*Right. So, how often would you say do you work in the induction room?*

Erm.. usually at least once a week.

*Ok*.

Erm.. more.. I go through phases. Sometimes I feel like I’m in it all the time. And then other times I might, like, have a couple of weeks when I’m not in it at all. But on average, sort of once or twice a week.

*Does it appear on your roster, like it’s been rostered to do it.*

Yeah. And they’ve now started doing the inductions overnight as well, so I’ve been rostered to a few on my night shifts.

*Oh, ok. So it’s pretty fair to say you’re, are you part of the induction team, or..*

No.. erm.. it’s.. at the moment, they only really have two people on the induction team, erm.. and they don’t do full-time hours, so, erm.. we’re sort of being picked up. Talk.. on speaking to [roster creator] erm.. who does the roster, she says, erm.. I think [the matron] has allocated a few midwives that she’d be happy to work in the induction room on a regular basis, erm.. so you’ve got to be a minimum of a band six.

*Ok. So experienced, erm.. you’ve been working there for a while. Ok, fine that’s perfect. So, erm.. in terms of, you know, women having outpatient induction of labour, have you come across many recently?*

Not recently.

*Yeah*.

When we first started the trial of it, erm.. I would have a few people come through and they’d go home, and then the reduced fetal movements guideline came in and that was all a bit.. difficult to interpret, erm.. so then I think on discussion with a lot of the doctors when I had questions, they’d say, ‘keep them in.’ So, at that point, I took that as if they had any episodes of reduced fetal movements at term, then they’d need to be an inpatient, especially if their induction was for reduced fetal movements.

*Sure. That makes sense. So, erm.. alright so just going back then to when it was a bit more popular let’s say, can you tell me.. just talk me through the process. So someone would arrive.. how would you assess them?*

So when they come in, we’d talk them through the induction process, erm.. and explain what the options were, erm.. because we score, erm.. Bishop score on the cervix, so if they weren’t eligible for a [pessary], if they were going to go for an ARM instead, then I would talk through that bit in case.. ‘cos some women came in expecting to have a [pessary] and in the time that they’d had a sweep with their midwife to then coming in, if they were two or three centimetres dilated, then they wouldn’t be eligible for it anyway. So we’d discuss all the options, do a set of observations to make sure they were all ok before we start, erm.. do a thirty minute CTG and then do an internal examination and, erm.. assess their cervix. If they’re appropriate for a [pessary] then, erm.. I’d insert that, have a one hour post-[pessary] CTG and then, erm.. if within that hour I would then phone [telephone triage], erm.. to let them know that they’re going to go home, so expect them to give them a phone call in the evening, usually about nine o’clock. Then, erm.. I would then document and, erm.. come back to them with all of the information about, erm.. care with the [pessary] that was in.. like, explain it’s a little tail that sits very similar to a tampon, erm.. and if it comes out then they should phone up and come back in again for reinsertion, erm.. yeah.

*Yeah. So probably the women are there for a couple of hours.*

Yeah, yeah. By the time that we’ve done their thirty minute CTG beforehand, their one hour post, erm.. and those discussions. Yeah, a couple of hours.

*Yeah. You talked about reduced fetal movements as being one reason why it may not be recommended to have outpatient induction. Looking back, can you think of any situations when you’ve had other women who perhaps it was a bit uncertain about whether they were eligible or not. What sort of things are you looking for in terms of eligibility?*

Erm.. oh, I remember a woman wanting a [pessary] and on her admission CTG she had a few decels, so if she was already deceling we weren’t going to put a [pessary] in and send her home. Erm.. I’m just trying to think of some others.. erm.. Sometimes if they come in and they’ve got raised blood pressures as well, erm.. if.. sometimes it’s just anxiety, so it’s not uncommon, erm.. so we just make sure we repeat them, but if they’re consistently high then we’d start.. start doing like bloods and urines and bits. Erm.. or if.. the thing is if they’re.. they’ve got, usually if they’ve had anything that makes them no longer low risk, that’ll be an exclusion criteria for the [pessary]. That was the original..

*Yeah, some kind of underlying medical problem, or..*

Erm.. yes. So do you mean previously or what it is now.

*Previously to start with.*

Yeah, so at the time, they had to be low risk primips, erm.. at term plus ten to term plus twelve. Sometimes women would come in a term plus thirteen just because there wasn’t any dates available on the term plus twelve, and because that was outside our criteria, we then couldn’t give it to them. Or when you recalculate someone’s dates, because it’s just been miscalculated throughout the entire pregnancy, they’re actually at term plus nine and they come for their term plus twelve induction and nobody’s picked up on that. They’ve gone.. they haven’t recalculated the scan, they’ve just gone by the LMP, then sometimes we do that as well.

*OK, so on the day, it would be new things like blood pressure or decels or.. and I suppose you’re looking back through admissions to day unit and stuff like that as well?*

Yes.

*So doing quite a thorough risk assessment. Yeah, ok. Erm.. you.. in terms of the women, what kind of situations do they decline outpatient induction? They might be eligible, but why.. why would they decline?*

Erm.. some people like the reassurance of just being in hospital. Erm.. but I mean.. that’s the only reason.. I think I’ve only had one that’s been eligible for an outpatient but they decided to stay in because they wanted closer monitoring, they wanted regular CTGs.

*Yeah. So, anxiety, or something like that?*

Yeah, yeah, absolutely. Yeah.

Fair enough. Alright. Erm.. from your point of view, when you sort of wave them off out the door, you know, do you have any concerns, what are you hoping will happen?

Erm.. so we always say to them, erm.. any episodes of reduced movements, any APH, not just a blood-stained show, erm.. any.. if their waters break, or they start contracting regularly, then to give us a call, and we’d invite them back in again. Erm.. and, erm.. I think at the time.. I don’t know.. it.. I think they said.. if they feel like, erm.. also if they go to the toilet, to make sure that they pat dry rather than wipe, because a few have wiped and.. a little bit too vigorously and, erm.. pulled the actual [pessary] out.

*Right*.

Erm.. so we say if they feel like it’s actually been dislodged, we’d tell them where to replace it, so long as it hasn’t actually left their body. If it’s left their body, then to give us a call and come back in again.

*Sure, sure, that’s fine. Erm.. is distance, where they live an issue?*

Erm.. we’d always make sure women were happy to go home and, erm.. if they didn’t feel like they could make it back in a timely manner then sometimes they.. we always give them the option to stay. Erm.. but we wouldn’t necessarily say, ‘oh you live x amount of miles away, you can’t have it.’

*So it’s more an individual decision would you say?*

Yeah, yeah, so long as they.. because, the thing is, if they phone up and say, ‘oh, my waters have broken,’ or ‘oh, I’m contracting regularly,’ if they’re not going to get in for the next hour, the person at the end of the phone on [telephone triage] can always say ‘well, you’ve got the string, just take the [pessary] out.’ Because that’s all we would do. Obviously we’d then monitor them and bits like that if they were in hospital, but the first step would be to take the [pessary] out, which because it’s got a handy string, it’s a pretty easy thing for the woman to do.

*That’s good. And in terms of the other stuff you’re doing in the induction room, how does having [the pessary] impact on that? Does it impact on your other workload in the induction area?*

It actually makes our lives a lot easier.

*Tell me a little bit more about that*.

Because women.. if they go for an outpatient or inpatient [pessary] induction, they’re, like you said, they’re only with us for a couple of hours, and then they transfer either home or upstairs to the antenatal ward. Whereas women with prostin, we then do their mid-points [CTG] and regular obs and, erm.. and things like that throughout the day. So they’re still under our care within the induction room, whereas women who’ve had the outpatient [pessary] they’re at home. We’re still at aware of them and we make a note on our Labour Ward board that they’re at home and we anticipate a call from them at some point potentially.. erm.. for them to come back in again, so the Labour Ward coordinator’s aware as well as [the telephone triage]. Erm.. so they are on people’s radar, but where they’re not physically in the building, it’s one less patient that we’ve got to manage, almost.

*Yeah, ok. So you said it’s not happening as much and you think it’s.. some of it’s due to perhaps the reduced fetal movements guideline. Is there any other reason why this isn’t happening?*

Erm.. a lot of the reasons. ↑Do you know what? Recently, we haven’t had a lot of post.. in my experience on the days I’ve been doing them, we haven’t had a lot of post-dates inductions, erm.. I’ve given [the pessary], I gave two [pessaries] yesterday, erm.. but for inpatient inductions. One was thirty-six and four [weeks of gestation] and in, erm.. being induced for IUGR and a non-reassuring CPR MoM and the other one was.. a.. what was she.. type two diabetic, erm.. and a VBAC. So they wouldn’t be eligible to go home. So we still give [the pessary], erm.. just most of them remain as inpatients, just because of their co-morbidities.

*Yeah, but there’s fewer post-dates primips.*

Yeah.

*Getting to the end of their pregnancy in that way.*

Yeah, yeah. Or they come in and they’ve got a Bishop score of five. Because our Bishop score.. how we do it is, erm.. [the pessary] is nought to four and prostin is a four to six, whereas there’s that overlap of a four, erm.. unless.. it depends how they’ve got their Bishop score. If it’s just a little bit of a length, but then everything else is in.. is quite favourable with their cervix, then erm.. I would probably opt to go more with the prostin, rather than the [pessary], because it’s just a case of shortening that cervix. So if for example they’re two centimetres dilated but just long, I would probably then opt for a prostin, just because if it’s just a case of shortening their cervix, it’s not like it’s having to.. move their cervix from a posterior to a central position and get it to efface and then dilate. If that was the case, I would go with the [pessary]. But where there is that overlap, it’s quite difficult because there’s a clear.. six is prostin, seven is ARM. Where there’s that overlap of the four, a Bishop score of four.. that’s left down to just clinical judgement.

*Sure*.

I know a lot of wo.. a lot of midwives have had a few bad experiences with [the pessary]. Erm..

*Yeah? Tell me a bit more about that.*

Erm.. it’s mostly just women, erm.. decelerating, erm.. having decels on their CTGs usually at their mid-points, erm.. a little bit later on in the day.

*So these are high-risk women having [the pessary] as an inpatient?*

I’m not too aware of their circumstances because I haven’t had any bad experiences with [the pessary]. It’s just there’s a bit of a rumour going around. Not a rumour because it is true, like, women.. who.. some midwives who have given [the pessary], the women have had cat one sections from the antenatal ward. So they’re quite cautious of it, and it’s just in professional conversations that you have around inductions that those stories are mentioned. Erm.. so I’m quite willing to give [the pessary]. I know other midwives are a bit more cautious.

*Sure, sure. No that’s really good. I was thinking of a question then and it’s gone. Erm.. it was something about.. oh yeah, so you’ve got a woman, she would be eligible, her cervix is in that sort of, oh actually, probably prostin’s better. If you’ve already spoken to her about potentially going home, what’s the kind of reaction that you get?*

Erm.. most women are very happy. I’ve had one, that has been quite upset, and where she was a Bishop score of four.. I always give women the option as well. I say, you’re in the inbetween, you can have the [pessary] and the twenty-four hour or the prostin and this re-examine in six hours, and ninety-five per cent of the time they will say prostin.

*OK. Why do you think that is?*

I think women don’t.. aren’t counselled properly about induction in the antenatal process. The amount of expectations I have to.. manage is quite tricky because women come in, they still come in thinking they’re going to come in for their induction and have their baby in the afternoon. And it’s not until you explain that it’s.. it might take a couple of days and it’s very normal, like, it’s a long day, you might have a few pains and niggles throughout the day, so it might be that you’re not perfectly comfortable for the entire day, and that’s quite a reality check for them. They don’t, don’t realise that when they.. they walk in for their induction. Even though they’ve read leaflets on it, I still insist on explaining about the induction process, just because.. they’re.. I don’t think they take in the information and I don’t think the leaflet is.. a realistic overview of what to expect for an induction.

*What should we be saying to women?*

I think maybe explaining a little bit about it’s a slow ↑process. I usually explain that we’re trying to cram in weeks of body preparation into a few hours, so it’s going to be uncomfortable, your body’s going through lots of changes within that time. And it’s not.. it’s weeks-worth, it’s not going to happen all of a sudden, it’s going to take a little bit of time to get your body up to the point where it’s ready for labour. Erm.. so I think.. it says all the very factual stuff about inductions and the process of inductions as in prostin and [the pessary] and ARM and how they work, but it doesn’t tell them about what they’re going to experience. Like.. as in it’s not a quick process, erm.. they’re most likely going to be uncomfortable, sometimes women hyperstimulate on the prostins so they’re contracting and we can only manage their pain to a certain point. We can manage with, like, dihydrocodeine, oramorph, paracetamol, but then when women want gas and air and we say, ‘fair enough you’re having a few niggles, it’s not labour pains and we can’t give you Entonox.’ That’s when they start to lose it a little bit.

*And then what do you do?*

It’s just a case of being there to support them. If you’ve given them.. if you’ve maxed out all the pain relief that you can give them, it’s just sort of a case of explaining this is normal, these pains might settle down, especially if they’re having the pains and their cervix is still.. we’re still unable to ARM. It’s just about, sort of sitting there and just talking them through it, erm.. and just.. they tend to calm down then but it’s.. because I don’t think they’re mentally prepared for that, it’s all quite traumatising for them. So, erm..

*How would that process look different if they were at home do you think? Do they talk to you about it if they come back the next day, did they talk to you in the past?*

It depends. If they come back.. following the post-twenty-four hour prostin, erm.. [pessary] insertion, it’s usually because the [pessary] hasn’t worked. They’ve slept all night.

*So they haven’t had all those things?*

Yeah, yeah. Erm.. but I’ve had a few come back in at five centimetres in labour overnight once I’ve gone home, erm.. but because then I’m.. usually by the time that I come in, I’ve got another labourer to look after, or I’m back on inductions and I’ve got another six to do that day, I don’t have time to go back in and chat to the women.

*About what their experiences were.*

Yeah. As much as I would love to and say ‘oh congratulations, how are you doing?’ Like, that thirty seconds I don’t have most of the time, just because the workload is so big that you are just running around focussed on what you’re doing. And then usually, by the time you get to the stage where you can go in and say congratulations, they’ve been transferred to the postnatal ward.

*So the opportunity’s gone.*

Yeah.

*No, that’s fair. So, there’s quite a lot of decision-making around that cervix and how ripe it is from what you’ve described. Erm.. so they come in perhaps with the expectation that they might have outpatient induction.. do people ever arrive and they’re like.. don’t know anything about it?*

Yes. Mostly when, erm.. it’s going to sound like I’m doctor bashing but I’m really not. Mostly when women have come in the night before, erm.. for.. some reason and the doctor’s said, ‘well, we’ll book you for an induction at the next available slot and that happens to be tomorrow. Here’s a leaflet, go home, we’ll see you in the morning.’ They don’t explain anything, and people aren’t always good at reading leaflets and sometimes they come in and go, ‘oh OK, I didn’t.. oh, OK.’ I had a woman before not realising VEs were part of the induction process, so she had to wrap her head around that before we could continue with the induction process. So, erm.. mostly women come in with the.. if women have had inductions before, they’re more prepared, erm.. but if it this is primip inductions, erm.. or multip inductions that laboured spontaneously previously, erm.. they’re usually quite happy to go along with it, but, like I say, because I don’t know what’s been said to them antenatally, I don’t just assume that they know. I talk through everything again. Because, sometimes.. sometimes, they just don’t have a clue what to expect. Or they have a vague idea based on what their friends have said, but of course that’s just their friend’s personal experience, it’s not the overall experience of an induction.

*So if they haven’t had a lot of information antenatally, or have had a bit of discussion but haven’t taken it in, potentially they could arrive and you would say you’re eligible for outpatient induction and that would be news to them.*

Yeah, yeah. Usually quite happy ↑news.

*So they’re alright about it on the whole?*

Yeah, yeah, yeah. Mostly they say, ‘Oh OK, I didn’t realise I could go home, oh brilliant.’ Erm.. so I think.. yeah, like I say, it’s only been, like, a few that have either not wanted to go home, or haven’t been eligible to go home. Erm..

*What happens if they’re desperate to go home and you.. you’re a bit worried about it? What would you do?*

Erm.. I would always.. I would explain my concerns to them. Usually that’s enough to dissuade them from going home. But if they are quite insistent, then erm.. I would just get a doctor to come and have a chat with them as well, just so that we’ve covered all bases. Erm.. but most women, if you explain your concerns and they’re valid concerns, women want the best for their baby and they’re not going to risk their baby’s health and, erm.. so most women are quite amenable, if you.. like, to your recommendations.

*OK. Erm.. I think that’s about it really. Erm.. have you got anything that you want to tell me about outpatient induction?*

↑Erm.. No, I think it’s just.. it’s one of those things that.. it’s such a small criteria, that very few women fit ↑it. Erm.. and, like I say, I haven’t had a bad experience with an outpatient induction. Some of them don’t work, some of them come back in labour. It’s all down to the woman, but.. like I say, I think people’s views are clouded by other midwives’ experience, erm.. and are a lot more cautious, because I’ve come in on a nightshift and certain midwives have been on and women have had a [pessary] in the morning and they’re still on a CTG in the evening in the induction suite and you sort of think.. These wouldn’t be outpatient, they’d be inpatient but I think women are.. midwives are.. some midwives are certainly much more cautious about it because of a few adverse outcomes.

*Yeah, OK. And you said about the criteria being very small. Do you see any areas where it could be broadened a little bit? Or do you think it.. it’s about right?*

I think it’s.. it’s still a relatively new.. thing that’s happening in the [hospital] so I don’t think we have.. enough.. evidence to say.. like I say, it all depends on how women react to it, and sometimes it’s not within the first hour which is what we have them on the CTG for, sometimes it’s a little bit later on that we have.. that we’ve put them on mid-points for. And I’m always cautious, like I know for low-risk, erm.. prostin inductions you don’t need to do a mid-point but I always do because that’s when I pick up the decels. And then of course they’re on it for ages and [laughter].. But I am just.. I don’t know, I don’t feel that I’d want to risk not doing a CTG on somebody for a mid-point, erm.. so if they’re completely low-risk.. if I was myself pregnant and post-dates I would opt for a.. an outpatient one, personally. But.. I am very low risk.

*Yeah*.

Women who aren’t.. it.. I see why it’s not ↑appropriate. Erm.. but I can’t see why they.. struggling to find my words now.. [laughter] I think at the moment, I think it’s ok the amount.. like, the criteria. I think..

*So something around reduced fetal movements you said. So if someone had reduced fetal movements, I don’t know, at 32 weeks.*

Oh no, I wouldn’t count that. Erm.. it would only be sort of within the last couple of weeks at term and how many episodes it would be. I.. I mean.. it’s one of the things that really grates on me and I’m really passionate about.. is.. doctors need to stop booking inductions for reduced movements.. for one episode of reduced movements at term. That’s not what our guideline says, erm.. and we’re setting our women up to fail. That’s something that I think.. and I’ve spoken to quite a few doctors about it.. and they go, ‘oh yeah, well I mean I am guilty of that but.. it’s better that than a stillbirth.’ But you sort of think it’s one episode, follow our guideline, do a scan, like.. it’s.. I think it’s, what.. two episodes and a scan or three episodes and a ↑scan I think it’s supposed to be?

*Yeah, two and a scan.*

Yeah, but they’re not following it.

*I think there’s some.. reduced movements at term.. it’s a discussion with the woman isn’t it? And they should weigh up the pros and cons, they should have all that explained to them about induction versus waiting.*

Yeah, but my issue is often.. usually by the end of their day unit assessment their baby is moving fine, their CTG’s met criteria and they’re still offered an induction.

*Yeah*.

And then when they come in for their induction the next day, we can’t trace their baby because it’s moving so much. And they’re the ones that really frustrate me because then I’m having to hold on a CTG, and then, almost neglect the rest of my women, who are there for valid reasons, to hold on a woman who really doesn’t need to be induced because her baby is fine [laughter].

*Yeah, it’s really difficult isn’t it?*

Yeah. Some doctors are fantastic. But I’d probably say, the majority of them.. aren’t with booking inductions.

*What is that about?*

They.. I think.. I don’t know what kind of teaching they have or what.. but they’re so concerned about stillbirth that they don’t.. I don’t know. I think it’s the stillbirth risk.

*Anxiety, fear.*

That they don’t want to be responsible because they’ve sent a woman home who came in with reduced movements. Erm.. which is perfectly.. within their right, it’s their professional, like, judgement. Erm.. but it’s just.. I feel like we’re letting women down because we’re putting them through a process where.. they might not want. I’ve had a few women come in, who have come in for an induction because of reduced movements and they don’t want an induction, but they feel like they’ve been bullied into ↑it and fear-mongered into it because they’ve been told their baby might die. Not in those terms, but in a roundabout way. Erm.. so that’s one of the things I would really like more.. research on. I know it’s not outpatient induction, but it..

*It impacts it.*

It really does. And we wonder why our induction rates are so high and it’s because the majority of the time, we’re inducing women that don’t need it. That’s my personal opinion.

*Yeah, yeah, I would agree. Lots of women having induction for reduced movements. I think it’s overtaken all the other reasons. So it.. it used to be postdates was the biggest group, then, erm.. pre-labour rupture of membranes, but now it’s reduced.. reduced movements I think at the top*.

And women aren’t stupid. They know how to get an induction if they want it. So it makes you question how realistic their.. what they’re saying is. Are they just coming in to say, ‘oh, I’ve got reduced movements,’ because they want induction but actually their baby’s moving fine. When they come in and their baby’s moving so much you can’t trace them.

*It’s difficult isn’t it? It’s really difficult.*

Yeah.

*Brilliant. That’s been really good thank you*.