Wirral University Teaching Hospital NHS
NHS Foundation Trust

WIRRAL WOMEN & CHILDREN'S HOSPITAL
INTRAPARTUM CARE **MIDWIFERY LED UNIT**

Guideline No: 25 Waterbirth (MLU)

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Document Review History

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1	July 2010	G Hughes, Matron P Brown, Senior Midwife	Supervisor of Midwives
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Monitoring Compliance with the Guideline

Minimum requirement to be monitored	Auditable Standards – See below
Process for monitoring	Audit of Guideline
Responsible individual/group/committee	Risk Management Department
Frequency of monitoring	3 Yearly
Responsible individual/group/committee for review of results	Obstetric & Gynaecology Audit Meeting
Responsible individual/group/committee for development of action plan	Audit Lead
Responsible individual/group/committee for monitoring of action plan	Clinical Governance Steering Group

COMPLIANT WITH:	
1.	NICE Intrapartum Care 2007
2.	RCOG & RCM 2006 – Joint statement no. 1 for immersion in water during labour and birth
3.	RCM 2000 – Position Paper 1a – The use of water in labour and birth

AUDITABLE STANDARDS	
1.	All women who opt for a waterbirth should have baseline observations performed prior to entering the pool
2.	Maternal and water temperature recorded hourly and documented within the health care record
3	All women in whom a complication arises during labour should be evacuated from the pool

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1.0 INTRODUCTION

The opportunity to labour and give birth in water is recommended by NICE as evidence has shown that water can provide excellent pain relief. Full immersion in water during labour promotes the physiological responses in a woman that reduce pain whilst stimulating the release of oxytocin[(8)].

Midwives should ensure they are competent to provide support to women who choose to use water and should keep themselves updated on the research evidence in this area[(5)].

Managers and supervisors should ensure that midwives acquire and sustain the competence, skills and confidence necessary to assist women who choose to labour or deliver in water[(6)].

2.0 GUIDELINE REGIME

2.1 Exclusion Criteria

A waterbirth is not advocated for women in the following circumstances: -

- < 37 completed weeks of pregnancy
- Multiple pregnancy
- Women with a BMI of >35 or a weight of 120 kgs at booking. Re-measurement of maternal weight for women with obesity in pregnancy in the 3rd trimester (individual assessment will be undertaken at time of admission for borderline BMI's because there may not be a need to re-weigh).
- Women with known obstetric complications e.g., pre-eclampsia
- Women with known medical complications e.g. hypertension, diabetes
- If the woman has received opiate analgesia within the last two hours[(4)]

2.2 Inclusion Criteria

A waterbirth is advocated in the following circumstances: -

- All low risk women who choose to have a waterbirth
- Women who have had one previous caesarean section should not be excluded from entering the pool as long as they have been appropriately counselled to the risks and benefits
- Women who are GBS positive - the cannula can be capped off and remain in situ should further antibiotics need to be administered
- Women who have had ruptured membranes for <24 hours and in spontaneous labour

2.3 Baseline Observations

Prior to entering the pool baseline observations should be performed and MEOWS score should be calculated and documented within the woman's health care record on the partogram.

2.4 Intrapartum Care

2.4.1 Fetal Heart Auscultation

Auscultation of the fetal heart is every 15 minutes during the first stage of labour and every 5 minutes during the active second stage of labour.

Auscultation should be for greater than 1 minute, before, during and following contractions. Maternal pulse should also be auscultated simultaneously every hour unless there is a suspected fetal bradycardia/distress whereby it would be undertaken every 15 minutes whilst listening to the fetal heart.

Women who have had a Caesarean Section should be counselled by a senior midwife/doctor and informed that unless a telemetry CTG machine is available for continuous fetal monitoring then only intermittent monitoring can be offered.

If any decelerations/persistent tachycardia are noted the woman needs to be removed from the pool for continuous electronic fetal monitoring. If after a 20 minute CTG, the fetal heart is deemed to be normal then the woman can return to the pool.

2.4.2 Temperature Regulation

There has been much debate surrounding the pool temperature from a strict policy of 34-37°C to women being encouraged to regulate the temperature themselves[1,3].

The RCOG/RCM (2006) state that it may be more beneficial for women to regulate the water for their own comfort. Therefore the water temperature can be recorded hourly in the labour records along with the maternal and fetal observations.

2.4.3 Labour and Birth

Vaginal examinations can be performed in the water if needed. Women should be encouraged to drink plenty of fluids and be informed that isotonic drinks have been shown to be beneficial[4]. Women can opt to have a light diet during labour e.g. biscuits, fruit, small snacks.

The use of electrical equipment is contraindicated within the birthing pool enviroment, spillage of water must be cleaned up immediately and the water within the pool should remain as clear as possible. In event of water

contamination the water will need to be drained and replaced with clean water. During this time the woman should be kept warm and encouraged to mobilise.

Directed pushing is not necessary and the traditional control of the head is not advocated[11]. Checking for the presence of the umbilical cord following the delivery of the head is also not required. Both of the above may cause stimuation to the baby and initiate respiration.

During delivery midwives must ensure that the baby remains completely submerged during the birth and brought to the surface within one minute[2]. Hypoxia may develop if the baby is left under the water or if the placenta begins to separate. Exposure to the air will initiate the baby's respiration. Midwives should allow for the cord to stop pulsating prior to clamping and cutting even if the woman wants active management of the third stage. Hutton and Hassan (2007) state that delayed cord clamping can be advantageous to the baby as they are more likely to have an increased haemoglobin.
If the woman chooses to have a physiological third stage, she can remain in the birthing pool to deliver the placenta, provided the clarity of the water is acceptable. For active management, it is necessary for the woman to leave the pool in order to receive the syntometrine injection. The placenta can then be delivered on dry land.

2.4.4 Emergency/Abnormal Situations

The woman should be asked to leave the pool immediately if a complication develops e.g. fetal distress. The appropriate help should be summoned and delivery expedited if needed.

When meconium stained liquor is identified women may remain in the pool if the meconium is deemed to be thin and old however, in situations where there is fresh significant meconium stained liquor NICE (2007) strongly reccommend that the woman should leave the pool and commence continuous monitoring via electronic fetal monitoring (EFM).

In such circumstances of obstetric emergencies i.e. Shoulder Dystocia, Cord Prolapse, Breech, PPH, Intra/Post partum Collapse the emergency drill must be initiated as per unit guidelines.

2.4.5 Estimating Blood Loss

Estimating blood loss cannot be measured accurately in the pool. The midwife must be vigilant to other signs of deterioration associated with blood loss e.g. hypotension, tachycardia etc.

2.4.6 Suturing

Sutring should be delayed for one hour post delivery depending on the extend of the perineal trauma and bleeding. In the cases of 3rd or 4th degree tears these will need to be referred immediately for confirmation of severity and repair in theatre.

3.0 REFERENCES:

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2. Balaskas J and Gordon Y (2004) Waterbirth. London

3. Geissbuehler V, Eberhard J and Lebrecht A (2002) Warerbirth:water temperature and bathing time – mother knows best. Journal of Medicine 30 (5):371-378

4. National Institute for Health and Clinical Excellence (2007) Guidelines for Intrapartum Care. London

5. RCM (2000) *Position Paper 1a 'The use of water in labour and birth'* Royal College of Midwives http://www.rcm.org.uk

6. NMC (2002) *Guidelines for Records and Record Keeping*. London, Nursing and Midwifery Council.

7. Royal College of Obstetricians and Gynaecologists/Royal College of Midwives (2006) Immersion in water during labour and birth. Joint Statement No 1. RCM

8. Katz, V., et al. (1990, Feb.). A comparison of bed rest and immersion for treating the edema of pregnancy. Obstet and Gynecol 75 (2): 147-51

9. Hutton EK, Hassan ES (March 2007). "Late vs early clamping of the umbilical cord in full-term neonates: systematic review and meta-analysis of controlled trials". *JAMA* **297** (11): 1241–52

10. Jackson V, Corasro N Niles C et al (1989) Incorporating waterbirth into nurse-midwifery practice. Journal of Nurses and Midwives 44:4 155-157