Bridgewater Community Healthcare NHS
NHS Trust
Halton and St Helens Division

CLINICAL GUIDANCE

Guideline for the Management of Water Birth in the Community.

For use in:	Midwifery Services
Target Audience:	Midwives
Purpose	To provide maternity staff with the correct procedure for water births.
Document Author:	Julie McIntosh
Approved by:	Clinical Guidelines Group or Equivalent
Ratified by:	Clinical Quality and Standards Group
Policy Index No:	HStHCL294
Version Number:	2.0
Effective From:	June 2011
Review Date:	June 2014

Statutory and legal requirements	CNST Policy based on recommendations from the NHS Litigation Authority
Implementation Lead	Corina Casey-Hardman Head of Midwifery
Implementation Process	Refer to attached dissemination plan

The Trust is committed to creating an environment that promotes equality and embraces diversity, both within our workforce and in service delivery. This document should be implemented with due regard to this commitment.

This document seeks to uphold the duties and principles contained within the Human Rights Act. All Staff within the PCT should be aware of its implications.

If clinical activity takes place i.e. examination, hand decontamination should take place before and after the procedure by following the *"Hand Decontamination Policy".*

This guidance is due for review by **June 2014**. After this date, this guidance and associated process documents may become invalid. All users should ensure that they are consulting the current version of this document.

Key individuals involved in developing the document (Internal Staff Only)

Name(s)	Designation
Julie McIntosh	Midwifery Community Coordinator
Angela O'Neill	Risk Management Midwife/Supervisor of Midwives

Distributed to the following for approvals and comments

Committee(s)	
Members of the Clinical Quality and Standards Committee	
Members of the Clinical Policies Guidelines Group (CPG)	

Individual(s) *(Include email address of external individuals (NON NHS))*	Designation
Corina Casey-Hardman	Head Of Midwifery/Supervisor of Midwives
Angela Black	Team Leader
Tracy McCann	Team Leader
Alison Vowles	Team Leader
Jo Lister	Supervisor of Midwives
Sheila Kennedy	Clinical Audit Facilitator

Revision History and Version Control

Revision Date	Reason for Change	Version No.	By Who	Version No.
0/6/2014	*Document Review*	*1.0*	*J McIntosh*	*2.0*

Table of Contents

Rationale

Labour and/or birth in water can be a wonderfully relaxing experience for the mother and baby. Deep water immersion in labour became popular in the 1970s, when women relaxing in water unexpectedly gave birth. It was realised that fears about drowning were unfounded (Odent,1983), and water birth evolved from there.

Water birth should be regarded as a core midwifery competence (RCM 2000). The Midwife must ensure that she is adequately prepared and competent to undertake this type of labour care (NMC, 2004).

The National Service Framework requires that 'all staff have up to date skills and knowledge to support women who choose to labour without pharmacological intervention, including the use of birthing pools' and 'where ever possible, allow access to a birthing pool with staff competent in facilitating water births' (DOH, 2004).

Scope

This policy applies to all midwives working in the community setting.

Criteria

It is the responsibility of the woman to arrange a water birthing pool for home use. This can be done independently or through her named midwife.

Please take careful note of the following: -

- As one litre of water weighs a kilogram, the woman must ensure that the structure of the floor is able to support the considerable weight of the pool when full.

- The midwife must ensure that the woman has given this matter consideration and document the discussion accordingly on the birthing pool risk assessment form. Appendix 1

- Women should be given information regarding the use of the pool and sign the Pool Hire Agreement form, this is then filed into the woman's notes by her midwife. (Appendix 3)

- It is the responsibility of the woman to ensure that the pool is set up and filled to the appropriate level according to the manufactures instructions, which may take up to an hour.

- The Midwife must familiarise herself with how the pool operates, either by seeking this information from the woman, or reading the manufacturers literature provided.

- Labour should be established before the woman enters the water. A cervical dilatation of 4cms appears to be the optimum time (Church 1989). However there is a lack of robust evidence to set criteria regarding the timing of immersion into water (Eriksson et al 2000). Women may want to use the pool as an analgesic effect within the latent phase. They should be given this as a 'choice' of pain relief.

- All women wishing to use a pool must be assessed by the midwife as low risk according to N.I.C.E Guidance (2008) and Planned Home Birth Care Guideline (2010).The maternal observations must be normal. (If any abnormalities are detected, appropriate medical advice must be sought).

- The woman must agree to leave the pool if requested to by the midwife. The midwife should prepare a safe environment in the event of an emergency evacuation from the pool.

- Midwives must give consideration to health and safety issues at all times during a water birth such as maintaining a safe working environment, keeping the floor dry around the pool, avoiding unnecessary lifting and handling, and poor posture during delivery. The room should be warm and well ventilated.

- The water temperature must be carefully monitored and be maintained at 36.5 degrees Celsius - 37.0 degrees Celsius. A high water temperature is uncomfortable for the woman and may cause a fetal tachycardia (Nightingale 1994, Anderson 2004). An adequate water supply must be available to allow easy removal and addition of water in order to maintain the desired temperature. The room temperature should be maintained at 21-22 degrees Celsius, in order to enable the women to maintain her body temperature by evaporation.

- Midwives will arrange a home visit at 36 weeks gestation to complete a comprehensive home birth /pool birth environmental risk assessment prior to the agreement of the home water birth. (Appendix 2)

1.0 Background

- Benefits of Water Immersion
- Reduced analgesia
- Increases Relaxation
- Increases mobility

1.1 Contraindications to Conducting a Water birth

- Infection
- Pyrexia
- Prolonged Rupture of Membranes
- Body Mass Index more than 35.

- Need for Electronic Fetal Monitoring
- Heavy bleeding/thick meconium
- Oxytocin /Augmentation
- Previous caesarean section
- Multiple birth / Breech presentation
- Women with a history of genital herpes.

The above list is not exhaustive.

2.0 Related documents

This policy should be read in conjunction with the following guidelines:

- Planned Home Birth Care Guideline (HSTHCL085)
- Management of Cord Presentation and Prolapse in the Community Guideline (HSTHCL153)
- Guideline for Perineal repair following a home birth. (HSTH168)
- Shoulder Dystocia at a Home Confinement Guideline. (HSTHCL228)
- Post Partum Haemorrhage at a Home Confinement Guideline. (HSTHCL238)
- Management of a Retained Placenta at Home Guideline. (HSTHCL238)
- Transfer of a Woman or Baby from the Community to an Obstetric Unit in the event of an Emergency Guideline. (HSTHCL 230)
- Intrapartum and Postnatal Bladder Care Guideline (HSTH250)
- Guidance for the Administration of Nitrous Oxide/Oxygen mixture by Midwives during Home Births. (HSTH 008)
- Cleaning and Disinfection Policy, infection prevention and control.(IC26)

3.0 Audit

Audit of compliance with this guideline will be undertaken 3 yearly. A retrospective audit will be presented at the Clinical Audit Meetings and Maternity Staff Meetings.

4.0 Glossary of Terms

The latent phase of labour is defined as a period of time, not necessarily continuous, when there are painful contractions and there is some cervical change, including cervical effacement and dilatation up to 4cm.

The established first stage of labour is defined from when there are regular painful contractions and there is progressive cervical dilatation from 4cm (NICE 2007).

Passive second stage of labour is defined from the finding of full dilatation of the cervix prior to or in the absence of involuntary expulsive contractions.

Active second stage of labour is defined as expulsive contractions with a finding of full dilatation or other signs of full dilatation of the cervix.

Active maternal effort following confirmation of full dilatation of the cervix in the absence of expulsive contractions when the baby is visible.

The third stage of labour is the time from the birth of the baby to expulsion of the placenta and membranes.

5.0 Equipment Required

- Thermometer's to check the water and the room temperatures.
- Fetal Doppler, (water proof if available)
- Delivery pack
- Gauntlet gloves
- Plastic apron
- Plenty of warm towels should be available
- Sieve and bowl to collect debris
- Hand held mirror

Also consider

- Bucket/Hose/Stool/ tap connectors.
- Floatation aids if preferred by the woman

6.0 Management of Labour (First Stage)

There is no clear evidence on optimal pool temperature. Burns and Kitzinger (2001) suggest 35-37°C for the first stage and 37°C for the second stage and birth. NICE (2007) recommend ≤ 37°C.

6.1 The surface temperature is cooler than deeper in the water, so stir the water well to mix it before measuring the temperature.

REMEMBER the fetal temperature in utero is 0.5°C above the maternal temperature.

- Two Midwives (one of whom must be competent in Water birth) must be present at the birth.

- Observations of maternal and fetal well-being are made as for any low risk woman in labour refer to Planned Home Birth Care Guideline (2010).

- Artificial Rupture of Membranes (ARM) must not be attempted in the water. Where ARM is required the women must be assisted to leave the pool.

- Bladder care- refer to Intrapartum and Post-natal Bladder Care Guideline (2010).

- Record the temperature of the water hourly. The room temperature should not exceed 22 degrees celsius to enable the woman to maintain a normal body temperature by evaporation whilst in the pool.

- Children are not allowed to enter the pool.

- No woman must be left unattended whilst in the pool.

- The fetal heart can be auscultated using a WATER PROOF (Blue) Sonicaid (NICE 2001) alternatively the woman can be asked to raise her abdomen slightly in the pool to aid auscultation.

- Ensure water is deep enough to cover the mother's abdomen. Recommended to submerge up to breast area Garland (2011)

- The woman should be encouraged to drink a minimum 500mls of fluid per hour to prevent dehydration Garland (2011)

- Any faeces and other debris, which may contaminate the water, should be removed using a disposable strainer. If the water is very contaminated then it should be changed completely or the woman may be asked to exit the pool.

- Performing vaginal examinations on 'dry land' gives the women the opportunity to stretch her legs and even walk to the toilet to void the bladder.

- Inhalational analgesia (Entonox) can be provided. Refer to Guidance for the Administration of Nitrous Oxide/Oxygen mixture by Midwives during Home Births (2008)

- Should the woman require narcotic analgesia, she should be asked to leave the pool and transferred to hospital.

- Cord prolapse – Remove the woman from the water and initiate the emergency protocol, keeping the pressure of the presenting part of the cord, refer to Cord Prolapse/ Presentation Guideline (2009).

- Eating and drinking in labour- The development of ketosis in labour may be associated with nausea, vomiting and headache and may be a feature of exhaustion. This in turn could lead to an increase in the need for active management of labour and instrumental delivery (Broach and Newton 1998).

  Women should be encouraged to drink during labour and be informed that isotonic drinks may be more beneficial than water.

  Whilst there is a desire to eat and drink in labour, women should be offered a light, nutritious and easily digested meal such as tea and toast.

6.2 Management of Labour (Second Stage)

- Keep the environment calm (low lighting and low voices help this mood, use within the boundaries of safety)

- Water temperature should be recorded every 15 minutes and maintained at 36 to 37 degrees centigrade for delivery (temperature must not exceed 37 degrees centigrade).

- *Spontaneous pushing should be promoted*. Observe for external signs and ensure once active pushing has commenced, that progress is being made.

- Observe progress/crowning/delivery of the fetal head.

- 'HANDS OFF APPROACH' allow the woman to 'BIRTH HER OWN BABY'. If any delay is suspected – assist the woman to get out of the pool.

- DO NOT CHECK FOR CORD

- Await next contraction. Occasionally a little help may be required to release the shoulder this must be a guide only.

- When the baby is delivered the woman is able to reach down and assist the baby to come to the surface of the water gently. Baby's head must come out of the water. To maintain the baby's temperature and so not to allow hypothermia, the body should remain in the water. If baby is not in the water ensure skin to skin with mum and wrap both in warm towels.

- Waterbirth babies do not always cry instantly

- Feel the baby's heart rate and observe the baby's colour assess apgar score at 1 minute and five minutes.

- Ensure the cord is left attached and is still pulsating. Check the cord by feeling it is intact, as a snapped cord can be a life threatening emergency if left unnoticed (Crow & Preston, 2002).

- The umbilical cord must not be clamped and cut while the baby is still under water - as this may initiate respiration (Sweet 1997).

- Under no circumstances if the head is delivered out of the water must you then submerge the baby to proceed with the delivery. This may result in drowning.

6.3 Management of Third Stage of Labour

For ease to the woman and practitioner it may be better to perform the third stage out of the pool. Following delivery the woman could get cold very quickly, for her comfort wrap warm towels around her shoulders, assist her out of the water and dry quickly.

6.4 Physiological and Active Management of Third Stage

Refer to Planned Home Births Care Guideline (2010) / Management of a Retained Placenta at Home Birth.

6.5 At present it is contraindicated to deliver the placenta under water. Therefore, the woman should be asked to leave the pool or the plug pulled following completion of the 2nd stage of labour.

The 3rd stage should be managed according to the woman's choice and existing risk factors.

Oxytocic administration - should not be given under water

7.0 Estimated Blood Loss

This can be estimated by the colour of the water and once emptied on the estimation of the clots that may have collected. It is always better to overestimate than underestimate.

8.0 Perineum

Should be repaired in accordance with the Perineal Repair Guideline 2010. Suturing of perineal tears should be delayed for a least 1 hour to allow for water retention in the tissues to dissipate (unless bleeding profusely).

9.0 Emergency Situations

IN EMERGENCY SITUATIONS THE MOTHER IS HELPED OUT OF THE POOL TO A SUITABLY PREPARED AREA OF THE ROOM

9.1 Meconium stained liquor – Assist the woman from the pool and exit low risk pathway.

9.2 Shoulder Dystocia – Remove the woman from the water and initiate the protocol for shoulder dystocia using the mnemonic HELPERR (ALSO 2001).

9.3 You can not tell if the cord is holding the baby back until the baby fails to deliver. If this happens, confirm the presence of a cord by gentle touch. In the rare eventuality that the cord will not slip over the head, DO NOT CLAMP AND CUT THE CORD UNDERWATER….. proceed with the following:

- Get the woman out of the water quickly. (standing up may be sufficient)
- Once out of the water apply two clamps to the cord and cut between them.
- Snapped Cord –This rare event is usually uneventful if recognised quickly. However, it is sometimes difficult to visualise a snapped cord due to cloudy water or the position of the baby.
- Several cases where the problem has gone unnoticed have had serious neonatal consequences (Crow & Preston, 2002)
- If the cord snaps:
- Grasp the baby's end of the cord quickly to prevent blood loss.
- Apply clamp securely
- Assess baby
- Inform paediatric team for review in hospital.

9.4 Postpartum Haemorrhage- ask the woman to leave the pool quickly and refer to Post-partum Haemorrhage at a Home Confinement Guideline 2010.

9.5 Loss of Consciousness

In the rare event of a women collapsing whilst in a birthing pool DO NOT remove the water (it acts as buoyancy which will assist the attendants when using manual handling techniques to evacuate the woman from the pool. This is an emergency situation so summon help immediately. Refer to Transfer of a Woman or Baby from the Community to an Obstetric Unit in the event of an Emergency Guideline. (2010)

9.6 The Unresponsive Baby

- Clamp and cut the cord
- Transfer the baby to a warm prepared area
- Commence neonatal resuscitation if required.

- Full documentation of observations and procedures should be recorded in the woman's health records and neonatal record.

10.0. Record Keeping

The principles of good record keeping apply to all types of records and must be contemporaneous accurate and timely.

NMC (2009)

11.0 Health and Safety

Practitioners must consider and evaluate manual handling throughout the episode of care.

Ensure correct water temperature for 1st and 2nd stage of labour as recommended in this document.

Ensure only battery operated appliances are used in the room.

Clean up any spillages immediately.

12.0 Cleaning

Liners are for single use only and should be placed in the yellow clinical waste bags for return to base following use. It is the responsibility of the midwife to supervise the cleaning of the pool. The pool should be wiped over with 1% Sodium Hypochlorite containing 10,000 parts per million (Milton solution). On completion this will then be recorded in the hand held notes. Please refer to: IC26 Cleaning and Disinfection Policy, infection prevention and control ((Version 1. 2010). The pool should be completely dry and checked by the midwife before it is packed away for return. The submersible pump should be immersed in warm water containing a neutral detergent such as Hospec and flushed through, if any particles are attached to the pump these should be removed whilst submerged under water with a soft brush.

REFERENCES

Reference	Relevance (whole document or section, please state)	Evidence Grade
Anderson T (2004) Time to throw the waterbirth thermometers away. Practising Midwife; 3 (2):12	Whole	1.
ARM Association of Radical Midwives (ARM) (2000) Association of Radical Midwives Netalk: Checking for cord. *Midwifery matters*, 87, 28-30.	7,10	1.
Crow, S & Preston, J. (2002) Cord snapping at a waterbirth delivery. *British Journal of Midwifery* 10 (8), 494-7	9,11	1.
Eriksson M, Mattson L, Ladfors L (1997) Early or Late bath during the first stage of labour: a randomised study of 200 women. Midwifery; 13:146-8	5	1.
Garland D, 2011 Revisiting Water birth, An attitude to Care. Palgrave McMillan Hampshire.	8	1.
Newton C. (1992) Bath Rights Nursing Times 88 (24) 34-35	Whole	1.
Nightingale C. (1994) Water birth in practice Modern Midwife Jan: 15-19	Whole	1.
Odent M, (1983) Birth Under Water Lancet ;1:1476-77	5	1.
RCOG & RCM (2006) Joint Statement No.1 Immersion in Water During Labour and Birth. RCOG & RCM, London.	whole	1.
RCM (2000) Position paper No 1a The use of water in labour and birth.	5	1.
Sweet B R. (1997) Mayes Midwifery 12th Edition Balliere Tindall London.	9	1.
Nursing and Midwifery Council (2004) Midwives rules and standards. NMC, London	5,	1.
Nursing and Midwifery Council(2009) Record keeping: Guidance for nurses and midwives. NMC, London	11	1.
National Institute of Clinical Excellence CG 62 (2008) Ante-natal Care. NICE London	6	1
National Institute of Clinical Excellence CG 55 (2008) Intrapartum Care . NICE London	6	1

APPENDIX 1	All questions should be asked and answered "yes" prior to a mother entering the birth pool, please complete and file in hand held notes.				NHS Halton and St Helens
Birthing Pool Assessment			Comments	Date	Signature/Print Name/Designation
The midwife is confident to undertake care of a mother in the pool during labour/for delivery. (delete as necessary).	Yes	No			
The midwife is up to date with moving and handling having attended a mandatory training day – in accordance with the Trust Policy.	Yes	No			
The midwife is familiar with Trust Clinical Guideline "Water birth"	Yes	No			
Has the mother requested to use the pool: During Labour /For Delivery (Delete as necessary)	Yes	No			
The mother can get in and out of the pool unaided.	Yes	No			
The mother agrees to leave the pool as requested to by the midwife.	Yes	No			
There are no known or envisaged obstetric problems.	Yes	No			
The mother has had no systemic sedation	Yes	No			
Membranes have been ruptured for less than 72 hours.	Yes	No			
Labour is spontaneous and at term (37- 41 weeks)	Yes	No			
Presentation is cephalic.	Yes	No			
Maternal observations are	Yes	No			

normal.					
Fetal observations are normal.	**Yes**	**No**			

APPENDIX 2

HOME BIRTH ENVIRONMENTAL RISK ASSESSMENT

HEATING	WARM ENVIRONMENT FOR INFANT Y / N	UNSAFE ASPECTS - I.E. STATE GAS LEAK/FALLING COALS/WIRING	STATE ACTION TAKEN
LIGHTING	ADEQUATE Y / N	UNSAFE – I.E. STATE TRAILING WIRES ETC. Y/N	STATE ACTION TAKEN
VENTILATION & EMERGENCY EXITS ACCESS FOR EMERGENCY SERVICES	WINDOWS /DOORS OPEN Y / N	STATE PROBLEM IF APPLICABLE	STATE ACTION TAKEN
WATER	ADEQUATE SUPPLY OF HOT/COLD RUNNING WATER Y / N	IF NO STATE ORIGIN OF WATER SUPPLY	STATE ACTION TAKEN
SPACE CONSTRAINTS	ADEQUATE ROOM TO PERFORM REQUIRED TASKS/EQUIPMENT Y / N	STATE RESTRICTIONS – I.E. FURNITURE	STATE ACTION TAKEN
OBSTACLES	SLIPPERY/UNEVEN FLOORS LOOSE RUGS Y / N	STATE ANY UNSAFE ASPECTS	STATE ACTION TAKEN
EQUIPMENT	ADEQUATE STORAGE AREA/DELIVERY BED/POOL ETC. Y / N	STATE ANY UNSAFE ASPECTS	STATE ACTION TAKEN

SIGNED:

DATE & TIME:

APPENDIX 3

Halton Midwifery Services Pool Hire Agreement

Woman's details /Sticky label

EDC ..... Tele.....

In order to ensure the safety of women and their partners who choose to use a birthing pool at home, we would like you to read the following information.

Location of the pool.

- **The pool should only be inflated and filled when it is needed.**
- **Due to the weight of the pool it is advisable to locate the pool on the ground floor, in the room where it will be used. Once inflated and full the weight equates to 12 adults standing together.**
- **The chosen area should be cleaned and an old blanket or sheet should be placed beneath the pool.**
- **The pool should be located in an area which allows access from all sides. If this is not possible then at least from 2 sides.**
- **The pool should not be leaning against sharp objects or hot radiators as this will cause damage.**
- **There should be a prepared area close by to the pool for you to use if the baby was to be born out of the water i.e. a mattress, a collection of cushions etc. This area should ideally have some plastic covering i.e a shower curtain or plastic sheeting with old clean bed linen or towels.**

Filling /Emptying of the Pool.

- **It will be the responsibility of your birthing partner to fill and empty the pool. The midwife looking after you will advise you on the appropriate temperature. Always fill the pool with cold water then add hot to the required temperature. Please be careful not to overfill the pool, to prevent spillages.**
- **Filling times for the pool vary from 30 minutes to 2 ½ hours depending on the water pressure.**
- **We recommend that you do not enter the pool unless advised to do so by your midwife.**
- **Filled pools should not be left unattended if small children are in the house, children will not be permitted to enter the pool.**
- **Pets should be kept away from the pool to prevent damage.**

Cleaning of the pool

- **After use the pool liner will be discarded by your midwife and she will supervise the cleaning of the pool and equipment.**

Disclaimer:

Halton Midwifery Services cannot accept any liability for any damage caused to your property when using the pool.

I accept the terms and conditions above……

Date……

J. McIntosh (Version 1. June 2011)

APPENDIX 4

EQUALITY IMPACT ASSESSMENT TOOL

To be completed with the corporate document when submitted to the appropriate committee for consideration, approval and ratification.

		Yes/No	Comments
1.	**Does the corporate document affect one group less or more favourably than another on the basis of:**		
	• Age	No	
	• Disability (learning disabilities, physical disability, sensory impairments, mental health problems)	No	
	• Gender Reassignment	No	
	• Marriage and civil partnership	No	
	• Pregnancy and maternity	Yes	Specific to pregnant women
	• Race (including gypsies and travellers)	No	
	• Religion or belief	No	
	• Sex	No	
	• Sexual Orientation	No	
2.	**Is there any evidence that some groups are affected differently?**	No	

If you have identified that there is a potential for one or more groups to be affected differently, then you must now complete a full Equality Impact Assessment Process to ensure that the Trust has covered its legal duties under the Equality Act 2010. For any advice in completing the above or a full EqIA please contact Vikki Morris, E&D Manager on 01744 457279 or vikki.morris@hsthpct.nhs.uk

APPENDIX 5

DISSEMINATION AND TRAINING PLAN

To be completed with the corporate document when submitted to the appropriate committee for consideration, approval and ratification.

The status column must be given a Red, Amber or Green rating with evidence to demonstrate an action has been completed.

DISSEMINATION PLAN

Title of document: Policy on development of corporate documents	Date finalised: May 2011				
Dissemination Lead: (Print name and contact details) Linda Spooner	Previous document already being used? No If yes, in what format and where? Electronic/Intranet				
Proposed action to retrieve out-of-date copies of the document:	Withdraw from the internet/intranet/portal N/A				
To be disseminated to: Corina Casey-Hardman Angela O'Neill Angela Black Tracy McCann Alison Vowles	Disseminated by whom? Angela O'Neill	Timescale (Date) June/July2011	Status R A G Red	Paper or Electronic Both	Comments
Trust Times ☐ Team Brief ☐ Training sessions (Give Details Below) Other (Give Details Below) √☐					

IMPLEMENTATION PLAN

Training	Timescale	Owner	Status R A G
Training Event (*Please provide details of available training venues/dates to educate staff about this document)*	Peer training June/July 2011	Julie McIntosh	Red
Training Plan Lead (*Please provide details of staff who will be responsible for overseeing this training)*	Midwives competent in Pool births.	Julie McIntosh	Red
Compliance Monitoring	**Timescale**	**Owner**	**Status R A G**
• Methodology to be used for monitoring/audit (please include PCT Audit Proposal Form)			
• Responsibilities for conducting monitoring/audit	2014	Sheila Kennedy	Red
• Frequency of monitoring/audit (e.g. annually, 6 monthly etc)	3 yearly		
• Process for reviewing/reporting results			

Denotes: Action not yet taken or deadline for action not met. Action plan to address this must be provided.

Denotes: Action partially implemented.

Denotes: Action complete.