirth journey.

R – Risks (or disadvantages)

- There is a slight chance the membranes may break during the procedure. If this happens, there is a slightly increased chance of infection. If you develop an infection, a more immediate form of induction may be recommended, for example, the oxytocin drip.
- Some people find the procedure uncomfortable, and a few are unable to tolerate it at all. If were to happen, we stop the procedure and consider alternative options with you.
- It may not be successful at inducing labour.

A – Alternatives

- Using other methods of IOL such as exercise, acupuncture or nipple stimulation may help you go into labour. Please be aware there is no evidence to support or disprove these methods.
- Consider behaviours that promote natural levels of oxytocin levels in your body. Oxytocin is also known as the love hormone - it is released by the body most effectively when you are relaxed and feel safe and happy. Having higher levels of oxytocin can help prepare your body for labour. Oxytocin is the hormone that also causes the uterus to contract during labour.
- Discussing the option of a caesarean birth.

I – Instinct

- What do you feel is right for you, what feels safest, what does your gut instinct tell you?

N – Nothing

- If you do nothing you may go into natural labour at a later date. You may also choose or need to have an IOL at a later time.
- If you do nothing, your pregnancy will become prolonged (overdue), and this may be harmful to you and your baby. Depending on individual clinical circumstances, this might also increase the chance of stillbirth.
- If you decide to decline IOL, extra monitoring may be offered to check the wellbeing of the baby and to check to see if the placenta still appears to be working normally (this is known as 'expectant management'). However, it is important to understand these checks may not be able to identify problems before they occur or prevent them from happening.

Artificial Rupture of Membranes (ARM)

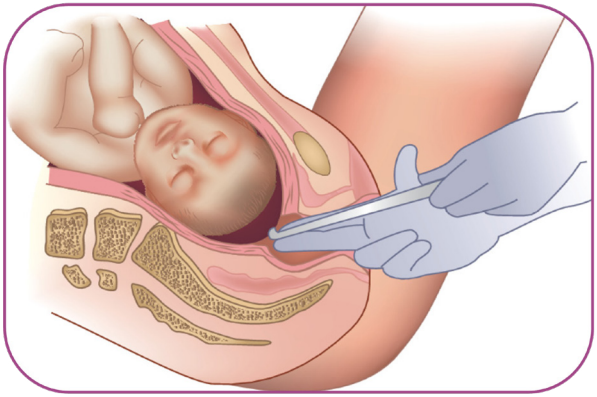
An ARM is also known as breaking the waters. This procedure is carried out by a midwife or doctor as part of an internal vaginal examination. Two lubricated, gloved fingers are inserted into the vagina to locate (find) the opening of the cervix.

If your cervix is starting to thin out and dilate (this may or may not be following a prostaglandin gel or Dilapan), an amnihook (pictured to the right) will be used to create a hole in the membrane sac to release your amniotic fluid/waters. This action, which releases hormones called prostaglandins, prepares the cervix for birth, and may help to start labour. An ARM means that the bag of waters that is in front of the baby's head is released which allows the baby's head to move down onto the cervix more easily. The pressure of the baby's head pushing down on the cervix often causes it to open more efficiently. Being upright and mobile (active) helps this process even more!

After an ARM, we recommend waiting up to 4 hours to see if labour gets going (the medical term for this is established labour). If this does not happen, we then recommend commencing the oxytocin infusion (artificial hormone).

This method can take up to 4 hours to take effect.

This is a picture of an amniohook.



This is a picture of what happens during an ARM.

R – Risks (or disadvantages)

- There is a small chance of a cord prolapse during or after an ARM. This is when part of the baby's umbilical cord slips down in front of the baby's head and through the cervix after the waters have broken (the chance of this is higher if the baby's head is not engaged/deep in the pelvis). This is a rare event and more commonly happens during labour but very occasionally can also happen after an ARM before labour starts. This is an obstetric emergency that requires the immediate birth of the baby – usually by emergency (urgent) caesarean section.
- Labour may not start without further intervention (oxytocin drip) by ARM alone.

A – Alternatives

- Using other methods of IOL such as exercise, acupuncture or nipple stimulation may help you go into labour. Please be aware there is no evidence to support or disprove these methods.
- Consider behaviours that promote natural levels of oxytocin levels in your body. Oxytocin is also known as the 'love hormone'- it is released by the body most effectively when you are relaxed and feel safe and happy. Having higher levels of oxytocin can help prepare your body for labour. Oxytocin is the hormone that also causes the uterus to contract during labour.
- Discussing the option of a caesarean birth.

I – Instinct

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N – Nothing

- If you do nothing you may go into natural labour at a later date. You may also choose or need to have an IOL at a later time.
- If you do nothing, your pregnancy will become prolonged (overdue), and this may be harmful to you and your baby. Depending on individual clinical circumstances, this could also increase the chance of stillbirth.
- If you decide not to have your labour induced, extra monitoring may be offered to check the wellbeing of the baby and to check to see if the placenta still appears to be working normally (this is known as 'expectant management'). However, it is important to understand these checks may not be able to identify problems before they occur or prevent them from happening.

Oxytocin Infusion
(also known as an oxytocin drip)

If labour does not start or become established within 4 hours of having an ARM, the doctor or midwife may suggest starting an oxytocin infusion (artificial hormone drip). This helps to increase the strength and frequency of your contractions. The oxytocin drip is given through a cannula (a very narrow, flexible tube) that is put into a vein (usually in the back of your hand, wrist or arm).
The oxytocin drip is started very slowly, which allows the contractions to build gradually over time.

This procedure involves putting a cannula (a small, thin plastic tube) into the back of your hand, wrist or elbow and attaching a bag of fluid that contains the artificial form of oxytocin (this is called a drip). The drip rate is started slowly and increased over a few hours until you are contracting every 2 to 3 minutes. It will then stay at that rate until your baby is born. Sometimes the rate of the drip needs to be reduced or stopped – for example, if your contractions are coming too frequently (often).

Sometimes the baby's heart rate may be affected during induced labour with an oxytocin drip in a way that may suggest the baby is distressed. The best way to monitor baby's wellbeing continuously is to begin a cardiotocograph (CTG) when the drip is started. A CTG involves having 2 small monitors placed on your abdomen (tummy), one to record the baby's heart rate and the other to track how often the contractions are happening.. This combined with the oxytocin drip is likely to limit your overall mobility in labour. However, we do try (wherever possible) to use wireless CTG monitoring to help you stay as active and mobile as you wish. CTG monitoring is only available on Delivery Suite. As we advise the baby's heartbeat is continuously monitored using a CTG when the oxytocin drip is used in IOL,
you would be on Delivery Suite for labour/birth.

This method can take up to 24 hours to take effect.

An active 3rd stage is recommended if you have had an oxytocin drip in labour, to help your uterus stay well contracted after birth and to help minimise bleeding. An active third stage is when a single injection of either artificial oxytocin or a drug called syntometrine is given into the muscle of your thigh after the baby is born.

If the oxytocin infusion is unsuccessful in helping you go into established labour, the doctor will discuss your options with you. It may be that certain aspects of the IOL process can be repeated, or that a caesarean birth is recommended.

B – Benefits

- The procedure is safe.
- The oxytocin drip will cause your uterus (womb) to contract with the aim of helping you to go into established labour.
- It helps to continue the labour and childbirth journey.

R- Risks (or disadvantages)

- CTG monitoring and having a drip in your hand/arm means that your overall freedom of movement may be more limited.
- Oxytocin can cause more intense contractions and therefore people may feel they need additional pain relief.
- It may not be successful at inducing labour.

A – Alternatives

- Using other methods of IOL such as exercise, acupuncture or nipple stimulation may help you go into labour. Please be aware there is no evidence to support or disprove these methods.
- Considering behaviours that promote natural levels of oxytocin levels in your body. Oxytocin is also known as the 'love hormone'- it is released by the body most effectively when you are relaxed and feel safe and happy. Having higher levels of oxytocin can help prepare your body for labour. Oxytocin is the hormone that also causes the uterus to contract during labour.
- Discussing the option of a caesarean birth.

I – Instinct

- What do you feel is right for you, what feels safest, what does your gut instinct tell you?

N – Nothing

- If you do nothing you may go into natural labour at a later date. You may also choose or need to have an IOL at a later time.
- If you do nothing, your pregnancy will become prolonged (overdue), and this may be harmful to you and your baby. Depending on individual clinical circumstances, this could also increase the chance of stillbirth.
- If you decide not to have IOL, extra monitoring may be offered to check the wellbeing of the baby and to check to see if the placenta still appears to be working normally (this is known as 'expectant management'). However, it is important to understand these checks may not be able to identify problems before they occur or prevent them from happening.

Commonly asked questions

Can I still give birth on the Spires?

If your pregnancy has been low risk and you go into labour following either one prostaglandin gel, one prostaglandin gel + an ARM or an ARM alone, then you can choose to labour on the Spires. However, if you require an addition intervention (such as two prostaglandin gels and an ARM for example) or if you need an oxytocin infusion, then the Spires is not recommended as a birth setting.

It is worth considering in advance what your preferences would be if you found yourself in this situation. Should you still wish to labour on the Spires, we would recommend speaking to a consultant obstetrician (senior hospital doctor) for further birth planning discussion.

Can my birthing partner stay with me during the induction process?

If it is clinically safe to be in a side room, then we will make every effort to accommodate your birth partner staying with you. However, if you have diabetes or raised blood pressure, or if there are no side rooms available then unfortunately, your birth partner will need to go home and return during visiting hours.

Please be reassured that if your birthing partner is unable to stay with you over night, they will be called as soon as you establish in labour or are transferred to Delivery Suite or The Spires.

What to expect in the initial IOL process

1. You will be asked to attend Level 6 in the Women's centre on the agreed date and time of your induction (this should be written in your induction booklet).
2. You will be welcomed to the ward and shown your bed space.
3. The midwife or maternity support worker will ask you for a urine sample that will be checked. A set of observations will also be performed (such as checking your blood pressure and pulse for example) to assess your wellbeing.
4. The midwife will monitor the baby's heart rate using a CTG (cardiotocograph) machine. This is to check that your baby is well and in a condition that allows the IOL process to safely begin.
5. Your midwife will also use this time to discuss the induction options with you and answer any questions you may have. They will make sure you understand what is involved and will obtain your consent before starting the agreed induction of labour process.
6. If the CTG recording of your baby's heart rate is normal, your chosen method of IOL can begin.

Things worth noting

- Very few people give birth on the day of their induction. Most women will give birth within 2 to 3 days of the IOL process starting.

  We would recommend telling your friends and family this, to ensure you are given the space you need to relax and focus on you and your baby.

- The IOL team work very closely with the Delivery Suite and Spires midwives to ensure there are always midwives ready to continue your care in the safest birth setting. During the times we are particularly busy, there may be a delay in the IOL process such as having to delay offering an ARM for example. We will keep you as informed as possible about any delays and will continue to offer you care and support on Level 6.

  We prioritise providing IOL care to women according to their clinical condition and level of risk to them or their baby's wellbeing, rather than order of arrival to the unit. We appreciate this can be disappointing when you are anticipating labour and the arrival of your baby. Please feel free to talk to a midwife and they will do their best to resolve any concerns you may have.

Coping mechanisms available during the induction process

- Heatpacks
- Gymballs and space to mobilise
- Paracetamol (for mild to moderate pain relief – taken by mouth)
- Dihydrocodeine (an opioid painkiller – for moderate to strong pain relief – taken by mouth)
- Oramorph (a liquid painkiller – for strong pain relief - taken by mouth)
- Once you are in established labour the following are available:
- Birthing pools (on Spires)
- Epidural (an injection in your back to stop you feeling pain in your lower body)
- Gas and air (also known as Entonox)

Please discuss pain relief options with your midwife. You are welcome to use the bath/shower and our birthing balls. Please bring a TENS machine if you would like to use one. Some people find IOL more intense because the body hasn't had time to build up endorphins (natural hormonal painkillers). Relaxation and acceptance practice (such as mindfulness meditation) can help relieve stress and help to cope with managing these sensations.

Packing suggestions

- ☐ Your maternity notes
- ☐ Your birth preferences
- ☐ Any clothes you feel comfortable in, there is nothing specific you need to wear
- ☐ Snacks
- ☐ Phone charger
- ☐ ipad/laptop and charger
- ☐ Water bottle with straw
- ☐ Headphones
- ☐ Lip balm
- ☐ Hairbrush and hair ties
- ☐ Face moisturiser
- ☐ Flannel
- ☐ Comfortable bra/nursing bra
- ☐ Deodorant
- ☐ Toothbrush and paste
- ☐ Your baby's bag
- ☐ Birth partners bag

Top IOL tips for you

(Recommended by people who have previously experienced the IOL process):

1. Be kind to yourself. This is probably not the birth plan you had in mind – give yourself time and space to process the information and the situation you are in.
2. Bring a speaker or headphone to listen to music/podcasts
3. Bring an iPad or equivalent to watch TV
4. Bring snacks, cereal bars, energy drinks, sweets, fruit
5. Be prepared for a lot of waiting – think about planning activities that will help pass the time/keep your mind busy
6. Keep mobile – use a birthing ball, think about forward leaning positions to help the baby's head descend into the pelvis (such as kneeling, squatting, being in an all-fours position), walk around in between observations. Being upright can open your pelvis by up to 30%!
7. Ask if wireless baby heart rate monitoring equipment can be used (if available). This will allow you more freedom of movement during labour
8. Keep lights low, listen to music, consider hypnobirthing techniques
9. Bring things that remind you of home – a pillow/blanket/slippers
10. IOL tends to be a long and lengthy process but remember, it will be worth it in the end!

Colostrum harvesting

Colostrum harvesting is felt to be safe during the third trimester and can be done by people in the days leading up to an IOL.

We recommend practicing colostrum harvesting from 36 weeks of pregnancy and collecting any colostrum that you manage to express from 37 weeks.

It involves hand expressing the colostrum from the breast (your midwife will explain how you can do this). You can store any colostrum that you manage to express in the freezer – this can then be defrosted and fed to the baby after birth.

Please be aware that we do not have freezer facilities for colostrum. Therefore, we recommend bringing just a small amount of colostrum in from home because once defrosted, colostrum is only safe (sterile) to be fed to baby for 12 hours at room temperature. You may want to use the spare time during the IOL process to express more colostrum which we can store in our fridges for you.

Ask your midwife for a colostrum harvesting pack and for help and guidance with getting hand expressing started. The QR code below can be used to find out more information on colostrum harvesting.

For more information on **Infant Feeding** and **Safe Sleeping** please scan the **QR code** or visit:

www.ouh.nhs.uk/maternity/feeding

Advice for birthing partner(s)

1. This process is a long journey for both of you therefore please ensure you eat and drink regularly and rest when you can.
2. Have a discussion with the person whom you are supporting regarding the birth plan and preferences. Make sure you know how to advocate (communicate their wishes/preferences) for them if needed.
3. When contractions start it is very helpful if you can time them. You are in a great position to do this!
4. Ensure the person you are providing support to stays as calm and relaxed as possible and remind them to eat and drink regularly.
5. If you have a medical condition, please remember all medication etc that you may need.
6. Read this article below for additional information in the beneficial ways birth partners can be influential in helping to improve in the outcomes for women and their babies.

https://apps.who.int/iris/bitstream/handle/10665/334151/WHO-SRH-20.13-eng.pdf

My induction of labour (IOL) journey

Date and Time of IOL :

Why I am being offered an IOL:

Preferred method of IOL and why:

Any IOL methods I would like to avoid and why:

I know I can decline to have an IOL and what this means for me and my baby: YES/NO

Things I would really like my IOL midwife to know:

Space to document your thoughts, feelings and things that are happening:

Useful Reading

NICE

Inducing labour:
www.nice.org.uk/guidance/ng207

Intrapartum care for healthy women and babies:
www.nice.org.uk/guidance/cg190

RCOG

Induction of labour: information for the public:
www.nice.org.uk/guidance/ng207

The BMJ

Induction of labour at 41 weeks versus expectant management and induction of labour at 42 weeks (SWEdish Post-term Induction Study, SWEPIS): multicentre, open label, randomised, superiority trial

www.bmj.com/content/367/bmj.l6131

NHS

www.nhs.uk/pregnancy/labour-and-birth/signs-of-labour/inducing-labour/

Tommy's

www.tommys.org/pregnancy-information/giving-birth/inducing-labour

Birthrights

www.birthrights.org.uk

Dr Sara Wickham

Midwife, author, speaker and researcher:
www.sarawickham.com/iol

MBRRACE-UK

Perinatal Surveillance Report 2020:
www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/perinatal-surveillance-report-2020/MBRRACE-UK_Perinatal_Surveillance_Report_2020.pdf

WHO (World Health Organisation)

apps.who.int/iris/bitstream/handle/10665/334151/WHO-SRH-20.13-eng.pdf

National Library of Medicine

Risks of stillbirth and neonatal death with advancing gestation at term: A systematic review and meta-analysis of cohort studies of 15 million pregnancies - PMC
www.ncbi.nlm.nih.gov/pmc/articles/PMC6605635/

Recommended Podcasts and Playlists

Available on Spotify:

- Birthing Playlist
- Calm Labour and Delivery
- Labour Music
- Labour/give me that oxytocin
- Hypnobirthing
- Hypnobirthing Tracks

My IOL summary

I went into labour on: ..... **at:** .....

My baby was born:

.....

.....

.....

I have had a:

.....

.....

.....

Born at: ..... **weeks:** .....

Weighing: .....

My midwife was called: .....

My most positive moment was:

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Women's quotes about IOL

Nilvér, H. et al. (2022) 'Women's lived experiences of induction of labour in late- and post-term pregnancy within the Swedish post-term induction study – a phenomenological study', *International Journal of Qualitative Studies on Health and Well-being*, 17(1), pp. 1–10. doi: 10.1080/17482631.2022.2056958.

Gatward, H. et al. (2010) 'Women's experiences of being induced for post-date pregnancy', Women and Birth, 23(1), pp. 3–9. doi: 10.1016/j.wombi.2009.06.002.

Murtagh, M. and Folan, M. (2014) 'Women's experiences of induction of labour for post-date pregnancy', *British Journal of Midwifery*. MA Healthcare London , 22(2), pp. 105–110. doi: 10.12968/BJOM.2014.22.2.105.

Feedback

We would really value your feedback on your induction of labour experience. Please scan the QR code and complete the questionnaire:

Further information

If you would like an interpreter, please speak to the department where you are being seen.

Please also tell them if you would like this information in another format, such as:

- Easy Read
- large print
- braille
- audio
- electronic
- another language.

We have tried to make the information in this leaflet meet your needs. If it does not meet your individual needs or situation, please speak to your healthcare team. They are happy to help.

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www.ouh.nhs.uk/information

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