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Water Birth Guideline

Summary statement: How does the document support patient care?	By providing evidence based guidelines for staff supporting pregnant women/people choosing water birth.
Staff/stakeholders involved in development:	Leads for Maternity Risk Management (Obstetric and Midwifery), Labour Ward Leads (Obstetric and Midwifery), Joint Obstetric Guidelines Group.
Division:	Women and Children's
Department:	Maternity
Responsible Person:	Chief of Service
Author:	Community Midwife Team Leaders
For use by:	All staff caring for women/people who have chosen water birth.
Purpose:	To provide clear guidance for staff caring for women/people who have chosen water birth
This document supports:	NICE CG190 (2014, updated 2017)
Key related documents:	**UH Sussex (SRH &WH) guidelines:** Care in Labour, Management of Pregnant Women/People and Neonates with Risk Factors for Early-Onset Neonatal Sepsis (including GBS) **Trust policy:** Meticillin resistant staphyloccus aureus (MRSA)- INFECTION CONTROL POLICY
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Version	Date	Author	Status	Comment
1.0	November 2013	Community Midwife Team Leader	Archived	New Trust Wide Guideline
2.0	January 2017	Community Midwife Team Leader	Archived	Triannual review and update
3.0	May 2017	Community Midwife Team Leader	Archived	Addition of pool cleaning advice
4.0	July	Practice Development	Archived	Addition for pool evacuation
5.0	August 2021	B. Corney, D.Tarrant, K. Henton, Community Team leaders	LIVE	Triannual review and update. Criteria for using pool updated. Management of third stage in the pool clarified.

The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician.

If in doubt contact a senior colleague or expert.

Index

1.0 Aim 4
2.0 Scope 4
3.0 Responsibilities 4
4.0 Introduction 4
5.0 Criteria for using pool for labour 5
6.0 Labour Management 5
6.1 Risk Assessment 5
6.2 Equipment needed 6
6.3 Pool Preparation 6
6.4 Midwife 6
6.5 Environment 6
6.6 Latent phase 6
6.7 First Stage of Labour 6
6.7.1 Documentation 7
6.7.2 Analgesia 7
6.8 Second stage of labour 7
6.8.1 Documentation 7
6.8.2 Care / management of delivery 7
6.9 Third stage of labour 8
6.10 Post Delivery 8
7.0 Indications to leave pool at any time during labour 8
8.0 Emergency evacuation from the pool 9
9.0 Audit 10
References 11
Appendix 1: Birthing pool evacuation 12

Water Birth Guideline

1.0 Aim

To provide clear guidance for all staff involved in all aspects of water birth.

2.0 Scope

- Midwives
- Obstetricians
- Health care assistants / maternity support workers

3.0 Responsibilities

Midwives & obstetricians have a responsibility to:

- To access, read, understand and follow this guidance.
- To use their professional judgement in application of this guideline.

Midwives also have a responsibility to:

- To feel competent to care for pregnant women/people in the pool.
- To be competent in the use of the net/hoist for emergency pool evacuation.

Management have a responsibility to:

- To ensure the guideline is reviewed as required in line with Trust and National recommendations.
- To ensure the guideline is accessible to all relevant staff.

4.0 Introduction

The evidence shows that immersion in water provides effective pain relief. Encouraging the pregnant woman/person to get into a warm bath or birthing pool will help reduce the pain of the first stage of labour, and mean they are less likely to request an epidural.

The Winterton Report recommended all maternity units should provide pregnant women/people with the opportunity to labour and give birth in water. A significant number of retrospective and prospective observational studies have identified maternal benefits of labouring and giving birth in water, including shorter labours, less pain relief, fewer episiotomies and lower blood loss; with no increased risks of neonatal infection (RCM Professional briefing on water birth in the time of covid)

Pregnant women/people who choose to labour in water feel a high sense of control and satisfaction. Preserving women/people's privacy and dignity whilst in the pool is important for both cultural and personal reasons.

There is no evidence that the use of water has any significant difference on adverse maternal or neonatal outcomes. There is insufficient evidence on:

- Timing of use of water in labour.
- The use of water in the second stage, particularly its effect on neonatal outcomes.

Using a bath or a birthing pool for pain relief does not mean that the woman/person has to remain in it for birth unless she wants to. Women/people can get out of the water at any time if they do not like it or want to try another method of analgesia.

5.0 Criteria for using pool for labour

- Low risk pregnancy at time of onset of labour.
- Singleton pregnancy.
- Minimum of 37/40 gestation.
- Cephalic presentation.
- No significant medical history.
- No previous or current significant obstetric complications.
- Spontaneous onset of labour.
- Labour following postdates induction with balloon, vaginal prostaglandin or artificial rupture of membranes and no requirement for oxytocin infusion as they are in active labour and contracting regularly and strongly. Risks and benefits should be discussed with any women/person who chooses to not follow this recommendation and clearly documented.
- Maternal weight 100kg or less or BMI less than 35 at booking OR consider implications if BMI over 35 at booking.

For pregnant women/people wishing to labour in water who do not meet the criteria, an appointment should be made in the antenatal period to discuss this with consultant and / or manager on call. An agreed individual plan should be documented in the Antenatal Record.

MRSA: Pregnant women/people who are MRSA positive at the time of delivery may labour and birth in the pool. The room would need an infectious clean after use and linen sent to the laundry in an infected linen bag. The standard pool cleaning used meet the required standard as agreed by infection control and manufacturer guidelines.

Group B Strep (GBS): is not considered a contraindication to using the pool. But remember to still administer the prophylactic antibiotics.

6.0 Labour Management

6.1 Risk Assessment

The Labour Risk Assessment within the Labour Care Record must be completed for all women in labour whether planning to use pool or not.

6.2 Equipment needed

Ensure the following:

- Waterproof sonicaid, pool thermometer and sieve are available**.**
- The room is adequately ventilated and furnished for the comfort, health and safety of parents and staff.
- Evacuation net is available.

6.3 Pool Preparation

- Clean pool daily and after each use according to UHSussex (SRH&WH) Sterilisation and Disinfection Policy. Keep record of cleaning and ensure all staff are aware of procedure.
- Fill pool deep enough to cover women/person's abdomen when sitting, and should be sufficient to facilitate mobility.
- No additives to be put into water
- Water temperature 36 - 37.5°C as comfortable for the woman for first stage of labour. (NICE 2017)

NB: If homebirth, the woman/person's birthing partner should take responsibility for assembly / inflation, filling and emptying of the pool.

6.4 Midwife

- Wear comfortable clothing.
- Consider posture and positioning whilst caring for woman in pool.
- Maintain fluid intake.
- Midwives with skin abrasions / eczema to hands and arms should **not** undertake water birth.

6.5 Environment

Water spillages should be dealt with immediately.

6.6 Latent phase

Labour should be established prior to entry to the pool. However, it is recognised that some individuals have prolonged and painful latent phases which may result in invasive analgesia. In these instances, should the woman/person desire, the pool may be used but be mindful that this may slow progress in the latent phase. Mobilisation and diversional therapies should also be encouraged.

6.7 First Stage of Labour

- Maintain adequate fluid intake to prevent dehydration – including isotonic fluids.
- Maintain pool temperature between 36 - 37.5°C.
- Ensure bladder care monitored.

- Vaginal examination (VE) - 4 hourly unless slow progress (see CG1196 Care of women in labour guideline).

NB: Ideally VE should be undertaken out of the pool. If undertaken in pool; ensure position of woman does not put midwife at risk of back strain.

6.7.1 Documentation

- Complete partogram with maternal / fetal observations as per care of all women/people in normal labour.
- Record time of entry to pool.
- Record maternal and pool temperature hourly on partogram.

6.7.2 Analgesia

- Encourage simple methods, relaxation, and diversional therapy.
- Entonox may be used under supervision whilst in the pool.

If opioid analgesia is required intramuscularly the woman must leave the pool. The woman /person may re-enter the pool 2-4 hours after administration if she is not adversely affected.

If the woman/person has required intramuscular opioid analgesia in early labour they may still use the pool when labour is established providing administration was at least 2 hours earlier.

6.8 Second stage of labour

- Increase / decrease and maintain water temperature to 37 – 37.5 degrees. **If not achievable, deliver out of pool.**
- Aim for room temperature of 21-22^{o}C.
- Record maternal and pool temperature 1/2 hourly and document on the partogram.

6.8.1 Documentation

Document maternal and fetal observations as per CG1196 Care of women in labour guideline on the partogram / Active Second Stage labour page.

6.8.2 Care / management of delivery

- A hands-off birth, supported by verbal guidance by the midwife should be practiced and if this is not feasible ask the woman/person to stand or empty the pool.
- There is no need to feel for the cord – evidence shows that baby will deliver through and can be unravelled.
- Deliver baby totally submerged as cool air will initiate respiration.
- Following delivery of the head, the shoulders should deliver with the next contraction. If this does not happen the mother/person should be asked to stand

and lean over the poolside. In rare instances of needing to cut the cord or perform an episiotomy, these procedures can be undertaken at this point, out of the water.

- If it is not possible to disentangle the baby from the cord it must **not** be clamped and cut under water. Ask mother/person to stand. Clamping and cutting cord with the baby undelivered or submerged may stimulate respiration.
- Guide the baby gently to the surface, face uppermost, leaving body submerged.

6.9 Third stage of labour

- Management and place of delivery depends on the woman/person's wishes i.e. physiological or active.
- Delivery of the placenta may take place in / or out of the water, the risk of water embolism being theoretical as no actual case has been reported.
- For active management of third stage the woman is asked to leave the pool promptly after delivery with the injection of Syntocinon or Syntometrine given intramuscularly ideally within ten minutes.

6.10 Post Delivery

- Attention should be given to maternal and baby's temperature in the immediate postnatal period. If the mother/person remains in the pool, the baby's head should be dried and hat given.
- Examine perineum out of the pool as soon as possible.
- If suturing is required this should be delayed for up to one hour unless there is concern re blood loss following exit from the pool. This allows the perineal tissues time to revitalise from immersion in water (Garland, 2000).

7.0 Indications to leave pool at any time during labour

- Maternal pyrexia:
  - If 37.3 – 37.9^{o}C administer oral paracetamol 1g and review after 30 minutes.
  - If 38 C or over, leave pool and inform on - call Obstetric Team.
- Hypertension blood pressure 140/90 or more.
- Meconium stained liquor.
- Maternal request.
- Significant blood loss.
- Concerns regarding fetal heart rate. Perform a cardiotocograph for 20 minutes. If fetal heart rate is normal after this, the CTG can be discontinued. If on the Birth Centre, the CTG can be performed on there in the expectation that it will be able to be discontinued in 20 minutes, and normal care resumed including returning to the pool if wanted. However if concerns persist, obstetric review and transfer to CLS are indicated.
- Opioid analgesia (see point 6.7.2) or epidural.
- Prolonged first or second stage.
- Excessive contamination.

8.0 Emergency evacuation from the pool

In the event of an obstetric emergency which results in maternal collapse (i.e. the woman/person is unable to leave the pool unaided or with assistance) the following steps should be taken (see appendix 1):

- Call for assistance and pull the emergency bell.
- Consider need to raise water level to aid evacuation.
- Slide the net under the patient, supporting the head and airway. **Ensure the red end of the net goes to the head and feet of the patient.**
- Move the bed alongside the pool.
- Ensuring adequate staffing, grip the edges of the net and move the patient onto the bed.

Please note: It may be necessary for staff to enter the pool to support the patient during evacuation.

9.0 Audit

Suggested questions:

- Pregnant women/people who wish to use the birthing pool, and who do not meet the criteria to use the pool, have a documented antenatal discussion with obstetric consultant or manager-on-call.
- Pool water temperature was recorded hourly in first stage and half hourly in second stage.
- Pool maintained at correct temperature range for first stage (36-37.5^{o}C) and second stage (37-37.5^{o}C).
- Documentation to show any required perineal suturing was delayed for at least one hour post exit from pool or documentation to show why this was not achieved (ie bleeding excessively).

References

National Institute for Health and Clinical Excellence (2014) Intrapartum Care for healthy women and babies G9190. Last updated 2017.

House of Commons Health Committee. Second Report on Maternity Services (Winterton Report) London HMSO;1992

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Appendix 1: Birthing pool evacuation