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Guideline for the Management of Women Requesting Immersion in Water for Active Labour and/or Birth

A Guideline

For Use in:	Delivery Suite (DS), Midwife Led Birthing Unit (MLBU), and at Homebirths
By:	Midwives and Obstetric Doctors
For:	Women requesting immersion in water for active labour/birth
Division responsible for document:	Division 3
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Assessed and approved by the:	Maternity Guidelines Committee If approved by committee or Governance Lead Chair's Action; tick here ☑
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If Yes - does the strategy/policy deviate from the recommendations of NICE? If so why?	No

Version and Document Control:

Version Number	Date of Update	Change Description	Author
6	22/06/2020	Reviewed and amended and links to Trustdocs 850	Tracy Miller

This is a Controlled Document

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Background

The therapeutic properties of water as a form on analgesia in labour and childbirth are well-recognised and documented. Evidence suggests that water promotes oxytocin production, thus encouraging the physiological progress in labour (Shaw-Battista 2017). The following benefits are associated with the safe use of water in labour (RCM 2018):

- Facilitating mobility and enabling the woman to assume comfortable positions
- Gives the woman a greater feeling of control
- Provides significant pain relief and greater satisfaction
- Promotes relaxation and reduces the need for drugs and interventions
- Can shorten the duration of labour
- Protects the mother from interventions by giving her a protected private space
- Can help reduce use of epidural and caesarean section rates
- Encourages an easier birth for woman and a gentle transition for the neonate
- Is highly rated by women - typically stating they would consider giving birth in water again

Inclusion Criteria

The inclusion criteria for using water for labour and birth is the same as that for midwifery led care of low risk women (see Intrapartum Care in all Settings Trust Docs Id 850 and Trust Guideline for the Midwife-Led Birthing Unit (MLBU) Operational Guideline Trust Docs Id Trustdocs Id 7181.

It is the responsibility of all maternity providers to ensure that women are supported to make an informed choice in relation to where they labour and birth their baby.

Women outside of the recommended criteria may still be appropriate for water immersion in labour/birth. In this instance, a clear plan should be agreed by the woman and the multi-disciplinary team. This plan should be documented on E3 and in the handheld records. Waterproof telemetry is available on DS if continuous fetal monitoring is recommended.

The midwife responsible for admission should also consider any issues with mobility that might hinder a rapid evacuation from the pool. These include, but are not limited to; pelvic girdle pain, raised BMI, mobility issues. This should to be discussed with the woman and a plan documented.

Low risk women, undergoing induction of labour (IOL) who go into established labour following artificial rupture of membrane (ARM) or administration of Prostaglandin, are eligible for water immersion in labour/birth.

Precautions.

Due to the sedating effect on the woman and fetus, when opiates such as pethidine or oromorph have been administered, the following should be considered: the NICE

Intrapartum Guideline (2017) states that 'Women should not enter water (a birthing pool or bath) within two hours of opiate administration or if they feel drowsy'.

If active labour is not established, using water for pain relief can sometimes slow the progress of labour. It is therefore advisable that labour is established before entering a birthing pool for use. This should not preclude women from using the bath or shower to help them cope in early labour.

The woman must be advised, prior to entering the pool, that she will be asked to leave the pool if complications arise or circumstances deviate from the norm.

Women planning to use a pool at home should be advised to wait until the midwife has arrived before entering the water. This enables baseline observations to be performed, assessment to confirm that the woman is in active labour and the fetal heart rate is within the normal range.

Observations

- Baseline observations should be recorded before entering the pool. All observations should then be carried out as per low risk labour with the exception of maternal temperature which should be taken and recorded hourly (see guideline for Intrapartum Care in all Settings Trust Docs Id 850).
- Intermittent auscultation of the fetal heart, using waterproof Doppler, should be performed as stated in the current NICE guidelines (intrapartum care 2017) and in accordance with the NNUH Intrapartum Care in all Settings Trust Docs Id 850).
- If there are any concerns about maternal or fetal wellbeing or progress of labour, the woman should be asked to leave the pool. If deviations from the norm are confirmed, the opinion of an obstetrician should be sought. This may require transfer to DS from MLBU or home via ambulance (See home birth guideline ID 805).
- All staff involved in the care of a woman using the pool must be familiar with the procedure for evacuation from the pool in an emergency (Appendix 1). When a woman wishes to labour/birth in water at home the logistics of evacuation in the case of emergency should be discussed with the woman and her birth partner(s) prior to entering the water.
- The water should be kept as clear and clean as possible and also at the appropriate temperature (see guidance below).

First Stage of Labour

- Care in labour should be undertaken as per Intrapartum Care in all Settings Trust Docs Id 850.
- During the first stage of labour, the water temperature should be comfortable for the woman and not above 37.5°C. The water temperature should be checked hourly and recorded in the maternal handheld records.
- Maternal temperature should be checked hourly and if the woman feels too hot she should leave the pool until she has cooled down.
- Women should be encouraged to drink adequate cool fluids while in the pool to prevent dehydration.

- The depth of the water should be, at least, up to the womans' axilla when she is in a sitting position. This aids buoyancy and promotes movement, which aids the progress of labour and increases maternal control. This will also give enough depth should the woman choose to give birth in the water.

Second Stage of Labour

- Care in labour should be performed as per Intrapartum Care in all Settings Trust Docs Id 850.
- Two midwives should be present for the birth, one of whom should be experienced in caring for women labouring and giving birth in water. If a 2nd midwife is not available, an experienced Maternity Care Assistant (MCA) is appropriate.
- The water temperature should be maintained at 37 - 37.5 °C for the birth (RCOG 2006).
- The water must be deep enough for the baby to be born completely submerged under water.
- Progress of the emerging head can be observed with a mirror. Slow crowning and birth of the head should be encouraged to minimise perineal trauma.
- The 'hands off' method of birth should be practised. This will minimize the stimulation to the emerging baby. Traditional control of the head during crowning and palpation of the umbilical cord following birth are unnecessary. (RCOG/RCM 2006; Nutter et al. 2014). The cord can be loosened and disentangled if necessary as the body emerges. The cord should never be clamped and cut whilst baby is still under the water. The woman or midwife reach down and support the baby as it emerges. Be aware that restitution still occurs under water and at no point should the midwife expedite the birth of the body unless suspected shoulder dystocia is observed. All manoeuvres for shoulder dystocia should be performed clear of the water.
- The baby should be brought to the surface, face uppermost, and care taken to ensure the cord is long enough to allow this. Following the birth rest the baby's head above the water keeping the body in the water, skin to skin with woman. This will keep the baby warm and promote skin to skin contact.
- Once the baby's head has come out of the water it must not be submerged again.
- Avoid undue traction on the umbilical cord as the baby's head surfaces from the water. This minimises the possibility of the cord snapping.
- Clearly document whether the baby was born under water and the condition of the baby at birth.

Third Stage of Labour

- If the woman is having a physiological third stage, and condition of woman and baby allows, there is no need to clamp the cord until the placenta is delivered.
- The mother may wish to remain in the pool for the third stage of labour and there is no evidence to contraindicate delivery of the placenta in water. However the

blood loss should be carefully observed and if the water is blood stained enough to impede visibility the woman should be asked to leave the pool.

- If the woman requests active management of the third stage or it is clinically indicated, she needs to sit above the water on the pool step or vacate the pool.
- The estimated blood loss should be recorded as less than 500 mLs or greater than 500 mLs.
- Both woman and baby should be kept warm following the birth.
- Perineal inspection should be undertaken as soon as is reasonably possible following exit from the pool and prompt senior review sought if 3rd/4th degree tear suspected
- Suturing should be delayed for one hour due to water saturation of the tissues unless bleeding is excessive and prompt suturing is required.

Infection control and safety

The following steps should be taken to maintain safety and minimise the risk of infection:

- Personal protective equipment (PPE) should be worn by the midwife; these should include either gauntlet gloves and plastic apron or standard gloves with care taken to wash hands and arms prior to and following auscultation.
- The area surrounding the pool should be kept clear and dry in case of emergency evacuation and to avoid slipping.

In hospital

- The pool must be emptied and rinsed as soon as possible after use.
- Cleaning is as follows: scrub with Hospec Scrub, using appropriate mop, followed by either Actichlor 10% (MLBU) & Tristel® (DS) solution made up as per the manufacturer's instructions to the correct concentration as per Infection control guidelines, rinse thoroughly thereafter.

Training and Awareness

- All midwives should be competent to support women choosing water for labour/birth. Any Midwife wishing to update his/her skills should contact the Practice Development Team and arrange to work on the MLBU.

Consultation

This guideline was originally written by Midwifery Guidelines group. It has been subsequently reviewed and amended to incorporate more recent research and practice and is in keeping with the NICE guideline for intrapartum care (2017). In April 2020 Tracy Miller reviewed and updated. This version is endorsed by Maternity Guidelines Committees.

Distribution List

Head of Midwifery
Risk Manager
Clinical Managers
Community Team Leaders
Trust Intranet

References

NICE Clinical Guideline (QS105) Intrapartum Care 2017

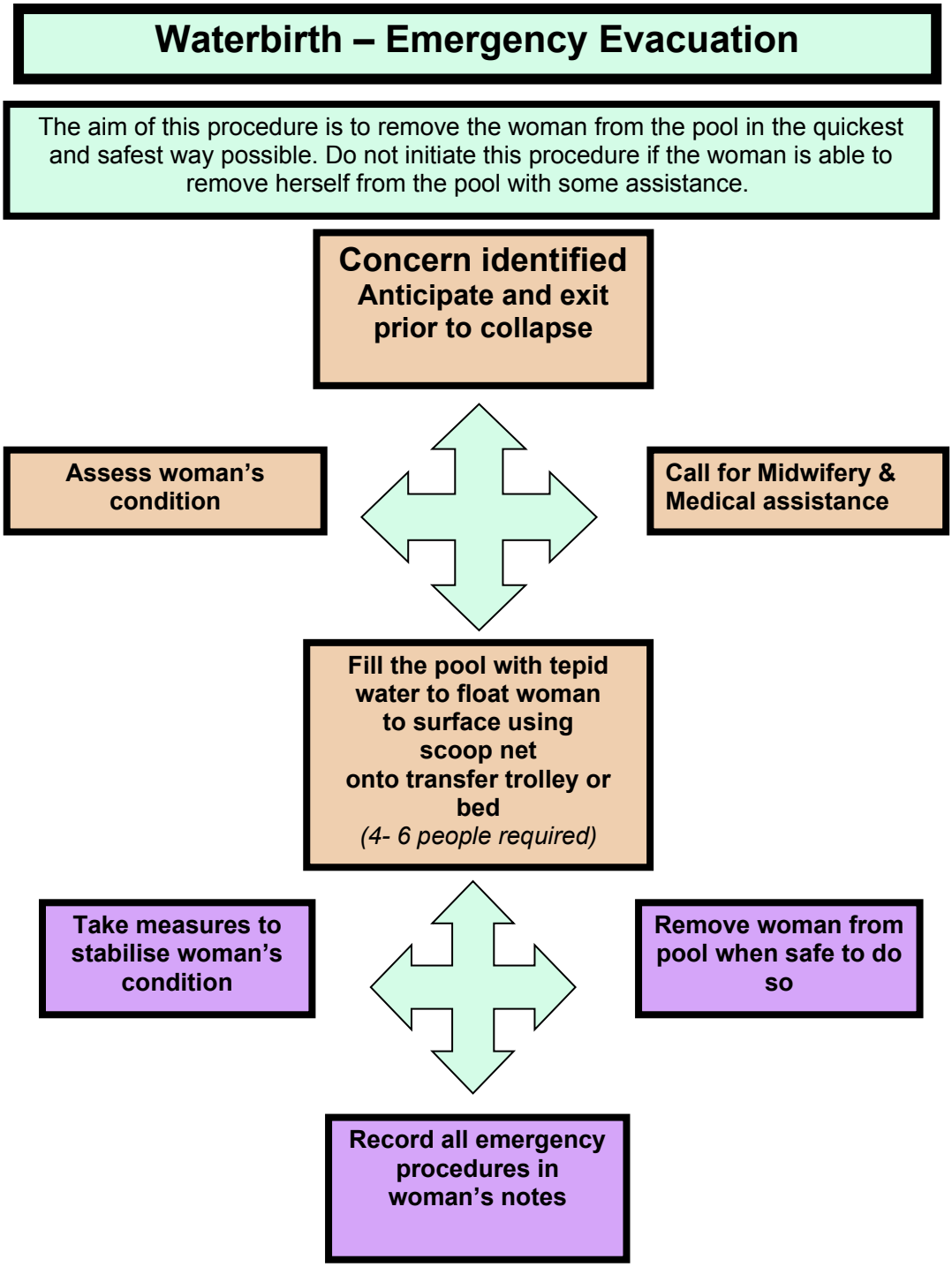
Nutter et al (2014) Waterbirth: an integrative analysis of peer-reviewed literature.

RCOG/RCM (2006) Joint statement No.1 Immersion in water during labour and Birth

Shaw-Battista, (2017) Systematic Review of Hydrotherapy Research: Does a Warm Bath in Labor Promote Normal Physiologic Childbirth?

RCM (2018) RCM Midwifery Blue top guidance: Midwifery Care for all women in all settings

Appendix 1



Drills for dealing with emergency situations should be practiced as part of the routine PROMPT updates and attendance will be recorded.