INDUCTION OF LABOUR GUIDELINES

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Author: Pina Amin, Obstetric Consultant,
Mary Coakley Midwifery Manager

Executive Lead: Ruth Walker, Executive Nurse Director

Group Consulted Via/ Committee: Labour Ward Forum

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<td>Abi Kaye Band 7 Midwife/Seconded Consultant Midwife</td>
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OUT OF DATE POLICY DOCUMENTS MUST NOT BE RELIED ON

Induction Of Labour. Aug 2012 AK/PA/AM
Induction of Labour Guideline

Evidence

Information in this guideline originates from the NICE Clinical Guidance 70, Induction of Labour (IOL) (July 2008).

Please refer to Appendix for IOL regimen in case of Intrauterine death.

Guidance

- Where possible, women should have their labour induced on delivery suite. If this is not possible due to bed capacity, Midwifery Led Care (MLC) women being induced for post dates may be cared for on C1.
- Women with high risk factors such as severe Intrauterine growth restriction (IUGR), oligohydramnios, previous Caesarean section, severe Pre-Eclamptic Toxaemia (PET) or any condition requiring close maternal / fetal monitoring, must have their IOL on delivery suite where individual care can be provided and labour monitored closely.
- All cases of IOL should be discussed with a Consultant except for post dates in MLC women.
- If bed capacity on the delivery suite is causing delay in commencement of IOL, an individualised risk assessment must be made by the most senior obstetrician available with clear documentation in the case notes.
- All on-going IOL’s on C1 must be recorded on the ‘IOL board’ on the delivery suite. The board must be updated on regular basis.
- A clear plan (including a prescription for prostaglandin) for IOL should be documented by the clinician prior to booking IOL in ANC.
- In healthy women with uncomplicated pregnancies a light diet may be eaten during the IOL process. All women should be able to eat until artificial rupture of membranes (ARM), and then diet should be individualised.
- Written information should be provided to women on IOL prior to the procedure so that they may be fully informed. If required an interpreter should be used to provide information.

Indications for Induction of Labour

Prolonged Pregnancy

Women with uncomplicated pregnancies at term plus 13 days should be offered IOL. The risk of stillbirth increases from 1 in 3000 at 37 weeks to 3 in 3000 at 42 weeks and 6 in 3000 at 43 weeks. Routine IOL at 42 weeks decreases the perinatal mortality rate without increasing the caesarean section rate. Women who decline IOL after 42 weeks should be referred to Consultant midwife – Ms Julia Sanders and offered increased fetal surveillance by twice weekly cardiotocograph (CTG) and liquor volume assessment.
Diabetes in Pregnancy
Women with pregnancies complicated by diabetes should be offered IOL prior to the estimated date of delivery.

Premature Rupture of Membranes after 37 weeks
This occurs in 6-19% pregnancies and 60% will go into labour spontaneously within 24 hours. As the time between SROM and the onset of labour increases the risk of infection increases. IOL reduces this risk and women should be offered IOL with SROM after 37 weeks. Women should be booked for IOL after 24 hours. If Bishop Score is less than 4, Propess is advisable. Syntocinon infusion should commence once Propess is removed. If Bishop Score is ≤ 5, Prostin Gel 2mg should be given vaginally. Syntocinon should be commenced 6 hours later. Vaginal examinations should be kept to the minimum and delays in IOL reduced as much as possible. SROM must be confirmed prior to booking IOL.

Macrosomia
There is no conclusive evidence to support IOL for suspected fetal macrosomia in women who are not diabetic. There are therefore no grounds for induction before term plus 13 in these circumstances.

Twin Pregnancies
Please see multiple pregnancy guideline. IOL for multiple pregnancy should be at the discretion of name Consultant Obstetrician.

Maternal Request
IOL for maternal request should be avoided. There is no conclusive evidence to support such a policy and IOL for this reason has resource implications.

Precipitate Labour
There is no conclusive evidence supporting IOL for women with a history of precipitate labour.

Previous Caesarean Section
Evidence suggests that the risk of uterine rupture is higher in women undergoing IOL. The clinician should facilitate informed consent with the women at the time of booking of IOL in ANC, and document a clear plan in the notes. There is no evidence to support induction of labour prior to term plus 13 will reduce associated risks with IOL for this group of women.

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METHODS OF INDUCTION OF LABOUR

Stretch and sweep should be offered to all women without SROM 24 – 48 hours prior to IOL. The Bishop Score of the cervix should be documented.

Bishop Score

<table>
<thead>
<tr>
<th>Score</th>
<th>0</th>
<th>1</th>
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<tbody>
<tr>
<td>Dilatation</td>
<td>0</td>
<td>1-2cm</td>
<td>3-4cm</td>
<td>5-6cm</td>
</tr>
<tr>
<td>Effacement (%)</td>
<td>0-30</td>
<td>40-60</td>
<td>60-70</td>
<td>80+</td>
</tr>
<tr>
<td>Station</td>
<td>-3</td>
<td>-2</td>
<td>-1/0</td>
<td>+1/+2</td>
</tr>
<tr>
<td>Consistency</td>
<td>Firm</td>
<td>Medium</td>
<td>Soft</td>
<td>-</td>
</tr>
<tr>
<td>Position</td>
<td>Posterior</td>
<td>Central</td>
<td>Anterior</td>
<td>-</td>
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</table>

All women should have a CTG prior to IOL, for at least 30 minutes to assess fetal wellbeing.

The cervix can be ripened and labour induced with either:

- Propess 10mg slow release
- Prostin Gel 2 mg

Propess

Propess is 10mg of PGE₂ in a hydrogel polymer pessary within a knitted polyester retrieval system. It is available mainly for use in primigravida with unfavourable cervix (Bishop Score ≤4). Propess will release 0.3mg/hr of active agent over 24 hours. Half life is 1-3 minutes. Propess is stored in the freezer and should be removed immediately prior to use.

Propess is inserted high into the posterior vaginal fornix (see Appendix). Women should be advised to lie down for 30 minutes following insertion. The CTG should continue for 60 minutes after insertion. The retrieval tape should be placed inside the vagina to reduce the risk of the propess becoming dislodged or accidentally removed.

Propess can be removed by gentle traction on the retrieval tape. It should be removed either:

- 24 completed hours insitu
At onset of labour, confirmed by vaginal examination

Prior to Syntocinon infusion (Syntocinon can be commenced 30 minutes after removal)

On evidence on uterine hyperstimulation (>5 contractions in 10 minutes for at least 20 minutes) with evidence of fetal distress. The decision to remove Propess should be taken by SSHO/SpR.

Propess should not be used more than once and if the cervix is not suitable for ARM after removal of Propess then the opinion of a senior obstetrician should be sought.

If Propess is removed early or falls out

If propess is removed before 24 hours, place it in a universal container so that it can be reinserted if required. Remember the 24 hours is up when the propess has been in situ for 24 hours. Not 24 hours from first insertion.

If the propess falls out a second propess can be inserted. Propess will only deliver a maximum dose of 0.3 mg /per hour therefore if the propess is removed after 24 completed hours only 7.2 mg will have been absorbed regardless of the number of pressaries used.

Fetal Monitoring

After insertion of propess uterine activity and fetal condition must be monitored. CTG should be performed a minimum of 12 hourly following administration of vaginal prostaglandins. CTG should be performed earlier in presence of regular uterine contractions.

Prostin Gel

Prostin gel contains 2 mg PGE_2 in gel form. It is for use where the Bishop Score is between 4 – 7. Prostin is stored in the fridge and should be removed immediately prior to use.

Prostin is inserted high into the posterior vaginal fornix. Women should be advised to lie down for 30 minutes following insertion. The CTG should continue for 60 minutes after insertion.

Prostin Gel 2 mg can be repeated 6 hours after first insertion if bishops score remains between 4-7. A vaginal examination should be performed 6 hours after the second dose to assess Bishop Score and suitability for ARM. If the cervix at this stage is unfavourable for ARM then the opinion of a senior obstetrician should be sought.

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**IOL Indicated for Post Dates in MLC Woman**

CMW to offer S & S at Term+7. IOL Leaflet should be given to woman.

Further S & S offered at T+9 and T+11

At T+11, Community Midwife to book woman into consultant led unit (CLU) IOL Diary. Primiparous women to attend delivery suite at 0800, multiparous at 1300. The cervical Bishop Score is to be recorded in the hand held notes.

If woman refuses IOL an appointment should be made for her to see The Consultant Midwife in Normality and for twice weekly CTG and liquor volume assessment.
Appendix 1

IOL regimen in case of Intrauterine death

Vaginal misoprostol is inserted in the posterior fornix and the woman is asked to remain supine for up to 1 hour after the insertion of misoprostol.

Misoprostol can be self-administered by the woman to maintain privacy. However midwife/doctor can administer the misoprostol in women who are not happy to self-administer.

Management of the woman who has had an IUD should be as per following regimen:

**Gestation 24-34 weeks:**
Oral mifepristone 200mg followed by vaginal misoprostol 36-48hrs later.

Misoprostol 200 micrograms 3 hourly (max 5 doses)

**Gestation 34-37 weeks:**
ARM if Bishop Score >7 with syntocinon
If BS ≤6, Oral mifepristone 200mg followed by vaginal misoprostol 36-48 hours later

Misoprostol 100 micrograms 3 hourly (x5 doses)

**Gestation >37 weeks**
Either ARM and syntocinon if BS ≥ 7 or
BS < 7 either Propess and or Prostin

If uterine evacuation does not occur with the above, the dosage of misoprostol can be repeated after an interval of 12 hours from the last dose of misoprostol.

**Women with previous caesarean section can be given the above regimen after discussion with the consultant on-call.**

- Women with single lower segment scar should be advised that, in general, induction of labour with prostaglandin is safe but not without risk.
- Women with two previous LSCS should be advised that in general the absolute risk of induction of labour with prostaglandin is only a little higher than for women with a single previous LSCS
IOL is indicated. Woman should be counselled by Consultant Obstetrician, information on IOL is given and S& S performed 24-48 prior to admission. Clear plan for IOL is documented in notes.

On arrival on Delivery Suite/Maternity ward, full antenatal check including urinalysis and admission bloods as appropriate. CTG performed for at least 30 minutes. Exclude low lying placenta.

VE to determine Bishop Score

- Bishop Score ≤ 3
  - 10mg Propess inserted followed by 60 minute CTG
  - 24 hours after insertion remove Propess and assess for ARM. CTG for at least 30 mins.
  - ARM then Syntocinon 30 minutes later
  - If not suitable for ARM then senior Obstetrician to review

- Bishop Score 4 - 7
  - 2mg Prostin inserted followed by 60 minute CTG
  - 6 hours after insertion, VE. If BS remains 4-7 then insert second Prostin Gel 2 mgs
  - 6 hours after second Prostin assess for ARM
  - If not suitable for ARM then senior Obstetrician to review

- Bishop Score ≥ 7
  - ARM
  - Syntocinon infusion commenced 2 hours after ARM in absence of regular contractions

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Action Plan for Hyperstimulation following Propess

- Definitions:
  - Tachysystole > 5 contractions per 10mins for at least 20mins
  - Hypersystole: A contraction lasting for at least 2mins.
  - Hyperstimulation: Tachysystole or Hypersystole with abnormal CTG (suspicious/pathological)

In the presence of Hyperstimulation of the uterus, tocolysis should be considered. Terbutaline 0.25mgs s/c if the excessive uterine activity continues following removal of Propess.

Suspected hyperstimulation

Commence CTG

Palpate uterus to monitor contractions

Confirm Tachysystole/hypersystoleystole

- No – continue with IOL as normal. Offer pain relief. Consider VE if thought to be in established labour. Propess to remain in situ if Cervix < 2cm dilated

- Yes
  - Abnormal fetal heart pattern recorded on CTG
    - Yes – continue CTG, propess to remain in situ – consider VE if thought to be in established labour. Needs obstetric review
    - No – change maternal position. Needs obstetric review. Consider removing propess – ensure propess is kept in universal container to be reinserted at a later point. Consider tocolysis – Terbutaline 0.25gms s/c

Suspicious CTG –
- Change maternal position. Needs obstetric review. Consider removing propess – ensure propess is kept in universal container to be reinserted at a later point. Consider tocolysis – Terbutaline 0.25gms s/c

Pathological CTG –
- Remove Propess. Urgent Obstetric review. Consider tocolysis – Terbutaline 0.25mgs s/c. Keep woman & family informed
Midwifery Guidelines for the use of Water in Labour and Birth

Policy Procedure Protocol Guideline
N N N Y

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Author Name and Job Title: Delyth Bebb

Responsible Officers Jane Herve, Head of Midwifery
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Midwifery Guidelines for the use of Water during Labour and Birth

Author: Delyth Bebb
Issued Date: August 2010
Review Date: August 2013
Introduction

There is evidence that water immersion in labour offers women the most effective non-epidural analgesia. (NICE 2007)

Aims

1. To provide women greater choice and control over their birth experiences
2. To facilitate a woman’s request for the use of water in labour and birth
3. To enable midwives to provide safe care to women using a pool during labour or birth.

Responsibilities and Legal Status

Midwives have a responsibility to ensure that they practice safely and competently. They must also recognise any limits of personal knowledge and skills which may prevent the meeting of the needs and interests of the client.

When a midwife is aware that she lacks the necessary skills to care for women choosing to use water for labour and birth, appropriate support must be sought in order to develop knowledge, skills and competence.

Criteria for Using the Water Pool

- Woman’s informed choice
- Pregnancy 37 or more weeks gestation
- Established labour (regular strong contractions, descent of presenting part and dilating cervix)
- Observations normal throughout labour
- At least 2hrs since administration of opioids
- Liquor amnii clear or with non-significant meconium
- No known or suspected infection

Prior to the water-birth

- Ensure that the woman and her birth companion have been give relevant information to facilitate informed choice and have had an opportunity to ask questions.
- Explain to the mother that she can choose to leave the pool at any time she wishes and would be requested to leave the pool should any complications arise
- Record in the mother’s notes the time of pool entry and exit.

Equipment

- Pool
- Supply of hot water
- Pool thermometer
- Step
- Headrest
- Sieve remove debris from water.
- Adequate light
- Small lightweight mirror
- Generous supply of towels / linen , bathrobe, t-shirt/nightwear

Midwifery Requirements

- Protective clothing – gauntlet gloves, goggles/visors, aprons.
- Waterproof fetal Doppler / monitor
Establishment of a water-birth facility at home

- Mother and her support person are responsible for hiring suitable equipment
- Mother and support person responsible for assembling, filling and emptying the pool
- Factors to consider when sitting the pool:
  - Weight of pool on floors and placement in the home
  - Access required all round the pool to facilitate removal of mother if the need should arise
  - Access to taps and drains
  - Adequate room ventilation, environment to be comfortable and not too hot
  - Protection of floors around the bath - waterproof sheeting covered with towels /blankets to ensure a non-slip surface
  - Dry area for mother to use if she comes out of the pool
  - An area prepared for resuscitation of the baby if necessary
  - Health and safety issues to be raised:
    - water spillage
      - use of electrical equipment
      - water temperature
      - positions adopted by midwives and the mother
      - access to equipment and dry areas in the room
      - room temperature and ventilation

Use of the Birthing Pool on the Consultant Led Unit

Prior to a woman being offered the birth pool consideration should be given as to the care package requirements of the mother and baby and the antenatal history fully reviewed. Whilst a list can never be exhaustive, and a full clinical assessment should be made on admission, women with the following factors that make CLU birth advised should be encouraged to use the pool during labour.

- Women induced with prostaglandin for postdates (providing <42/40)
- Women induced with an ARM only.
- Thyroid disease requiring neonatal follow-up
- Hep B / Hep C positive
- Jehovah’s Witness
- Severe confirmed latex allergy
- Asthma indicating birth on CLU
- Thromboembolic risk requiring postnatal clexane
- Women receiving steroids in pregnancy indicating neonatal review
- PC dilatation requiring neonatal follow-up
- Women on CLU by maternal choice
- Mild hypertension in pregnancy, but normal BP on admission, without medication.
- Women using street drugs requiring neonatal observation.

The following nulliparous women should also be encouraged to use the pool during the first stage of labour but advised to leave the pool for birth:

- Women with a fetus with confirmed growth > 97th centile.
- Women measuring ‘large for dates’ on admission.
- Women with a booking BMI >35 but for whom fetal monitoring is considered achievable in the pool.

If a waterproof CTG facility is available this will enable some women for whom continuous fetal monitoring is indicated to use the pool. This would include, for example a woman with significant meconium stained liquor with a normal CTG.
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<th>GUIDELINE</th>
<th>RATIONALE</th>
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<tbody>
<tr>
<td>The midwife involved should be adequately prepared</td>
<td>To provide an acceptable standard of care and ensure safety of the mother and baby</td>
</tr>
<tr>
<td>If possible two midwives to attend pool births</td>
<td>Encourages reflective practice and skill sharing</td>
</tr>
<tr>
<td>Health and safety guidelines on moving and handling should be adhered to at all times</td>
<td>To prevent injury to the midwife (RCM 1999)</td>
</tr>
<tr>
<td>All equipment to be checked. Thermometer, water, waterproof sonicaid, Entonox</td>
<td>To maintain a safe environment</td>
</tr>
<tr>
<td>Pool should be filled to level of mother’s breasts when she is sitting in the pool</td>
<td>This depth of water and increased buoyancy promotes movement in the pool which helps progress of labour (Hall et al 1998)</td>
</tr>
<tr>
<td></td>
<td>Fetal safety (Johnson 1996)</td>
</tr>
<tr>
<td>Temperature of the bathwater should be comfortable for the mother and maintained between 35 - 37°C in first stage and check and record hourly in the first stage.</td>
<td>To prevent fetal hyperthermia</td>
</tr>
<tr>
<td>Temperature of the bathwater to be checked every 30 minutes in the second stage of labour and recorded on the partogram.</td>
<td>To ensure optimum temperature maintained for delivery</td>
</tr>
<tr>
<td></td>
<td>Fetal health and safety</td>
</tr>
<tr>
<td>The mother should be enabled to move and adopt different positions in the pool</td>
<td>Optimal positioning facilitates the mechanism of labour (Russell 1992, Roberson 1997, Sutton 1996)</td>
</tr>
<tr>
<td>Mother’s temperature to be checked hourly and pulse half-hourly</td>
<td>To detect any pyrexia / tachycardia</td>
</tr>
<tr>
<td></td>
<td>To ensure they remain within normal limits</td>
</tr>
<tr>
<td></td>
<td>To disturb mother as little as possible</td>
</tr>
<tr>
<td>Other maternal / fetal observations to be taken as indicated. Use a waterproof Doppler</td>
<td>To prevent dehydration (RCOG 2001)</td>
</tr>
<tr>
<td></td>
<td>Safe practice</td>
</tr>
<tr>
<td>Mother to be encouraged to drink plenty of fluids and to leave the pool to urinate</td>
<td>To ensure safety of mother</td>
</tr>
<tr>
<td></td>
<td>Prior to VE woman will need to leave bath to empty her bladder</td>
</tr>
<tr>
<td>Entonox may be used for analgesia, mother not left unattended. At least 2hrs since the administration of opioids</td>
<td>To facilitate abdominal palpation carried</td>
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<td>Non directed pushing</td>
<td>The length of second stage is less significant than the length of active pushing (Piquard et al 1989)</td>
</tr>
<tr>
<td>“Hands off” approach to delivery supported by verbal guidance from the midwife</td>
<td>There is no substantive evidence to support manual flexion of the baby’s head at birth Fetal safety (Garland 1996)</td>
</tr>
<tr>
<td>Allow head to deliver spontaneously</td>
<td></td>
</tr>
<tr>
<td>Do not feel for nuchal cord</td>
<td>Health and safety of mother and baby</td>
</tr>
<tr>
<td>It can be loosened and disentangled as the baby is born, in the usual manner</td>
<td></td>
</tr>
<tr>
<td>Shoulders would be expected to be delivered within two contractions following birth of the fetal head. Gentle downward traction may be used to facilitate delivery of the shoulders if needed. If delivery not completed within two contractions following delivery of the fetal head. Rapidly Initiate moving the woman above the water level and initiate active management.</td>
<td>Be aware of potential shoulder dystocia</td>
</tr>
<tr>
<td>Baby must be born completely under water and then brought to surface gently. The head should be facing down</td>
<td>To prevent inhalation of water from premature breathing To facilitate drainage of water from mouth and nose</td>
</tr>
<tr>
<td>Do not cut cord underwater</td>
<td>Safety of baby</td>
</tr>
<tr>
<td>On rare occasion that cord breaks, clamp the fetal end of the cord between fingers to control bleeding then bring the baby to surface gently but as quickly as possible.</td>
<td></td>
</tr>
<tr>
<td>Keep baby’s body submerged in water at level of mother’s uterus following delivery, supporting head above water</td>
<td>To prevent excessive transfusion to baby To maintain baby’s temperature</td>
</tr>
<tr>
<td>Mother’s choice of active or physiological management of third stage,</td>
<td>Theoretical risk of water embolism and increased bleeding (RCOG 2001)</td>
</tr>
<tr>
<td>Syntometrine to be given once out of the pool</td>
<td></td>
</tr>
<tr>
<td>Estimate and record blood loss.</td>
<td>To identify post partum haemorrhage</td>
</tr>
<tr>
<td>If necessary perineal suturing to be delayed for up to one hour.</td>
<td>To allow tissues to revitalise after water immersion</td>
</tr>
</tbody>
</table>
EVACUATION FROM THE BIRTHING POOL

The method described is intended to be used in an emergency when the life of the mother or baby is at risk and the woman unable to leave the pool herself.

Any partner left on their own with a mother should know how to summon help either by pressing the emergency call button or by shouting. When no member of staff is present the door to the room should be left open with the curtain pulled across to provide privacy.

In an emergency the following method is to be used:

1. Summon help;
   - Pull red emergency call button
   - By shouting

2. Do not pull the plug out

3. Support mother's head clear of the water using both hands. (Staff A)

N.B. The person who supports the head continues to do this until the mother is on the point of leaving the pool. (See step 10)
4. As help arrives in the room send a member of staff to dial 2222 and request the obstetric emergency team.

5. A member of staff (Staff B) enters the pool and the mother is manoeuvred to the end of the pool where the 2 handles are located.

6. Raise the bed to a working height and remove the foot board. (Midwife / MCA C)

7. Unplug the bed, unlock, and position at right angles to the pool, by the pool handles. Lock castors. (Staff C)
8. Take the Birthing Pool Net from the wall unit and place under the woman, feeding it down behind her head, shoulders, bottom to feet. (Staff B and C). The top and bottom edges of the net are red.

9. Staff B ensures the mother is securely enveloped within the net and takes a firm hold supporting the mother’s lower body.

10. Staff C takes a firm hold on the corner of the net nearest her, taking up the tension, and supporting the mother’s head. This will allow Staff A to release her hold on the mother’s head and take a firm hold on her top corner of the net.
11. Nurse A gives the command “Ready” “Steady” “Lift” and the mother is pulled from the water onto the edge of the pool, upper body resting on the bed.

12. Staff A gives further commands, “Ready” “Steady” “Move”, until the mother is positioned completely on the bed.