Mid Essex Hospital Services NHS
NHS Trust

| GUIDELINE FOR WATERBIRTH LABOUR, DELIVERY IN WATER AND THIRD STAGE MANAGEMENT | CLINICAL GUIDELINES<br>Register no: 04237<br>Status: Public |
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| Consulted With | Post/Committee/Group | Date |
|---|---|---|
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| **Professionally Approved By** | | |
| Mr Spencer | Clinical Director, Obstetrics & Gynaecology | August 2009 |

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| 1.0 | Julie Bishop | November 2005 |
| 2.0 | Maggie Jarrett | February 2007 |
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| 3.1 | Sarah Moon - Amendments to guideline post move to PFI | April 2011 |

It is the personal responsibility of the individual referring to this document to ensure that they are viewing the latest version which will always be the document on the intranet

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## 1.0 Purpose of Guideline

1.1 The aim of this guideline is to provide staff with the appropriate information to enable suitable women who request it, the option of water for labour and delivery.

## 2.0 Equality and Diversity

2.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

## 3.0 The Benefits of Water for Labour and Delivery

3.1 The benefits of water for labour and delivery are as follows:

- Lowers anxiety
- Fewer instrumental deliveries and caesarean sections
- Fewer third degree tears
- Normal birth reduces risk of postnatal depression
- Greater satisfaction for the woman and midwife
- Water reduces the need for pharmacological analgesia

## 4.0 The Criteria for using the birthing pool

4.1 The Criteria for using the birthing pool are as follows:

- Spontaneous onset of labour
- Low risk patients 37-42 weeks gestation
- No known obstetric problems
- Cervical dilation >5cms
- No fetal distress
- Spontaneous rupture of membranes < 48 hours
  (Refer to 'Guideline for the management of term pre-labour rupture of membranes'. Register number 08049)
- No sedation in the last 4 hours
- No bleeding
- Good progress

## 5.0 The Criteria for Exclusion from the Birthing Pool

5.1 The criteria for exclusion from the birthing pool are as follows:

- Small for gestational age (SGA)
- Fetal abnormalities
- <37 weeks or > 42 weeks gestation
- Multiple births
- Meconium stained liquor
- Fetal distress
- Raised blood pressure (BP) or temperature
- Previous LSCS
- Any patient whose parameters fall outside of the normal labour criteria
  (Refer to the' Guideline for the management of normal labour and prolonged labour in low risk women'. Register number 09079)

## 6.0 Adverse Effects of Delivering in Water

6.1 The only form of pain relief available for patients who choose to labour and deliver in water is entonox. Any other form of pain relief will require the patient to leave the pool.

## 7.0 Care of the Patient and Fetus during the First Stage of Labour

(Refer to the guideline entitled 'Guideline for the management of normal labour and prolonged labour in low risk women'; register number 09079)

7.1 The room temperature should be kept at an ambient temperature, to assist in maintaining maternal core temperature a fan should be available along with cool drinks to prevent dehydration.
(Any fan in the room should be far enough away from the water to not be deemed a hazard).

7.2 The ambient air temperature should be between 21-22 degrees centigrade for delivery:

- Half hourly measurements of water temperature should be regulated between 36-37 degrees, thus preventing hypothermia or hyperthermia
  (water temperature recordings should be recorded on the partogram)
- The patient should be free to enter or leave the pool as desired
- Patients should be encouraged to void every 2-3 hours in labour with a low threshold for catheterisation if unable to void. The patients are encourage to exit the pool to use the toilet
  (Refer to 'Guideline for the management of bladder care'. Register number 09007)

7.3 Maternal and fetal observations are as follows:

- Half hourly pulse
- Hourly maternal temperature
- Four hourly BP recordings
- Auscultate the fetal heart rate every 15 minutes with water proof dopplar.
- All maternal and fetal observations must be entered onto the partogram and recorded in the patient's healthcare records

7.4 At no time should a woman be left unattended in the pool. In the event that the midwife is required to leave the room, the patient's partner /carer should be present and they should be made aware of how to summon help either by pulling the emergency button or shouting.

7.5 The midwife caring for the patient should ensure that the water birth audit is completed for all patients entering the pool and/or delivering in the pool. The designated midwife for the water birth audit will ensure audit data is collated from both the CLU and MLU's for analysis.

## 8.0 Care of the Patient and Fetus during the Second Stage of Labour

(Refer to the guideline entitled 'Guideline for the management of normal labour and prolonged labour in low risk women'; register number 09079)

8.1 The second stage of labour must be conducted by two practicing midwives. The midwife responsible for the delivery should be competent and skilled in caring for patients who choose to deliver in water.

8.3 The water temperature should be maintained between 37.0 - 37.5 degrees centigrade. Evidence suggests that this range of temperature enhances uterine activity and prevents initiation of respirations in the newborn.

8.4 Auscultate the fetal heart rate every 5 minutes following a contraction.

8.5 Once the vertex is visible the patient will respond to the expulsive contractions

8.6 **A 'hands off' approach** is recommended for delivery of the head. Immersion in water appears to enhance the elasticity of the perineum. The counter pressure of the water enables the mother to push more steadily and thus encourages controlled birth of the head.

8.7 **Do not feel for the cord**. Cord stimulation may initate respirations.

8.8 **Under no circumstances** should the **cord be clamped** and **cut under water.**

8.9 The baby should be brought gently to the surface. This can be facilitated by the mother or father supported or assisted by the midwife, to allow the cold air to stimulate respirations.

8.10 The baby's body should be submerged in the water up to his neck to help maintain the correct body temperature, with the head held slightly tilted to assist the drainage of mucous.

8.11 Once the cord has stopped pulsating it may be clamped and cut. If the infant does not established respiration's after gentle stimulation the cord should be clamped and cut immediately, and the infant taken to the resuscitation area for neonatal resuscitation.

## 9.0 Care for the woman and fetus during third stage of labour

9.1 It is recommended that the placenta is delivered outside of the pool to enable more accurate assessment of maternal bleeding. Warmth has a relaxing effect on the uterine muscle that could, theoretically lead to increased bleeding after delivery of the placenta or possibly retained placenta. The amount of blood lost during delivery may also be difficult to estimate when diluted in the pool.

9.2 If the patient has opted for the active management of the third stage, syntometrine® 1ml intramuscularly, should be given when the patient has left the pool.

9.3 After birth encourage all patients to void within one to two hours, with a maximum of 6 hours.
(Refer to 'Guideline for the management of bladder care'. Register number 09007)

## 10.0 Perineal Repair

10.1 If the patient requires suturing this may be postponed for up to 1 hour post delivery, allowing the perineal tissue to revitalise after being submerged in water.
(Refer to the 'Guideline for perineal repair'; register number 07066)

## 11.0 Situations that require the patient to leave the pool

11.1 The patient should leave the pool for the following indications:

- The need for pharmacological pain relief
- Maternal pyrexia or tachycardia
- An abnormality in fetal heart rate
- The presence of meconium stained liquor
- Failure to progress
- Any vaginal bleeding other than a show
- At delivery if the cord is tightly around the neck
- In the event of shoulder dystocia
- Postpartum haemorrhage

## 12.0 Health and Safety

12.1 The cleaning and maintenance of all equipment used during a water birth will help prevent the spread of infection.

12.2 Health and safety regarding moving and handling should be adhered to at all times. (Refer to Appendix A)
(Refer to the Trust policy entitled 'Moving and Handling'; register number 04090)

12.3 The hoist should be checked prior to the patient getting into the pool and the midwife should have been trained in its use.

12.4 Staff should not be bending over the pool thus it is permissible to ask the patient to hold the dopplar to her abdomen or stand for auscultation.

12.5 Any spills or water on the floor of the pool room should be cleared up immediately with dry towels to prevent slips. For this reason a good supply of clean towels should be kept in an easily accessible place.

12.6 In the event of an emergency the emergency exit procedure should be followed. (Refer to Appendix A)

## 13.0 Staffing and Training

13.1 All midwifery and obstetric staff must attend yearly statutory training which includes skills and drills training, including the management of PPH, maternal resuscitation and early recognition of the ill patient.
(Refer to 'Mandatory training policy for Maternity Services (incorporating training needs analysis. Register number 09062)

13.2 All midwifery and obstetric staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal.

## 14.0 Infection Prevention

14.1 All staff should follow Trust guidelines on infection control by ensuring that they effectively 'decontaminate their hands' before and after each procedure.

14.2 The pool taps should be run for 10 minutes once a week.

14.3 The pool should be cleaned with warm soapy water and rinsed. It should then be cleaned with a concentration on Sanichlor: 10 tablets in 1 litre of water. The pool should be cleaned using a mop with a disposable mop head to prevent leaning over the pool.

## 15.0 Audit and Monitoring

15.1 The risk management lead will review all risk event forms and complaints. Any immediate training or educational issues relating to lack of compliance with this guideline will be addressed on a one to one basis.

15.2 All incidents and trends analysis will be reviewed at the Maternity Risk Management Group meeting.

15.3 Audit of compliance with this guideline will be undertaken annually in accordance with the Maternity annual audit work plan. The Audit Lead in liaison with the Risk Management Group will identify a lead for the audit.

15.4 A review of a minimum of 0.25% of health records will assess compliance with the guideline.

15.5 The findings of the audit will be reported to the Risk Management Group and an action plan developed to address any identified deficiencies. Performance against the action plan will be monitored by this group on a monthly basis.

15.6 A survey will be undertaken by the Lead Midwife for Guidelines and Audit, at least annually, to establish staff awareness of how policies should be accessed and the document management process. Any deficiencies identified will inform the staff training programme.

## 16.0 Guideline Management

16.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.

16.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.

16.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are now downloaded from the intranet and filed appropriately in the guideline folders. 'Spot checks' are performed on all clinical guidelines quarterly.

16.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for further training; possibly involving 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

## 17.0 Communication

17.1 A quarterly 'maternity newsletter' is issued and available to all staff including an update on the latest 'guidelines' information such as a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly.

17.2 Approved guidelines are published monthly in the Trust's Staff Focus that is sent via email to all staff.

17.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.

17.4 Regular memos are posted on the 'Risk Management' notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folders.

## 10.0 References


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Royal College of Obstetricians and Gynaecologists (2007) Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour. October: RCOG

UKCC (1994) Registrar's letter. Postion Statement on Water Birth

Winterton Report (1992) cited by RCOG (2006) Immersion in Water During Labour

**Appendix A**

## Emergency Exit Pool Procedures

**DO NOT empty the pool prior to any of these evacuation strategies being carried out as this may hinder the process**

### Simple Equipment Free Evacuation

The following are the guidelines for getting a woman out of the pool in an emergency situation where the woman is still conscious and able to stand, e.g. shoulder dystocia.

1. Summon help

2. If there is no bed in the room it may be considered the best course of action to move a bed into the room at this point and position it at right angles to the end of the pool with the foot board removed, level with or just below the height of the pool edge (The bed must be unplugged from the wall and the castors locked).

3. Ask for assistance from a partner or another midwife to stand beside the pool.

4. Tell the patient she needs to get out of the pool quickly and ask her to stand up.

5. Ask the patient to lift one of her legs and place her foot so that it is resting on the edge of the pool (her knee will now be facing the ceiling). In a situation where there is shoulder dystocia, sometimes this position will actually allow the baby to be born whilst the woman is on the side of the pool.

6. If this does not work or full evacuation from the pool is necessary, ask the patient to swing her leg over the side of the pool and proceed to get out.

7. Transfer the patient to the bed.

### Evacuation Using the Hoist

The following guidance sets out the procedure for exiting a patient from the pool in an emergency situation where the patient is unconscious or unable to stand.

1. Summon help (at least three members of staff should be present for this procedure)

2. If there is no bed in the room it may be considered the best course of action to move a bed into the room at this point and position it at right angles to the end of the pool with the foot board removed, level with or just below the height of the pool edge. (The bed must be unplugged from the wall and the castors locked).

3. Staff member A is required to support the patient’s head clear of the water (this should be done until the patient is on the point of leaving the pool)

4. Ask for assistance from another midwife (staff member B) to stand beside the pool with the appropriately sized sling.

5. Staff member C should enter the pool and assist to manoeuvre the patient to the edge of the pool.

6. The sling should be slid down behind the patient and positioned appropriately underneath her ready for connection to the hoist.

7. The bar of the hoist should be lowered to a position just above the patient using the handset and the sling connected

8. The hoist should then be raised using the handset to an appropriate height to clear the edge of the pool and the patient manoeuvred over the bed.

9. The hoist should then be gently lowered using the handset until the patient is resting fully on the bed

**Evacuation Using the Pool Net**

The following are the guidelines for getting a patient out of the pool in an emergency situation where the patient is unconscious or unable to stand and a hoist is not available.

1. Summon help (at least three members of staff should be present for this procedure)

2. If there is no bed in the room it may be considered the best course of action to move a bed into the room at this point and position it at right angles to the end of the pool with the foot board removed, level with or just below the height of the pool edge (the bed must be unplugged from the wall and the castors locked).

3. Staff member A to support the patient's head clear of the water (this should be done until the patient is on the point of leaving the pool

4. Ask for assistance from another midwife (staff member B) to stand beside the pool with the pool net

5. Staff member C should enter the pool and assist to manoeuvre the patient to the edge of the pool

6. The pool net should be slid down behind the patient and positioned appropriately underneath her ready for evacuation.

7. Staff members A and B should take a firm grip of the corner of the net nearest to them ensuring that the patient's head is within the net

8. Staff member C ensures that the patient is securely enveloped within the net and takes a firm hold supporting the' patient s lower body.

9. Staff member A then gives the command for the manoeuvre (Ready, Steady, Slide) and the patient is pulled from the water onto the edge of the pool, upper body resting on the bed.

10. Staff A gives further commands (ready, steady, slide) until the patient is positioned completely on the bed.