Induction of labour

Information for pregnant women, their partners and families

HSC Health and Social Care

This leaflet:

- gives information to help you make choices about induction of labour – you have the right to be fully informed and share in the decision making;
- provides information on how labour is induced;
- summarises the risks and benefits of induction of labour;
- is informed by the evidence-based guideline on induction of labour (2008) from the National Institute for Health and Clinical Excellence (NICE).

Most women will go into labour spontaneously by 42 weeks. However if your baby is overdue, your doctor or midwife will discuss the options with you and recommend how to proceed.

What is induction of labour?

In most pregnancies labour will start spontaneously between 37 and 42 weeks.

In preparation for labour, your cervix softens and shortens. This is sometimes called 'ripening'. Before or during labour the membranes (bag of fluid that surrounds your baby) rupture (break) releasing the fluid which surrounds your baby. This can be called 'your waters breaking' or 'spontaneous rupture of membranes' (SROM). During labour the cervix dilates (opens and widens) and the uterus (womb) contracts to push the baby out.

Induction of labour, or 'being induced', is a process that starts labour artificially.

Why should labour be induced?

The most common reason for labour to be induced is when your baby is overdue. Induction of labour is usually recommended between 41 and 42 weeks gestation as after this time the placenta may become less effective and make complications more likely.

However if it is felt that your health or your baby's health is likely to benefit, induction of labour at an earlier stage may be recommended and offered by your doctor.

Approximately 30% of women in Northern Ireland will have their labour induced.

When induction of labour is offered your doctor or midwife should explain:

- the reasons for induction being offered;
- when, where and how induction could be carried out;
- the arrangements for support and pain relief (recognising that women are likely to find induced labour more painful than spontaneous labour);
- the alternative options if you choose not to have induction of labour;
- the risks and benefits of induction of labour in specific circumstances and the proposed induction methods;
- that induction may not be successful and the options should this occur.

What is a membrane sweep (stretch and sweep)?

A membrane sweep involves your doctor or midwife performing a vaginal examination, placing a finger just inside the cervix and making circular sweeping movements to separate the membranes from the cervix.

This can increase the chance of labour starting naturally and reduce the need for other methods of induction to be used. This procedure should be offered at all antenatal appointments/visits after 39 weeks by your doctor or midwife. If it is not offered you should discuss this with your doctor or midwife.

Afterwards it is normal to see a slightly blood stained 'show'; this is painless and causes no harm to you or your baby.

How is labour induced?

There are several ways of inducing labour and you may be offered one or all of them depending on need. This will be discussed with you by your doctor or midwife.

Generally, when an induction of labour is started you are committed to continue. The process may require one method only or possibly require all the methods described in this leaflet. If you are not in labour by the evening of the first day you will be advised to stay in hospital overnight. Your birth partner will have to go home, but would be contacted to return if labour starts overnight. On occasion, and only after discussion with your doctor, if induction of labour has not worked you may be advised to go home and return for another attempt at a later date.

- **Prostaglandin induction**
  Prostaglandins are drugs that help to induce labour by encouraging the cervix to soften and shorten (ripen). This may cause your cervix to open and contractions to start. Prostaglandins are given during a vaginal examination and the procedure occurs in hospital. Some maternity units use one dose (requiring one vaginal examination) of slow release prostaglandin, which is removable but can last up to twenty four hours. Other maternity units use repeated doses of prostaglandin.

- **Artificial rupture of membranes (ARM)**
  If your waters haven't broken a procedure called an ARM may be recommended. This is when the midwife or doctor, during a vaginal examination, makes a small hole (breaking the waters) in the membranes around the baby to allow the waters to drain and the baby's head to press on the cervix and stimulate contractions.

  This procedure will cause no harm to you or your baby but the vaginal examination may be uncomfortable.

- **Oxytocin (drip)**
  Oxytocin is a drug which encourages contractions. It can be used when contractions have not started or are not increasing in strength despite having tried the above methods.

  It will be given by a drip and increased slowly until you are having contractions regularly (3–4 in every 10 minutes). These contractions are similar to those you would have if you went into labour naturally.

  If this type of induction is used your baby's heartbeat will have to be monitored continuously.

What about my baby?

Wherever induction of labour is carried out, facilities will be available for continuous electronic fetal heart rate and uterine contraction monitoring.

Before induction of labour is carried out your baby will be monitored to ensure a normal heart rate pattern is present.

After administration of prostaglandins when contractions begin, your baby will be assessed with continuous electronic monitoring. Once the tracing is confirmed as normal, this can be removed and your baby listened to intermittently as required.

If you are receiving oxytocin by a drip you will have continuous monitoring of your baby's heartbeat.

What are the risks?

- **Hyperstimulation**
  On occasion induction of labour may lead to your womb having more frequent contractions than usual, which may cause problems for you or your baby. If this occurs your baby will be closely monitored and you may be given another drug to reduce the number of contractions.

- **Failed induction**
  Failed induction is defined as labour not starting after one cycle of treatment. If induction of labour fails:
  - Your doctor should discuss this with you and provide support. Your condition, your baby's wellbeing and the pregnancy in general should be fully reassessed by a senior doctor.
  - Decisions about further management should be made in accordance with your wishes, and should take into account you, your baby and the reasons for induction of labour at this stage.

    The subsequent management options include:

    - a further attempt to induce labour at a later date;
    - caesarean section.

Induction of labour in special circumstances

If delivery is indicated (the baby needs to be born for his or her own safety or that of the mother), and you have had a previous caesarean section you may be offered induction of labour. You will be advised by your obstetrician of the advantages and disadvantages of induction of labour in these circumstances.

Your induction of labour information

Doctor/midwife signature

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