*So basically, I want to ask you some questions about outpatient induction of labour if that’s OK. Erm, let’s start off really general. Could you just tell me, erm.. about your experiences.. what usually happens when you, erm.. admit a lady who you think might be eligible for outpatient induction?*

Erm, so I would automatically give them, erm.. the general induction sheet, erm.. just so just they get a full picture of what the options are. And then, I then give them a verbal discussion and explanation that, erm.. they may be eligible for outpatient induction, erm.. and give them the information. So, we do have the leaflet that’s got.. that comprises all the methods. And there’s a separate one, an outpatient induction one as well.. so I generally give them that one.. that one also. Erm.. and then I let them have a little discussion on their own, so that they can.. you know, don’t feel under pressure. And then ask them whether, you know, if they’ve got any questions to come back. So that’s the general discussion around that.

*OK, OK, so is it fair to say that it’s.. it’s new to the women when they arrive, that they haven’t heard of it before? Or do you think some of them have had a discussion with their own midwives?*

Some of them have, erm.. I think generally now they all know about [the pessary], erm.. as a method but.. some of them don’t know that they can go home with it.

*Yeah***.**

Some of them come and feel that, you know, they’re coming in, and.. that they will stay in. And the end process would be, the next time they go home will be with their baby.

*OK so what happens next after they’ve had a discussion with their partner?*

Right, so then, erm.. obviously.. you do observations. Well, I’ll have done those before actually. But, observations, CTG, erm.. and just make sure everything is completely low risk. So, erm.. occasionally.. well, I’ll talk about that later. But generally speaking, you just do your baseline examination and observations and, erm.. make sure that they’re all within normal parameters. And CTG normal.

*OK, so you’ve got to the point where everything’s OK and you’ve administered the [pessary] and they’ve had another CTG. Can you tell me what happens after that?*

So personally, after they’ve had the CTG, I wouldn’t send them home straight away, so I’d just want to see, once.. I like to keep them for an hour, or.. at least an hour or two because, erm.. I like to see just what the, how the absorption rate is going. So, I let them have a wander, usually send them off for a cup of coffee at the [main hospital site]. And then, erm.. obviously with instructions if anything.. they get, anything like bleeding, excessive pain etcetera then to come straight back. But I let them have a little wander for a couple of hours. Erm.. then they come back, we have a bit.. another discussion, see if there’s anything going on. Erm.. at that point I might have another listen in, just to make sure everything is fine.

*Yeah.*

And if everything’s fine and there’s not.. any.. uterine activity then I would send them home.

*Erm.. that’s fine. So what’s led you to adopt that practice, erm.. to let them stay at the hospital for a couple of hours?*

Becau.. the reason I personally do, is because I’ve had a few ladies with [the pessary] who’ve hyperstimulated. So I, erm.. and I’ve sort.. I have thought about it, and although we have a standard, that x number of milligrams is released every hour, erm.. do we know that for sure? And I err.. I like to err on the side of caution with my practice so that’s why I make sure that, erm.. they’re not hyperstimulating before I send them home.

*OK. So once they go home, you.. what sort of information are you giving them as they go out the door?*

So just generally to, erm.. keep an eye on movements and, erm.. that they would need to contact us if, erm.. the membranes go. Or they feel that they’re getting contractions frequently, so any more… I would tell them to come back in if they’re contracting two in ten. Erm.. if there’s any bleeding. All the obvious ones. Erm.. er.. or any concerns basically. So that would be the advice I give them but generally to carry on as normal. Erm.. if the [pessary] comes out, as long as, you know, it’s not contaminated then they could just slip it back in again. If it has come out or they’ve lost it then, erm.. to come in. That sort of ↑thing.

*OK so what’s your contact with the women after they’ve gone home?*

So after they’ve gone home, then we phone [the telephone triage] and just explain we’ve sent somebody home with, erm.. [the pessary] in situ. And then, erm.. I would.. I usually say to the lady give [the telephone triage] a ring round about.. it depends on what time the [pessary] has gone in, so if it’s later on in the day I’d probably say ten-ish, if it’s early then I’d say eight o’clock just to update them so that they’ve got an idea what’s happening, and then they can give further advice to the woman. Erm.. or if they’ve got concerns then to phone [the telephone triage]. But it’s mainly [the telephone triage], erm.. that would be the point of contact.

*Sure. And when they come, what would your interaction be with them if.. if you were working.. on the Labour Ward the next day?*

Oh, so that’s after the twenty-four hours. So, erm.. obviously you’d get the history, you do another admission.. so baseline observations, urine, abdo palpation, CTG, erm.. and then you would assess them. Erm.. and if it was over twenty-four hours you would remove the [pessary], and see what state of the cervix is like. If the cervix is not.. erm.. very favourable then you would give them a prostin. If it’s favourable then you would ARM them.

*So you talked about working out if they were low risk or not. What.. what would concern you when you do your risk assessment initially?*

Anything that is not.. bog standard normal. So I wouldn’t send them home with a [pessary] in if there were concerns about movements, erm.. growth, if.. if.. erm.. if there were concerns maternal with blood pressure. So anything that falls out of the remit of normality, I would not be sending them home. Or if I thought that the CTG was not meeting the criteria, I wouldn’t send them home. And if.. if they had more uterine.. if they had uterine activity very quickly following the insertion, I wouldn’t send them home.

*Erm.. so you, you sound, erm.. you’re doing a thorough risk assessment. Are these women all eligible to, erm.. go to a birth centre environment? Erm.. or…*

I think if.. if it’s bog standard normal, erm.. they probably are. Erm.. however, it depends on whether we’ve got them into labour or not. So, it’s all very well having the [pessary] in for twenty-four hours but if when they come back, they might need ongoing methods to get them into labour, so, you know, if they’ve gone into labour, for example with the [pessary] in, and came in within that twenty-four hour period in labour and they were low risk, I think they ↑are allowed to go to the birth centre.

*Does that happen very often do you think?*

[Shakes head] Seldom I would say.

*Seldom. OK. So, erm.. you’ve talked a little bit about how you do your risk assessment. In terms of, erm.. the cervix, the cervix and the changes, can you tell me a bit about what makes you think, er.. consider breaking someone’s waters over giving them prostin over giving them [a pessary]. Those.. those sorts of decisions and.. and uterine activity in the background of that I suppose.*

OK. So.. erm.. I feel it’s very important the process as normal as possible, because, you know, if a cervix is one centimetre open you can ARM it, but it’s whether it’s in that woman’s best interests and often if it’s unfavourable with length then, erm.. it isn’t, I don’t think. So I would take into account the length of the cervix, the dilatation, so anything under two centimetres dilated, and two centi.. and if it’s long as well, I would want to give some hormone like a prostaglandin for.. for those. This is with no uterine activity. Erm.. if I’ve got a fully effaced cervix or a very thin cervix and it is two centimetres, I would do an ARM.

*OK and, erm.. in terms of eligibility where the women live and, erm.. perhaps social considerations. What.. what sort of things do you take into.. into the equation when you’re working out, perhaps the distance they.. they have to travel or.. their social background?*

Erm.. well, the distance because most of the catchment area is fairly close, I have to say, it’s not primarily on my radar. Erm.. if they were out in the sticks somewhere, you know, in the [rural area] and they were a multip and they’ve got a history of.. you know, frequent labours then obviously I would be a bit more, erm.. that.. that I would take into consideration. Erm.. or if there was issues with transport and stuff like that, I would take that into consideration. But if they were a [city] lady, you know, it’s not going to take.. a long time to get in to the hospital. So it’s not really a big problem. Socially.. erm.. I would take into consideration, erm.. you know, like we had for example, we had someone I, erm.. induced in the last month who.. the husband was starting chemo..

*Oh right, ok…*

for [a type of] cancer the next week so obviously I, you know, you take all of that into consideration. And occasionally you have mums who’s got other children in the [main hospital site], not often, but that sort of thing I would, erm.. it does.. it does factor in.

*Sure, sure.*

Because actually some women are induced for social reasons aren’t they?

*Of course. So in your opinion, why do you think we don’t offer outpatient induction very frequently?*

I think it is because fear of the unknown. Because I think historically, we’ve not done it. I think the reason you’re not getting good numbers is your criteria is too limited. So your.. the criteria is term plus, postdates, low risk, primip. Erm.. so.. just that group is gonna reduce the numbers that can fall into it. And then you factor in, you know, like the trace may be, erm.. not being great or reassuring should I say. Or.. they haven’t felt the baby move. And then you’re going to knock off a few of those. Erm.. so that’s one issue is that your criteria group, your inclusion group. The other is the midwives aren’t used to doing it. And because.. well you could actually, you know, they don’t actually get to go in and do inductions very often because we’ve got a dedicated team although we do have it, it’s not covered every day of the week, but we tend to put senior midwives in, in there because, simply because of the decision making. Erm.. but I think they get a bit anxious, if they’re giving something.. so it’s kind of defensive I think.

*What are they anxious about, you said about the unknown?*

Well I think it is the unknown isn’t it? And also you’re sending somebody off, you’ve put, erm.. you’ve put in.. a drug which is.. is still acting. So it’s, you know… And you’ve got no control over what’s going on. Whereas, you know, at least if they are an inpatient, you know, if you’ve got concerns you can speak to the lady, or you know, you’ve got more of a dialogue going on with the woman. So you’ve got more of a feel of what’s happening. Whereas send the woman off home and, you know, basically she’s gone.. off your radar. So, I think they get anxious about that. And because they’ve not had much exposure to it.. to it. So I think that’s the problem. And there’s bad publicity about prostin, er.. [the pessary], sorry.

*Erm.. do you.. do you want to tell me a bit more about that?*

When I say bad publicity.. Erm.. there is at least one hospital in the region that has withdrawn it because of hyperstimulation. And, erm.. we have, since we’ve started using it, we’ve had some cases of hyperstimulation so.. those midwives are a little bit reticent now in using it. So I think, erm.. I think that’s.. that’s what’s.. fuelled it a bit.

*What do you think the woman think?*

I don’t think they know anything about erm…

*Just about their experience?*

Oh, their experience? Well…

*In your experience what do they come back and tell you?*

Well some of them, they’ve gone off and they’ve come back and they’ve had nice normal deliveries, erm.. in fact one of our midwives did, didn’t she? So, I think if it works, they’re very happy with it. Some women who don’t particularly want to be induced like the idea because it gives them another twenty-four hours and maybe a bit of a kickstart, so they.. they like it. But, erm.. you often.. don’t get the.. if you’re the one doing the induction and doing it, you often don’t get, because you’re not there the next day, you don’t get the feedback, the story on how it was, if it worked. I haven’t heard any of them complain about it.

*No, no, OK. Erm.. how does it affect your workload? Erm.. is it a good thing or does it make things more difficult?*

Well I think because, are we talking outpatient? Erm... I don’t think you’ve got the numbers to really.. I don’t think it really.. affects the workload because we haven’t got big numbers. Erm.. I think if you had…

*Is it more hassle than a.. sort of.. a prostin and staying in?*

No, because.. I don’t think it.. I think.. I don’t think it is because if you’re going to send them home then you haven’t really got them.. there, have you, to, erm.. be doing observations and CTGs on, so effectively it would be reduced workload.. on the day that you’re giving it. But if it hadn’t worked and they arrived.. the next day then you’ve got an extra one added on to your list haven’t you? So, swings and roundabouts.

*I was just going to say swings and roundabouts.*

But, erm.. I don’t think we’ve got the numbers for it to.. affect it at the moment.

*Ok, is there anything else that’s burning in your mind that you’d like to tell me about, about outpatient induction that you think’s important to.. know?*

I think, erm.. maybe it needs promoting more, because.. and some of the, erm.. because I think that because where it’s not done very frequently, it’s an unusual thing to happen as opposed to run of the mill and on our radar, so I think to.. prom.. I think I think it probably would be worth promoting it.

*For the midwives or the women?*

With the midwives. Midwives. Er… both. So both. I mean.. in fact both would be important because if you promoted it to the women and the women requested it then the midwives would, erm.. be more likely to do it, wouldn’t they?

*Yeah*.

So I think a bit of maybe.. ↑ [communication of the week].

*Yeah.*

To promote it a bit.

Yeah. Oh right, well, that’s been really, really helpful. Thank you.