Worcestershire NHS
Acute Hospitals NHS Trust

Guideline for Use of Water during Labour and Birth

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and/or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

Water can be used as pain relief during labour and birth, both at home or in hospital. It is suitable for any pregnant woman who is expected to have a normal birth. This applies to pregnant women booked with either a midwife or Obstetric Consultant. Water increases women's choices for analgesia during childbirth and is the cheapest, most available form of pain relief available to us.

The midwife has a duty to attend the woman, whatever her choice regarding place and type of delivery.

Water has an increasing role as a method of pain relief not only for women with no risk factors, but also for women who do have known risk factors.

This guideline is for use by the following staff groups:

Trained midwives, student midwives, medical students working under supervision and medical staff
NB: Any midwife who has not received instruction in water births/labours, should call to her assistance, either:-

1. A midwife who is competent to facilitate birth in water or
2. A Supervisor of Midwives

Lead Clinician(s)

Rachel Duckett	Consultant Obstetrician
Judi Barratt	Clinical Midwife Specialist

Guideline reviewed and approved by Maternity Clinical Governance on:	23rd March 2014
Extension approved on:	22nd July 2015
This guideline should not be used after end of:	23rd March 2017

Key amendments to this guideline

Date	Amendment	By:
11.10.07	Revised document approved by Obstetrics Guideline Group	
11.12.07	Approved by Medicines Safety Committee	
14.10.09	Document reviewed with minor amendments made	A Talbot
16.12.11	Revised version agreed by Obstetric CGRM. Revisions relate to guidance for VBAC, induction of labour, women with GBS, complications and 'pool in a box'.	Tracey Cooper
16.05.12	Women should be informed that delivery in water may increase their risk of sustaining a third degree tear. Approved by Obstetric Governance Committee 15.06.2012	Miss R Duckett
18.03.14	Audit showed reduction of third degree tears for women who deliver in water have reduced to 4.2% below national average of all third degree tears of 5%. Therefore remove this line from guideline (page 4) Additional information regarding action to take if water temp exceeds 37.5 degree.(page 4)	Louise Turbutt
25.04.16	Document extended for 12 months as per TMC paper approved on 22nd July 2015	TMC

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Introduction

Water can be used as pain relief during labour and birth, both at home or in hospital. It is suitable for any pregnant woman who is expected to have a normal birth. This applies to pregnant women booked with either a midwife or Obstetric Consultant. Water increases women's choices for analgesia during childbirth and is the cheapest, most available form of pain relief available to us.

The midwife has a duty to attend the woman, whatever her choice regarding place and type of delivery.

Water has an increasing role as a method of pain relief not only for women with no risk factors, but also for women who do have known risk factors:

VBAC

Women who have had a previous caesarean section but are suitable for Vaginal Birth after Caesarean Section (VBAC). Although the National guidance recommends continuous fetal monitoring for women attempting VBAC in labour some women may choose to labour and deliver in water. This option should be discussed with the obstetric consultant and a senior midwife when discussing VBAC and the woman made aware of the risks. (WAHT-OBS-046).

Induction Of/ Delay In Labour

There is evidence to support the use of immersion in water when labour is not progressing normally, either following PGE2/ARM, as well as in established labour (WAHT-OBS-058). If the use of oxytocin is required, the use of water is then not appropriate.

Group B Streptococcal Infection (Gbs)

There is evidence to support the use of water in labour and birth for women experiencing GBS (Zanetti-Dallenbach et al 2006). Women experiencing GBS infection should be given antibiotics intravenously (WAHT-OBS-002 GBS guideline) prior to entering or while in the water. The hand with the venflon sited should be covered with a plastic/latex glove and the woman should be asked to keep this hand out of the water.

Competencies Required

Trained midwives, student midwives, medical students working under supervision and medical staff

NB: Any midwife who has not received instruction in water births/labours, should call to her assistance, either:-

1. A midwife who is competent to facilitate birth in water or
2. A Supervisor of Midwives

Inclusion and Exclusion Criteria

All healthy women with uncomplicated pregnancies at term (37 - 42wks gestation) should have the option of waterbirth available to them and should be able to proceed to a waterbirth if they wish. This includes women undergoing induction for post-maturity less than 42 weeks gestation (unless a oxytocin infusion is required), GBS Infection and VBAC (see above).

If labour deviates from the normal risks should be given using evidence based information, this would include:

- Presence of thick /particulate meconium that would necessitate paediatric attendance at delivery.
- Evidence of abnormal FHR
- Evidence of severe intrauterine growth restriction

If a deviation occurs a recommendation should be given to the woman to leave the pool. The written documentation of any discussion is essential.

Complication in pregnancy include:

- Prolonged ruptured membranes (more than 24 hours)
- Active herpes
- Maternal pyrexia/infection
- Hepatitis B/HIV carrier
- Less than 2 hours of Pethidine/meptazinol administration
- Epilepsy
- Previous delivery complications e.g. shoulder dystocia, PPH (may labour in water transferring to dry land for second stage)
- Induction/acceleration of labour for fetal or maternal compromise requiring intravenous oxytocin. (Women being induced solely for post-maturity at less than 42 completed weeks gestation may labour in water.)
- Women requiring a intravenous infusion.

Women with a raised BMI can use the pool if they are able to get in and out of it easily. They should be advised that in the event of maternal collapse and they need to be removed from the pool that there may be a delay in accessing urgent treatment.

Discussion in Pregnancy

An information leaflet is available for all women requesting to use water during labour or delivery. This should have been discussed with a midwife and the woman antenatally, preferably with her partner present.

Temperature of room and water

The temperature of both the water and the woman should be monitored hourly to ensure that the woman is not becoming pyrexial and the water temperature does not go above 37.5° If the water temp exceeds 37.5° add cold water to pool or take woman out until water temp is 37.5°

Women should be encouraged to regulate the temperature of the water to suit themselves (in line with the above monitoring) for their own comfort and encourage them to leave and re-enter the pool in the first stage of labour as and when they wish.

The ambient room temperature should be comfortable for the woman.

Women should be encouraged to drink throughout labour to prevent dehydration.

In labour

- Discuss the use of water with the woman and her partner.

- Allow her to leave and re-enter the pool when she wishes.
- If uterine contractions cease, encourage mobilisation.
- Discuss physiological and active management of the third stage and document her choice. The woman should not be left unattended in the pool (Partner and or midwife should be present).
- Follow normal birth guideline (WAHT-OBS-058) - use a Pinnard stethescope or a waterproof sonicaid/doppler for intermittent monitoring in water.
- If the woman raises herself out of the water and exposes the fetal head to air once the presenting part is visible she should be advised to remain out of the water to avoid the risk of premature gasping under water by the baby.
- Observation of vaginal loss – may be difficult as the loss is diluted in the water, however, observation of blood and/or heavy meconium stained liquor would be obvious.
- Mop up any spillage immediately.
- **The use of additives, i.e. aromatherapy oils, should be avoided.**

Further Pain Relief

- Consider entonox only.
- If further pain relief is required, the mother must leave the pool.

Delivery of Baby

- Check the temperature of water as previously stated.
- Allow the head to deliver naturally ('hands off'), there is no need to encourage pushing.
- It is not necessary to feel for the presence of nuchal cord.
- Keep two cord clamps available in the event of the nuchal cord snapping as the baby comes to the surface.
- Ensure baby is delivered fully immersed and brought gently to the surface – head first – assist mother to hold baby. Avoid undue traction of umbilical cord as baby's head surfaces from the water.
- Observe for breathing movements.
- Assess apgar score.
- Following the birth of the baby, consider resting baby, head above the water, at the level of the mother's uterus (baby's body still submerged for warmth).
- **Physiological third stage:**
  Physiological third stage should be an option, as for any other low risk birth. The cord is left unclamped and uncut until the placenta and membranes are expelled by the mother in the pool. See normal birth guideline (WAHT-OBS-058).
- **Active management of third stage:**
  Clamp and cut the cord only when the baby's head is completely out of the water. Syntometrine can be administered by IM injection in to the deltoid muscle in the arm, to avoid disturbing her. Continue with active management as normal in or out of the water, depending on the woman's choice.

- **Following delivery of placenta**
  Examine for perineal/vaginal trauma – delay repair of perineum for 30 - 60 minutes as perineum will be water saturated.

  Blood volume to be estimated as less than 500mls or more than 500mls.

  NB: In an extreme emergency, i.e. if the woman were to become unconscious, a lifting net is supplied which can be slipped under the woman whilst still in the water to aid lifting the woman from the pool. This procedure will require at least four members of staff. To be laundered after use (send as special/single item to laundry). Do not empty pool.

  Woman should be lifted from the pool using approved local manual handling device.

  Where a woman refuses to leave the water, the midwife should call another midwife and/or Supervisor of Midwives to her assistance. In these circumstances written documentation of any discussions with the woman and her birth partner are extremely important.

Health & Safety Guidance / Considerations

1. Any midwife or attendant suffering from rashes, cuts or lesions to the hands and arms, must not attend or assist at waterbirth and should attend Occupational Health Department for advice.

2. Protective clothing should be worn when contact with bath water is anticipated.

3. Midwives and attendants at waterbirth should be aware of manual handling risks and assessment. Midwives must attend annual mandatory updating in this area. Backache could occur if the attendance/midwife was constantly kneeling or leaning over the bath.

4. Part of the philosophy of waterbirths is 'minimal handling', therefore, it should not be necessary for midwives to remain very close to the bath for any length of time.

5. Bath mats must not be used inside the bath. If the woman wishes to use a 'lilo' type pillow whilst in the bath, this can be supplied by herself and taken away with her after use.

6. If a 'pool in a box' is used, this should be inflated, filled and emptied as per manufacturer's instructions. Photographs and information of how to do this are available on the Delivery Suites.

7. The bath water should be sieved as required (using plastic sieves provided) to keep the water as clear and clean as possible. Plastic sieves are thrown away following each birth.

8. The debris should be collected in a bedpan and disposed of as normal i.e. sluice/toilet.

9. Clear away any spillage immediately (to prevent accidents) a clean mop and bucket should be kept in the 'bath room' solely for this use.

10. After use, all equipment used in the bath should be cleaned as directed:-

a) The bath should be rinsed with hot water, cleaned with detergent, rinsed and then cleaned with a solution of sodium hypochlorite (Presept tabs) 1,000 parts per million

(1 tab to 1 litre of water), rinsed again with hot water and dried thoroughly using paper towel. Surrounding areas should be wiped with sodium hypochlorite – 1,000 parts per million for the pools in hospital. When using a 'pool in a box', a disposable liner is used, this should be disposed of according to manufacturer's instructions.

b) Water sonicaid/bath thermometer – should be wiped over with alcohol wipes and allowed to dry before storing.

11. No electrical mains operated equipment to be used in the bath e.g. CTG monitor.

Check with cleaning policy and RA.

NB: It is not necessary to collect water samples for microbiological assay.

Monitoring Tool

STANDARDS:

Item	%	Exceptions
Appropriate exclusion criteria are adhered to for all women	100%	Woman's choice to enter water against medical advice
Water temperature kept within recommended range	100%	

How will monitoring be carried out?	Audit of medical records
Who will monitor compliance with the guideline	Obstetric Clinical Governance/Audit Groups or Directorate Group.

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Contribution List

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Circulated to the chair of the following committees/groups for comments

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Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	Race	No	
	Ethnic origins (including gypsies and travellers)	No	
	Nationality	No	
	Gender	Yes	Pregnant women only
	Culture	No	
	Religion or belief	No	
	Sexual orientation including lesbian, gay and bisexual people	no	
	Age	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	N/A	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	

If you have identified a potential discriminatory impact of this key document, please refer it to Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Human Resources.

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	**Yes/No**
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval