

WOMEN'S HEALTH AND PAEDIATRICS
MATERNITY UNIT

Induction of Labour Guideline

Amendments			
Version	Date	Comments	Approved by
5	5/7/22	Merging induction of labour and outpatient induction guidelines, review of whole document to in line with NICE IOL guidance Nov 2021	
6	December 2022	Updated to include biomechanics information	Perinatal Guidelines Group

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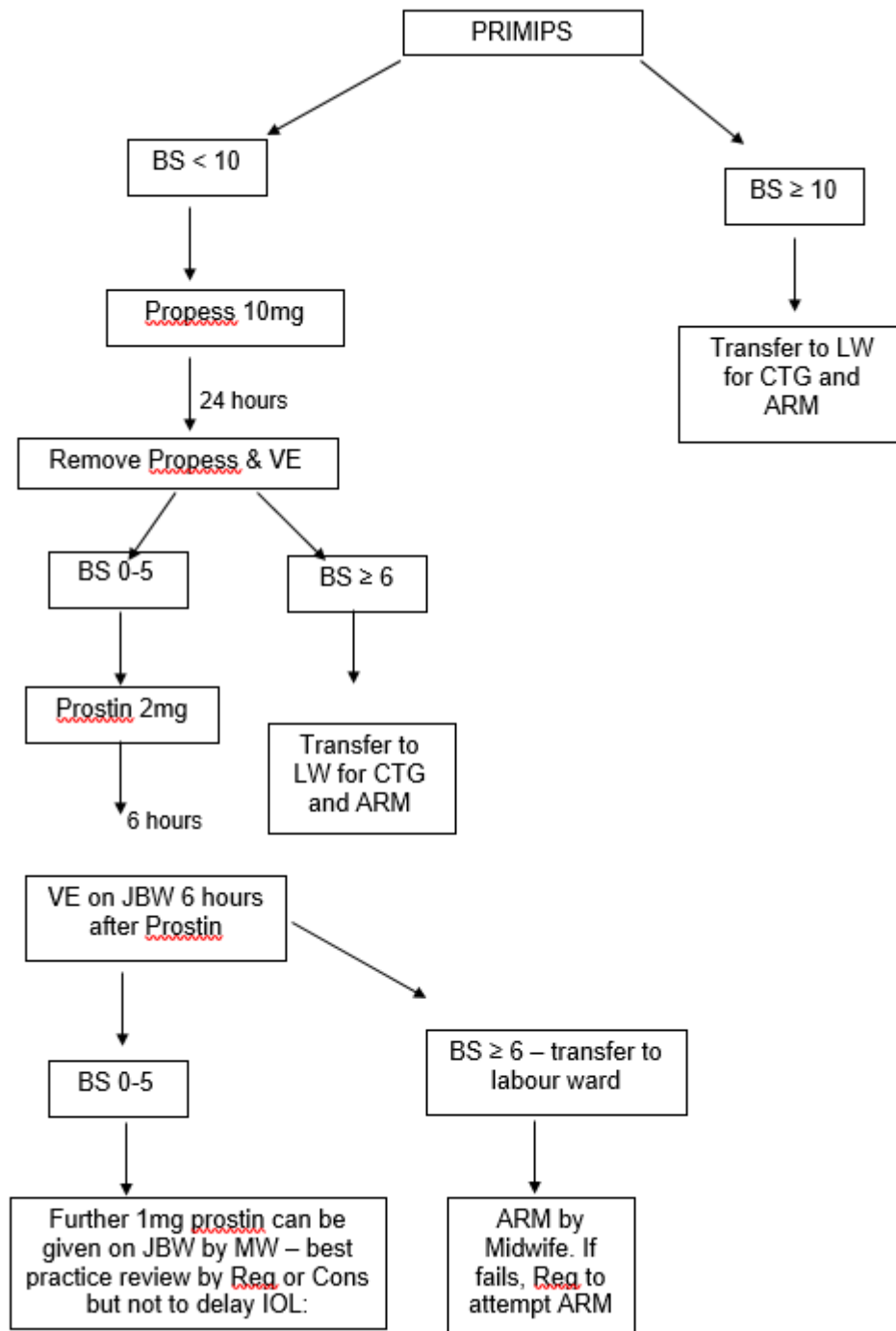
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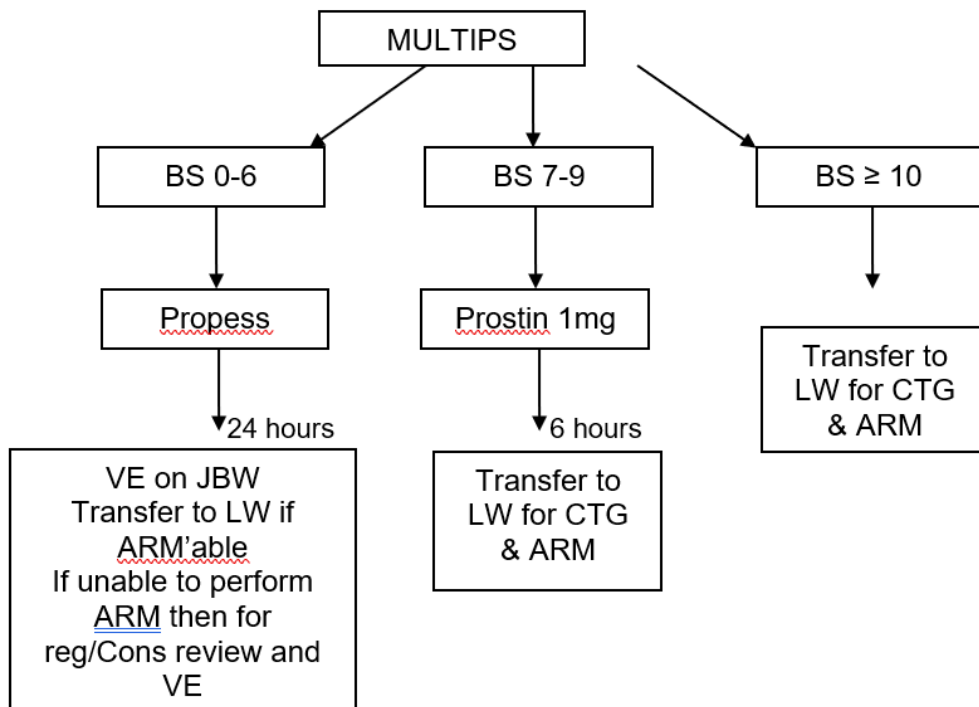
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IOL in Primips flow chart

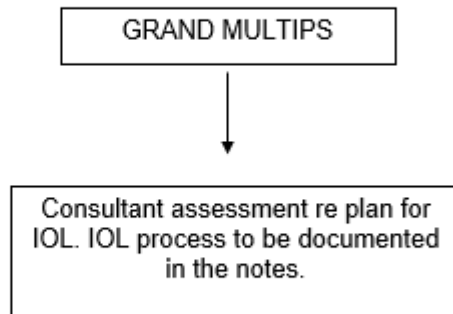


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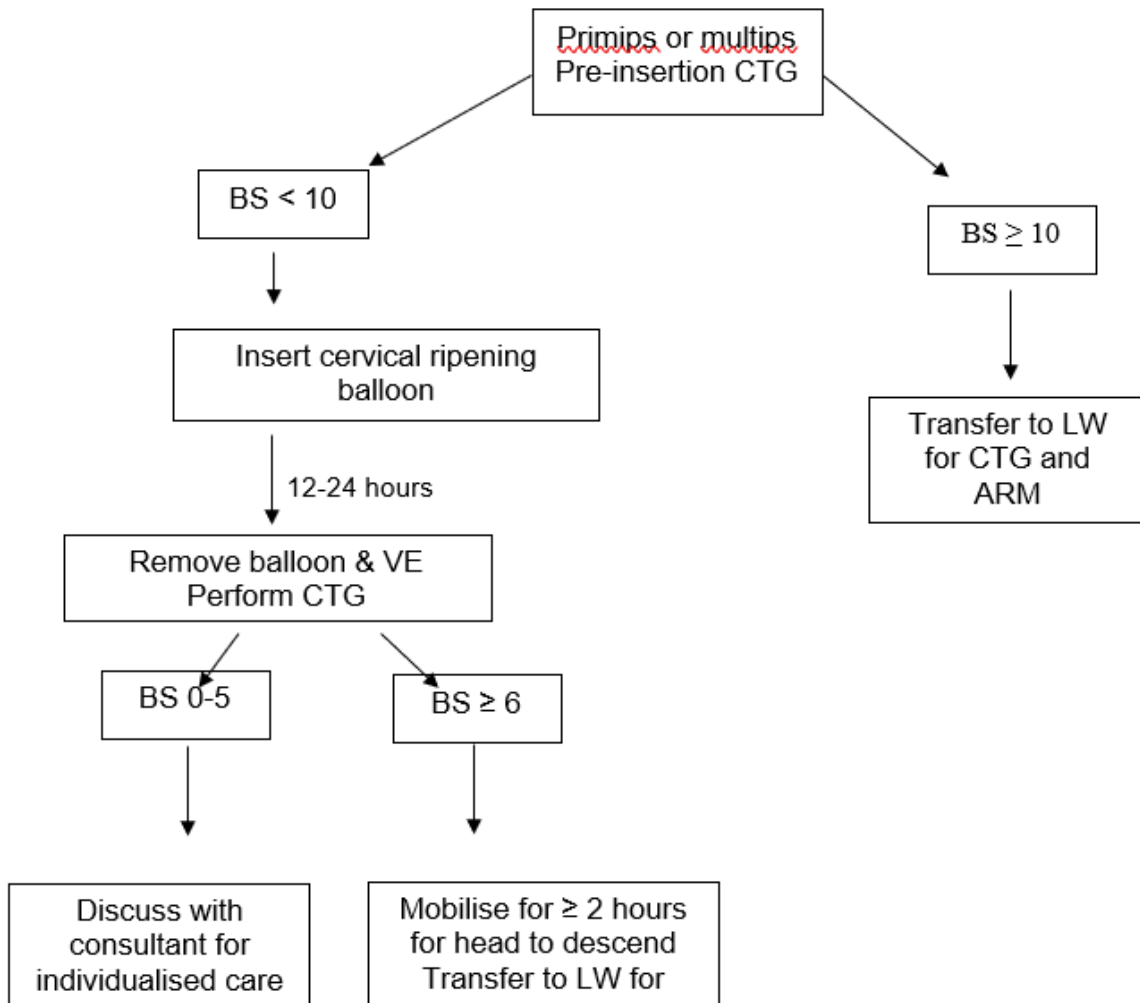
IOL in Multips flow chart



IOL in Grand Multips



Flow chart for IOL with cervical ripening balloon (e.g. CCRB)



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Table 1 - Modified Bishops Score (BS)

Modified Bishops Score (BS):				
	0	1	2	3
Dilatation (cm)	<1cm	1-2cm	2-4cm	>4cm
Length of cervix (cm)	>4cm	2-4cm	1-2cm	<1cm
Station of presenting part	-3	-2	-1/0	+1/+2
Consistency	Firm	Average	Soft	-
Position of cervix	Posterior	Mid/anterior	-	-

Induction of Labour

Induction of labour (IOL) is a relatively common procedure with approximately 30-35% of deliveries in the UK being induced.

This guideline includes both inpatient and outpatient IOL

Women should be informed that most women will go into labour spontaneously by 42 weeks.

Women with uncomplicated pregnancies should be offered induction of labour (IOL) at 41 weeks gestation in line with NICE guidance – please see [Appendix 2](#) for the rationale from the NICE guidance around offering IOL at 41 weeks.

The discussion regarding IOL at 41 weeks and prolongation of the pregnancy past this point must include the increased likelihood of caesarean birth, increased likelihood of the baby needing admission to a neonatal intensive care unit and increased likelihood of stillbirth and neonatal birth.

The reasons for IOL should have been discussed with the woman when the decision to induce was made. At this time the woman should have been given an information leaflet about induction of labour.

Inpatient inductions will be carried out on Joan Booker ward (JBW).

Outpatient inductions will be organised through the maternity day unit but can be facilitated by Joan Booker on the weekend if there was a suitable patient.

1.1 Maternal request for Induction of labour

Women that request induction of labour prior to 39 weeks must be referred to a Consultant

Women from 39-41 weeks can have IOL booked by a midwife and this does not need to be approved by a Consultant

1.2 Declining Induction of labour

Women who decline induction of labour at 42 weeks must be reviewed by a Consultant and offered increased antenatal monitoring.

A specific plan of care individualised to the clinical circumstances must be clearly documented, which must include:

- Frequency of monitoring
- Growth ultrasound
- Membrane sweeping
- Assessment of any maternal medical conditions
- Discussion of risks including increased risk of IUD or maternal morbidity
- It must be clearly documented that the woman can change her mind at any time and can contact the labour ward

Monitoring only gives a snapshot of the current situation, and cannot predict reliably any changes after monitoring ends

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2.0 Sweeps prior to induction

Explain to the women

- What a membrane sweep is
- That it might make it more likely that labour will start without the need for additional pharmacological or mechanical methods of induction
- Pain, discomfort and vaginal bleeding are possible from the procedure

Nice guidance suggests that at antenatal appointment after 39+0 weeks gestation, discuss with women if they would like a vaginal examination for membrane sweeping, and if so obtain verbal consent from them before carrying out the sweep. Briefly discuss Biomechanics as a tool to encourage optimal fetal positioning. Explain to women that although we do not have robust evidence to suggest that Biomechanics increases the chances of labour starting on its own, it is thought that the positions adopted may help to apply more pressure on the cervix. Signpost to Biomechanics leaflet, encouraging the woman to practice it at home.

Discuss with women if they would like to have additional membrane sweeping if labour does not start spontaneously following the first sweep

3.0 Methods of Induction

3.1 Propress controlled release vaginal pessary (10mg).

This is routinely used for IOL in the following circumstances:

- Prolonged pregnancy
- Maternal diabetes
- Third trimester IUD
- Poor Obstetric history
- Twins
- Hypertension/PET requiring IOL
- Other medical, social or emotional conditions, including maternal request (Agreed by consultant only)
- Fetal growth restriction <3rd centile or abnormal fetal dopplers will have an individualised management plan
- Prostin vaginal gel (1mg, 2mg)

This may be used at the discretion of the consultant in special circumstances:

- Failed Propress induction
- Multip with BS>6 at first assessment
- Previous Caesarean section
- Prelabour SROM at term (2mg prostin)
- Preterm prelabour rupture of membranes

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3.2 Mechanical Induction of Labour (Balloon Induction):

- Previous Caesarean Section – preferred induction agent as reduced risk of uterine rupture
- Failed Prostaglandin induction of labour
- Consider if previous history of hyperstimulation secondary to prostaglandin induction
- Fetal growth restriction (reduced incidence of hyperstimulation)
- Women who decline Prostaglandin induction

3.3 Exclusion criteria to induction of labour

- More than one previous CS, J or inverted T incision
- Classical Caesarean section or previous uterine rupture
- Ruptured membranes prior to balloon induction, previous myomectomy with cavity breeched

4.0 Admission for IOL

Confirm the following:

- Indication for IOL
- Gestational age (by early ultrasound scan)
- Parity
- Placental position
- Presentation and 5ths palpable in the abdomen
- Maternal observations and a general assessment of wellbeing should be carried out prior to IOL including blood pressure, pulse & temperature.
- Prior to administration of prostaglandin a 30 minute CTG must be performed.
- Provided the CTG is normal, the midwife should perform a vaginal examination, record the findings and modified Bishops score in BadgerNet and give Propess /Prostin.
- If the CTG is abnormal DO NOT continue with the induction process. Document a plan of care and request urgent obstetric review.
- If the Bishops score is greater than or equal to 10, do not give Propess/Prostin and transfer the woman to Labour ward for artificial rupture of membranes (ARM).
- All women with BS<10 at the first assessment should be given prostaglandin prior to ARM. Primips should be given Propess, multips with BS>6 should be given 1mg Prostin gel with a plan for ARM 6 hours after this single dose.

At the commencement of their IOL, those women and birthing people who are deemed suitable, can be signposted to the biomechanics leaflet and encouraged to practice Biomechanics to aid optimal fetal position. They should be advised that although we do not have robust evidence to support the use of Biomechanics to increase their chances of a successful IOL, it is thought that by adopting biomechanical positions, the cervical ligaments are stretched allowing an increase in room in the lower uterus and this may encourage the baby to rotate into a more favourable position for labour. Whenever acuity allows, the midwife can support the woman to perform Biomechanics.

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5.0 Care management using Propess

Unless there are clinical indications for the induction to be performed on the labour ward, these women will call Joan Booker ward at 10.30, and a time for attendance to commence the IOL should be given to the woman at this time. Women will remain on Joan Booker ward until they require analgesia or ARM, or are in established labour.

Primigravida & multipara with a BS<7 are managed in the same way.

Propess should be stored in a freezer in the original container in order to protect from moisture. It can be removed from the freezer immediately before use, or up to 20 minutes before insertion.

If the Propess insert falls out and has remained clean, e.g. dropped onto clean bed sheets and not dropped on to the floor or into the toilet, it may be reinserted and used to the 24 hour limit.

It is recommended that a new Propess should be inserted if there is any doubt of possible contamination and this could be used up to 24 hours after the insertion of the first Propess.

5.1 When to remove Propess

Propess should only be removed in the following instances:

- When labour is established (regular painful uterine contractions >3:10, with associated cervical change)
- Uterine hyperstimulation & hypertonic uterine contractions
- PV bleeding
- Evidence of fetal compromise
- Evidence of maternal adverse dinoprostone effects
- Following 24 hours, even if labour is not established

5.2 SROM with Propess in situ

Commence CTG and assess contractions. If there is regular uterine activity, perform a vaginal examination (VE) to assess if labour is established. If there is no regular uterine activity or labour is not established, Propess can be left in situ.

Maternal observations of temperature, pulse and blood pressure should be recorded 4 hourly.

5.3 24 hours after Propess insertion:

- Assess contractions
- Commence CTG (can be on Joan Booker ward)
- Remove propess and assess bishops score – follow IOL flowchart for further actions

6.0 Use of Prostin gel

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Prostin gel may be used in certain circumstances with consultant approval. These may include:

- IOL for SROM at term – these women can be offered a single dose of Prostin 2mg gel (regardless of parity)
- IOL in multiples with a favourable cervix
- IOL in grand multiparae
- Failed proposs IOL
- IOL in woman with previous Caesarean delivery

In these circumstances a specific plan for Prostin administration should be agreed with the Consultant and documented in BadgerNet. This should include guidance as to number & strength of doses to be given and a plan for appropriate review

7.0 Mechanical Induction of Labour (Balloon Induction)

A balloon induction of labour may be considered where the use of vaginal prostaglandins is contraindicated e.g. in the presence of a uterine scar, fetal growth restriction or where vaginal prostaglandins have been unsuccessful or declined.

The use of a balloon is supported by NICE and has similar outcomes to prostaglandin induction with a lower risk of hyper stimulation with no increased risk of caesarean section. NICE Interventional Procedures Guidance (IPG) 528 supports its use in women without previous Caesarean Section. Women must be given this information. The incidence of tachysystole is less with mechanical IOL when compared to Prostaglandins.

The type of balloon used may vary but may include a Foley's catheter with a 30-50ml reservoir or a Cook Cervical Ripening Balloon. (Note – Cooks balloon is licenced for induction of labour, whilst foleys catheters are not, however, neither are licenced for use in VBAC's)

Insertion will be performed on the labour ward by a person trained in the insertion technique

7.1 Benefits and Risks - NICE Intervention Procedures Guideline (IPG528)

Benefits:

- No increase in caesarean section risk
- Hyperstimulation in 5% in comparison to 17% of women requiring prostaglandins.
- CTG abnormalities in 2% in comparison to 15% with prostaglandins.

Risks

- Malpresentation - 2 women out of 293, one of whom required a caesarean section.
- Cord prolapse in 1/302.
- Post-partum Endometritis 1:59 women.

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7.2 Process for Balloon IOL

1. Book induction of labour on BadgerNet and chose balloon induction at time of booking, direct to leaflet on BadgerNet
2. Advised to call Labour ward at 08.30am on the day of induction for the time of arrival to be allocated
3. cCTG for 30minutes prior to balloon insertion
4. Verbal consent to be obtained prior to insertion of balloon
5. Balloon to be inserted by an appropriately trained person
6. cCTG for 30minutes post balloon insertion
7. Transfer to JBW
8. After 12-24 hours, the balloon should be removed on JBW (this can be performed by MW) and the MW to perform a vaginal examination to assess suitability for ARM.
9. Mobilise and consider biomechanics for two hours after the balloon is removed to allow head descent prior to ARM.
10. If ARM is not possible after removal of balloon, consultant to make individualised care plan.
11. Inform medical staff if the patient complains of severe abdominal pain, vaginal bleeding, abnormal CTG or any concerns. Remove balloon immediately

7.3 Balloon insertion

With a sterile speculum, clean the cervix with sterile water or saline. If using a foleys catheter, this is passed through the cervical canal and into the extra-amniotic space where the balloon is inflated. If using a Cook Cervical ripening balloon, this is also passed through the cervical canal with the first balloon inflated in the extra-amniotic space and a second vaginal balloon then inflated to increase cervical ripening. The catheter could to be secured with a tape to the thigh of the woman.

If the woman feels faint or unwell, then the balloon should be removed and the woman reviewed by a senior obstetrician.

Simple analgesics may be needed for discomfort post insertion.

7.4 Balloon removal

The balloon should be removed after 12-24 hours on JBW by deflating both balloons and applying gentle traction if using Cook's balloon. If foley's catheter is used, then deflate the single balloon and remove catheter.

The balloon should be removed under the following conditions:

1. Spontaneous rupture of membranes
2. Spontaneous labour
3. CTG abnormalities
4. Scar tenderness
5. Heavy vaginal bleeding.

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If the balloon falls out this will normally indicate that the cervix has dilated and a VE should be performed and Bishops score documented. Please manage the woman as you usually would for Prostaglandin induction based on the Bishop's score.

8.0 Management of Hyperstimulation for all IOL's

Tachysystole: ≥ 5 contractions in 10 minutes with normal CTG

Hypertonus: painful contractions lasting ≥ 90 seconds with normal CTG

Hyperstimulation: Tachysystole or hypertonus with abnormal CTG

- If tachysystole or hypertonus are suspected, CTG monitoring should be commenced immediately, if the CTG shows any abnormalities the woman should be transferred to Labour Ward where obstetric review should be sought.
- If in ABC then tachysystole/hyperstimulation should be considered when there are $>5:10$ contractions and/or insufficient time to listen to the fetal heart rate between contractions for a full minute and a CTG should be commenced
- Propess should be promptly removed if the CTG shows significant abnormalities; this may need to be considered before transfer to Labour Ward (keep Propess clean as reinsertion may be considered).
- If CTG abnormalities persist despite removal of Propess, Terbutaline 250mcg s/c should be considered, however due to the short half-life of dinoprostone and the low dose released per hour, the hyperstimulation should resolve spontaneously in 15 – 20 minutes.
- If no fetal heart rate abnormalities are noted then further management should be decided after discussion with a band 7 MW or a Registrar
- Hyperstimulation is extremely rare with balloon IOL. Please deflate and remove balloon catheter and give terbutaline as above

9.0 Observations and timing of CTG's for all inductions

9.1 Fetal Observations – Propess/prostin

- Prior to insertion of a prostaglandin a 30 minute CTG must be performed
- A CTG should be continued for at least 60 minutes following Propess insertion
- CTG monitoring should be continuous if there is abdominal pain or suspicion of fetal compromise.
- A CTG should be carried out every 8 hours.
- Once contractions start, the CTG should be commenced

9.2 Fetal Observations – Balloon

- Prior to insertion of a balloon a 30 minute CTG must be performed
- After insertion of a balloon a 30 min CTG must be performed

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- CTG monitoring should be continuous if there is abdominal pain or suspicion of fetal compromise
- A CTG should be carried out 8 hourly and after removal of the balloon
- Once contractions start, the CTG should be commenced

If there is meconium stained liquor or vaginal bleeding then this the patient should have continuous CTG monitoring and a prompt and timely review by the Obstetric Registrar or Consultant

9.3 Maternal Observations for any type of IOL

Maternal observations of temperature, pulse and blood pressure are routinely completed on admission and 4 hourly.

The woman should discuss with the midwife if:

- Her contractions become regular (every 5 minutes or more frequent)
- She becomes uncomfortable with contractions
- She has vaginal bleeding
- Her membranes have ruptured
- Propess falls out or drops lower in the vagina
- For Spontaneous Rupture of Membranes (SRM) see SRM section below

10.0 Unsuccessful Induction (including following one dose of Propess)

The definition used by NICE for unsuccessful induction with prostaglandin is “the failure to induce progressive labour after one cycle of treatment”. In practice this means following the insertion of one Propess for 24 hours, or the insertion of two vaginal prostaglandin gel doses at 6 hourly intervals.

The decisions regarding the management of an unsuccessful IOL must be made in accordance with the woman’s wishes and with regard to the clinical circumstances and urgency of IOL. A full assessment should be made of the pregnancy in general, the woman’s condition and fetal wellbeing using electronic fetal monitoring (EFM).

If ARM is not possible after a single Propess in multiples, or Propess plus one 2mg dose of Prostin gel in a primip, it would be best practice for the woman to be examined by a Registrar or Consultant. However, this should not delay the induction process and the midwife can examine the patient and give further prostin if necessary.

If ARM is not possible after 1 propess in multiples or Propess and 2 prostin gels in a primip then a plan will need to be made in conjunction with the Consultant or Registrar. This could be to delay the IOL, give further prostaglandin, consider balloon induction or consider caesarean section. **The plan must be discussed with the woman and a Consultant. All discussions must be clearly documented in the woman’s notes.**

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There is anecdotal evidence to suggest that biomechanics may be of use when induction of labour has been unsuccessful. An example of this is given below:

If ARM has been performed on LW but fetal head remains high, you may consider combining biomechanic techniques alongside synthetic oxytocin (if needed) to aid the descent of the head. (see appendix). The techniques are thought to work best when utilised in the presence of strong regular contractions (as a guide 2 in 10 for a multip and 3 in 10 for a primip).

11.0 Outpatient induction of labour

Outpatient Induction of Labour is the process of induction that starts in the hospital maternity unit for women who are then discharged to home and return to hospital for the birth of their baby.

Outpatient IOL carries a number of **benefits** for healthcare providers and women, including:

- Reduction in length of antenatal stay in hospital
- Less strain on antenatal units and resources
- Potential reduced financial costs
- Higher maternal satisfaction
- Avoidance of unnecessary hospital admission

11.1 Outpatient induction of labour can be offered to the following women:

1. Uncomplicated singleton pregnancy requiring induction for prevention of prolonged pregnancy after 40 weeks gestation
2. Number of previous births less than or equal to three
3. Booking BMI <35 with no mobility restriction
4. Women should have been offered a sweep prior to IOL
5. GBS +ve requiring IV antibiotics in labour
6. No relevant obstetric problems:
 - Previous stillbirth/neonatal death
 - Gestational hypertension, PET
 - Oligohydramnios/polyhydramnios/Unstable lie/SROM
 - Fetal abnormality/Macrosomia (>4.5kg)/IUGR
 - ≥2 episodes of reduced fetal movements after 30/40
 - History of significant PPH (>1000mls)
 - Previous birth by caesarean section
7. No relevant medical problems
 - Diabetes
 - Hypertension, Cardiac disease, CVA
 - Haematological disorders
 - Psychiatric disorders or social issues
8. No previous major uterine surgery (Myomectomy/Hysterotomy)
9. No significant vaginal bleeding after 24 weeks of pregnancy

The patient must also:

- Have transport available and live within 30 minutes of ASPH geographical area

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- Have a functional telephone
- Have the ability to communicate with Birth Centre staff
- Have an adult as companion at all times
- Have reassuring pre and post prostaglandin fetal heart rate monitoring

11.2 Method of Outpatient IOL

On arrival to MDAU for IOL the following must be confirmed by the Midwife:

- Induction of labour is for low risk pregnancy only
- Confirm gestation 40+0 to 41+5 weeks
- Parity 3 or less
- Placenta praevia has been excluded by ultrasound scan
- Cephalic presentation and presenting part in the pelvis
- Maternal observations including blood pressure, pulse, temperature, respiration rate and urinalysis are within normal range as per MEOWS chart

Proress is used for outpatient IOL.

- A 30minute CTG pre-propess is commenced
- A vaginal assessment is performed and the BS calculated as per table 1.
- The propess is then inserted
- A 60 minute CTG post propess insertion is commenced
- If there are no concerns the woman is then allowed to go home with clear information regarding what to expect after the procedure, what to look for and when to return or contact the ward. The information should be given verbally and in writing.
- The midwife can discuss Biomechanics as a tool for optimizing fetal position and maximizing the pressure on the cervix.. The midwife will signpost the woman to the Biomechanics leaflet and encourage her to practice it at home.

If there are any concerns at any stage of this process, the Midwife will transfer the woman to LW or discuss with the LW/MDAU Registrar via bleep 5059 for advice.

A patient information leaflet should be provided with a clearly marked 24 hour contact number for **Abbey Birth Centre Triage 01932 723761** and advised about contacting the unit if any concerns, particularly if:

- She thinks her waters have broken
- Having regular and painful contractions or constant pain
- Requiring stronger pain relief for contractions other than Paracetamol
- Has any fresh bleeding
- Feels baby's movements are reduced
- The Propess falls out or drops lower in the vagina

In the event of any of these concerns the woman must be advised to return to **the ABC** immediately for an assessment and possible transfer to Labour Ward as necessary.

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If no concerns, the woman will be advised to return to **Joan Booker Ward** between **08:30 to 09:00 hours** the following morning (**24 hours** after insertion of Propess) for removal of Propess and to be assessed by midwife.

12.0 References

1. NICE Guidance NG207 – Inducing Labour Nov 2021

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Appendix 1

Table 2 – Gestational age at which labour started, as a proportion of labours which started spontaneously

Gestational age (weeks)	Proportion of spontaneous labours that started at this gestational age	Cumulative proportion of spontaneous labours that started by this gestational age
31 weeks and under	2.4%	2.4%
32+0 to 36+6 weeks	5.3%	7.7%
37+0 to 37+6 weeks	5.1%	12.8%
38+0 to 38+6 weeks	12.1%	24.9%
39+0 to 39+6 weeks	25.4%	50.3%
40+0 to 40+6 weeks	32.5%	82.8%
41+0 to 41+6 weeks	16.2%	99.0%
42+0 weeks and over	0.9%	100%

Appendix 2

These tables are taken from the NICE Guidance NG207 – Inducing Labour Nov 2021

One of the included studies (Grobman 2018) included nulliparous women only (defined as no previous pregnancy beyond 20+0 weeks), but the remaining studies included both nulliparous and multiparous women, therefore the data could not be reported for multiparous women only.

Table 3 – Outcomes for women that may be more likely with induction at 40-42 weeks (nulliparous only)

Outcomes	Induction of labour at 39 weeks	Induction of labour at 40-42 weeks	Risk difference
Caesarean birth	About 1,860 per 10,000 women would be expected to have a caesarean birth (so 8,140 would not)	About 2,220 per 10,000 women would be expected to have a caesarean birth (so 7,780 would not)	About 360 more women per 10,000 whose labour was induced at 40-42 weeks would be expected to have a caesarean birth; so for 9,640 per 10,000 the outcome would be the same irrespective of the timing of induction
NICU admission	About 1,170 per 10,000 babies would be expected to be admitted to NICU (so 8,830 would not)	About 1,300 per 10,000 babies would be expected to be admitted to NICU (so 8,700 would not)	About 130 more babies per 10,000 whose mothers' birth was induced at 40-42 weeks would be expected to be admitted to NICU; so for 9,870 the outcome would be the same irrespective of the timing of induction

Table 4 – Outcomes for women that may be more likely with induction at 42 weeks (mixed parity)

Outcomes	Induction of labour at 41 weeks	Induction of labour at 42 weeks	Risk difference
Perinatal death	About 4 per 10,000 babies would be expected to die (so 9,996 would not)	About 35 per 10,000 babies would be expected to die (so 9,965 would not)	About 31 more babies per 10,000 whose mothers gave birth at 42 weeks would be expected to die; so for about 9,969 babies per 10,000 the outcome would be the same irrespective of the timing of induction
NICU admission	About 300 per 10,000 babies would be expected to be admitted to NICU (so 9,700 would not)	About 440 per 10,000 babies would be expected to be admitted to NICU (so 9,560 would not)	About 140 more babies per 10,000 whose mothers gave birth at 42 weeks would be expected to be admitted to NICU; so for about 9,860 babies per 10,000 the outcome would be the same irrespective of the timing of induction

Table 5 – Outcomes for women that may be more likely with induction at 43 weeks (mixed parity)

Outcomes	Induction of labour at 42 weeks	Induction of labour at 43 weeks	Risk difference
Caesarean birth	About 1,330 per 10,000 women would be expected to have a caesarean birth (so 8,670 would not)	About 2,040 per 10,000 women would be expected to have a caesarean birth (so 7,960 would not)	About 710 more women per 10,000 would be expected to have a caesarean birth; so for about 9,290 the outcome would be the same irrespective of the timing of induction

Appendix 3

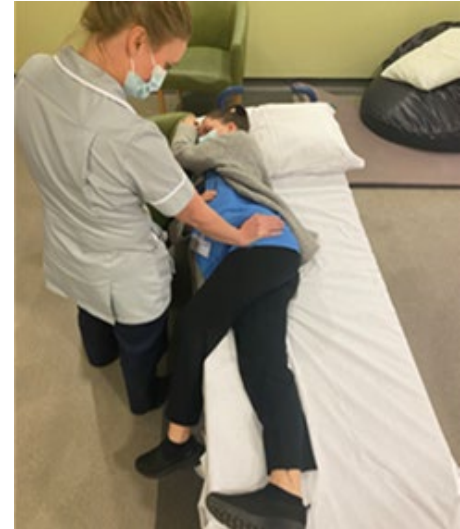
BIOMECHANICS

All of the positions and techniques can be found in the Biomechanics packs in all of the labour ward rooms, birth centre rooms and in the homebirth bag, being thoroughly explained.

SIDE LYING RELEASE

Stretches the pelvic floor, the pelvic ligaments and the sacro-iliac joints. Can be so effective to aid immediate and significant progress in labour and the resolution of a stall. Most effective at stations -2 and -1 but also can be very helpful in second stage. Advisable to repeat every 4 hours. Needs to be done on both sides and with bed completely flat.

The birthing person lays on their side, as close to the edge of the bed of possible, abdomen protruding slightly. Head on pillow with neck in line. They hold the bed rail or a chair with their upper hand. Their legs are straight. As the helper is holding their hips stacked with both hands, the birthing person lifts their upper leg and let it hover floppy over the edge of the bed, keeping the other leg on the bed and flexing the foot toward the knee. The helper keeps maintaining their hips stacked and this is maintained for 2-3 contractions on both side.



FORWARD LEANING INVERSION

This technique stretches the cervical ligaments and corrects any imbalance and twist in them, increasing the space in the lower uterus, whilst slightly backing the baby's head upwards, allowing for better flexion and rotation. Technique of choice when in presence of stubborn anterior lip, severe asynclitism, deflexed op. Also brilliant to utilise in early labour to aid active labour establishment and better fetal position. Works best at station -2 or -1. The earlier it is performed, the better. Needs to be repeated 2-3 times in a row, better if with a contraction.

Can use lowered bottom of LW bed. The birthing person kneels facing the lower surface, then lowers hands, then elbows, onto the lower surface, transferring their weight onto the arms. Head is tucked but does not rest on the surface. Knees are slightly pulled back into a 90 degree angle. This position is maintained for 40 seconds breathing deeply, better if during a contraction, then the birthing person slowly comes back up with her hands onto the upper surface and kneels high breathing deep for another 60 seconds. Repeat a couple of times.



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ABDOMINAL SIFTING

This technique is used to relax the broad ligament, create vibration which can prompt the baby to rotate in a more favourable position, and for deep relaxation. It is advised in early labour and early first stage, particularly when the birthing person is distressed with pain. The birthing person kneels leaning over a birthing ball or a big pillow, relaxing completely, and the helper wraps a folded sheet or a long scarf around their abdomen, folding it in half and holding the extremities in the helper's hands, making sure the material is even on the abdomen. The helper then, standing behind and very close to them, lifts completely the weight of the pregnant abdomen and performs some gentle sifting. It can be paused or continue through a contraction on the birthing person's preference. It is recommended that the sifting continues for at least 10 minutes. It will be necessary to have at least 2-3 people to take turns as this is very tiring on the arms .



IMPORTANT: Side lying release, forward leaning inversion and abdominal sifting constitute the bundle for the treatment of the distressed early labourer.

ROLLOVER TECHNIQUE

This technique comprises a series of resting positions that are changed roughly every half an hour and allows to change the angle the baby can use to go through the midpelvis, facilitating rotation and descent. It is perfect with epidural and when unsure of fetal position. It can be started in left lateral, moving on to exaggerated left lateral, all fours, exaggerated right lateral and right lateral. **Exaggerated lateral** is a position when the birthing person lays on their side leaning more forward with shoulders and hips, and the upper leg is bent at the maximum and resting over a big pillow in front of the person. This position opens the midpelvis at the maximum. It is possible for the person to rest in all fours for about 15-20 minutes also with an epidural if their knees are on the lowered bottom of bed and their upper body is leaning over a pile of pillows on the higher part of the bed.

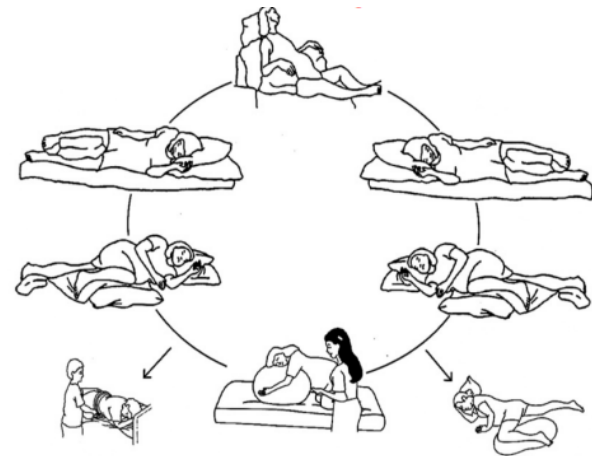


Image from 'The Labour Progress Handbook: Early Interventions to Prevent and Treat Dystocia' by Penny Simkin, Lisa Hanson, Ruth Ancheta



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BUTTOCKS JIGGLING (PELVIC FLOOR RELAXER)

This technique is useful in late first stage or second stage to aid fetal descent and rotation, and can be helpful when fully dilated but not feeling any pressure. It works by relaxing the pelvic floor and using the vibration to facilitate descent and rotation and cause relaxation.

The birthing person is kneeling leaning over a birthing ball or a big pillow, relaxing their weight over it, and the helper wraps a sheet or a big scarf around the buttocks in an even way, holding the sheet either side. The helper then starts to jiggle vigorously the sheet, making sure it doesn't slide over the skin or the clothes but that it moves the tissue. This should be performed for about ten minutes and can be done with a two-person technique when the birthing person is kneeling on the bed and the two helpers are standing either side.



TECHNIQUES TO FACILITATE DESCENT WHEN HIGH HEAD

This group of techniques is recommended when head is high and not engaged (-3) or barely engaged and malpositioned or deflexed at -2. The main requirement for these techniques to work is to have strong contractions, at least 3 in 10 for a primip and at least 2 in 10 for a multip. In absence of these contractions, it is advisable to utilise oxytocin and to use the techniques when contracting, without assuming that the contractions will cause the engagement.

ABDOMINAL LIFT AND TUCK

This technique opens the inlet of the pelvis whilst encourages flexion and descent of the fetal head and puts extra pressure on the cervix. Better to avoid if forewaters SROM with high head. To use for 10 contractions in a row. Can be extremely effective and lead to quick delivery in multips.

At the beginning of the contraction, the birthing person interlaces their hands at the base of the abdomen and lifts the weight of it, whilst flattening their lower back and bending their knees slightly. Easy to explain whilst laying against a wall, by flushing the lower back against the wall. The birthing person maintains the lift and tuck for the whole contraction and repeats for 10 contractions. The same technique can be performed whilst laying on the side.



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WALCHER'S OR FROGGIE WALCHER'S

Walcher's utilises hip extension to open the inlet at the maximum. The birthing person lays with their bottom on the very edge of the bed and lets their legs hang freely in the air, without the feet touching the floor. This technique is maintained for three contractions and is preferable when mobile.

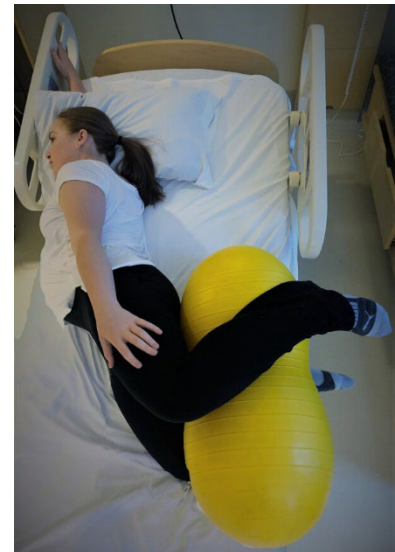


Froggie Walcher's is an easier variation but just as effective. It can use the lowered bottom of the LW bed as a lower level and combine hip extension with external rotation of the femur. The birthing person lays on upper part of the bed (which is completely flat) with their bottom halfway hanging off it, hovering over the lower part of the bed. The legs are bent and the soles of the feet touching, with the knees relaxing out. Again it is maintained for three contractions. This technique can also contribute to resolve a misengagement/ malposition when combined with other techniques like SLR.



FLYING COWGIRL

This is a resting position that utilises the peanut ball and opens the inlet at the maximum by using hip extension and external rotation of the femur. The birthing person lays on their side with the peanut ball in between their knees which are separated as much as possible. The feet are closer together but don't quite touch each other. The person sends their thighs as back and far away from the abdomen as possible, the back is slightly arched. This position is maintained for at least 20 minutes and then repeated on the other side.



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