No.31 Guidelines for Waterbirth

Before using the pool.

The midwives should have attended the emergency pool evacuation training and achieved the competency required before caring for a woman in the pool. However, if the co-ordinator is competent in this skill this is satisfactory. As part of the routine checks the hoist and slings should be checked (check MEMS is in date on the hoist) before pool use, which should also be documented in the handheld notes.
NB The maximum weight for the hoist is 180kg.

A waterbirth at home with the Jubilee Team can be facilitated. Cross reference with AN 26 "Homebirth guideline".

1. Criteria for Mothers Suitable for Waterbirth

- Present in spontaneous labour
- Be between 37 – 42 weeks gestation
- Cephalic presentation
- Singleton pregnancy
- BMI <35
- No significant medical / obstetric complications, e.g.:
  - Previous caesarean section
  - Obstetric complications, i.e. APH, mec
  - Previous obstetric complications e.g. shoulder dystocia, difficult instrumental delivery, third degree tear
  - Severe skin lesions
  - Hypertension/ pre-eclampsia
  - Women requiring syntocinon infusion for induction / acceleration of labour
  - Multiple pregnancy
  - Malpresentation
  - Pre-term labour
  - Intra-uterine growth retardation/SGA IOL
  - IOL for reduced fetal movements
  - Medical conditions, e.g. epilepsy, please refer to obstetric team for review
  - Hepatitis B carrier, active herpes

NB Group B strep infections are not a contraindication for waterbirth (however, do not forget to give intrapartum antibiotic cover – see guideline AN 7 GBS).

VBAC is permissible in water as long as there is IV access and continuous electronic FH monitoring, i.e. use of wireless waterproof CTG monitor. Use of the FSE is contraindicated in water.

Following IOL for post dates or social inductions with Propess, women who then proceed to labour actively with no further augmentation required, and have had a normal CTG, may consider a waterbirth, where intermittent auscultation is acceptable.
Induction of labour: Women who labour without syntocinon infusion following Propess induction can be offered use of the pool providing there is no evidence of hyper-stimulation and a risk assessment has been performed. If the IOL is for maternal/fetal reasons, then continuous electronic fetal monitoring is required.

2. Guidelines Specific To Water Birth Management

Management of labour and delivery continues to follow along the normal guidelines but there are some specific issues that need to be considered when caring for a woman having a water birth.

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.

The woman should be encouraged to leave the pool to mobilise if her contractions become irregular, infrequent, short lasting or weak. It is essential that the effectiveness of contractions is monitored closely to ensure the labour continues to progress. The fetal heart should be monitored as per unit guideline.

If the woman has received a single opioid for pain relief (oral morphine/diamorphine) she must wait 2 hrs before entering the pool and until she is no longer drowsy.
If she has received multiple doses then wait 4 hrs before entering the pool again.

2.1. Nutrition in Labour

Additional fluids are required due to the dehydration effects of being in the pool. The woman should be encouraged to have frequent clear fluids.

2.2. Management in the Pool

Additional observations and recordings:

2.3. Water temperature

For women labouring in water, monitor the temperature of the woman and the water hourly to ensure that the woman is comfortable and not becoming pyrexial. The temperature of the water should not be above 37.5°C (NICE 2007).

NB The pool at PHNT does not hold the heat well so midwives must check half hourly or at least after adding more hot water. Monitor readings from the bottom of the pool by agitating the water if required, dependant on the thermometer being used.

2.4. Maternal Temperature

Record maternal temperature hourly. Apply normal reference points for abnormality. Where labour is progressing normally an isolated rise in temperature may be indicative of early signs of dehydration rather than maternal infection, the woman should be encouraged to increase her fluid intake and temperature monitored closely to ensure it settles to within the normal range.

2.5. Fetal Observations

As per normal

2.6. Assessment of progress.

As per IP guideline no.13 *General principles of intrapartum care & cord bloods*.

2.6. Management of Second Stage

A "hand's off" approach is encouraged to avoid tactile stimulation of the fetus. In addition traditional controlling of the head is considered unnecessary.

If during delivery the fetal head does not remain totally immersed the mother must not re-enter the pool. The baby should be brought to the surface as soon as possible at delivery.

N.B. The cord should not be cut or clamped under water.

2.7.Indications for Leaving the Pool

- Inadequate progress.
- Abnormal maternal or fetal observations.
- Meconium liquor.
- Excessive blood loss, with APH suspected.
- Excessive water contamination.

3rd Stage

The placenta is normally delivered out of water. A physiological 3rd stage is usually appropriate following a waterbirth. Syntometrine may still be used at the discretion of the midwife and in accordance with the mother's preference. This should be administered out of the water.

3. Management of the Neonate

If the mother wishes to keep the baby in water after delivery ensure the baby is submerged to shoulder level and the water temperature kept between 37°c and 37.5°c. Alternatively the baby may be wrapped warmly in the usual way.

4. General Safety Issues, Personal Protective Equipment (PPE) and Electricity

- The pool is deep. A 'hands off' approach is encouraged to avoid neck and back injury to staff.
- Should a vaginal assessment be required use the high seat of the pool to avoid over stretching.

Unexpected maternal collapse:

- Call for immediate assistance.
- DO NOT remove the water. Continue to fill the pool; this will facilitate buoyancy and assist the midwives to evacuate the woman and safe application of the hoist.
- Keep the woman's head above the water and manage her airway. One person should maintain the woman's airway throughout the evacuation procedure and while on the transfer trolley or bed.
- Start immediate resuscitation if required. The ABC of resuscitation always applies.

N.B. Water is a conductor of electricity. Please ensure your hands are thorough dry before using electric power points.

Water birth at home: (Refer to AN guideline 26 Homebirth)

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.

5. Partners in the Pool

We do not advocate partners entering the pool. Partners should be encouraged to support the woman by other methods.

6. Cleaning the pool

Instructions for cleaning and disinfecting water birth pool and surrounding area (infection control)
Before use

The pool needs to be cleaned every 24 hours, as per instructions below. On completion please sign the Labour Ward Coordinator Daily Checklist. If a member of Serco has cleaned the pool as per guidance below please sign on their behalf.

Prior to each use and every 24 hours (to coincide with the daily pool cleaning), the pool taps need to be run for 2 minutes, as per water flushing guidelines.

After Use

6.1. Use the standard infection control precautions (plastic apron and disposable gloves) when cleaning the pool. Ensure the area is well ventilated.

6.2. Remove any debris from the pool, using the sieve, before emptying the pool (to prevent debris blocking the pool outlet). Please ensure the thermometer has been removed from the pool prior to emptying the pool, in order not to block the pool outlet.

6.3. Use a non-abrasive detergent to clean the pool of any further debris and blood; ensure the tap is cleaned first, so as not to transfer micro-organisms from the “dirty” pool area to the cleaner tap region. Rinse well with warm water.

6.4. Ensure the pool tap outlet is turned to “closed” prior to cleaning the pool tap and pool area with the Actichlor Plus chlorine releasing disinfectant tablets with detergent (1 tablet to 1 litre of water).

6.5. Clean the pool tap first prior to cleaning the pool with the Actichlor Plus solution, as above.

6.6. When cleaning the pool itself, pour the Actichlor Plus solution around the side of the pool. Using a clean disposable cloth, clean the surfaces of the pool. Leave the solution in the pool for 10 minutes. Discard this cloth.

6.7. Open the tap outlet and empty the pool of the Actichlor Plus solution.

6.8. Using cold water, rinse the tap then the pool to remove all traces of the Actichlor Plus solution, to prevent any residue being left on the pool surface.

6.9. Dry the entire surface of the pool using a clean cloth or fresh disposable cloth. Ensure all cloths are disposed of in a yellow clinical waste bag.

6.10. Ensure the outside of the pool, window ledges, sink and its tap are cleaned with an Actichlor Plus solution.

11. To clean the equipment (pool thermometer, mirror) used: wash and rinse these in warm water. Then soak for a minimum of 30 minutes in Actichlor Plus solution. After this, rinse and dry the equipment. Throw the sieve away. These are one use only.

7. Record keeping

It is expected that every episode of care be recorded clearly, in chronological order and as contemporaneously as possible by all healthcare professionals as per Hospital Trust Policy. This is in keeping with standards set by professional colleges, i.e. NMC and RCOG.

All entries must have the **date and time** together with **signature and printed name.**

Monitoring and Audit

Auditable standards:
Please refer to audit tool, location: 'Maternity on cl2-file11', Guidelines

Reports to:
Clinical Effectiveness Committee – responsible for action plan and implementation of recommendations from audit

Frequency of audit:
Annual

Responsible person:
Senior CDS midwife

Cross references

Antenatal Guideline 7 - Group B strep

Antenatal Guideline 13 General principles of intrapartum care & cord bloods
Antenatal Guideline 31 - Maternity Hand Held Notes, Hospital Records and Record Keeping

Antenatal Guideline 44 - Guideline Development within the Maternity Services

References

Church (1989)
National Institute for Clinical Excellence (2007) NICE Clinical Guideline 55**. Intrapartum Care: Care of healthy women and their babies during childbirth**. London: NICE.
Royal College of Midwives (2012) Immersion in Water for Labour and Birth. Evidence Based Guidelines for Midwifery-Led Care in Labour. Royal College of Midwives Trust.

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