

Guideline

Water birth

Key messages

1. Midwives should discuss the use of immersion of water in labour with all low-risk women in the antenatal period.
2. Accurate contemporaneous record-keeping should reflect:
 - a. Maternal assessment prior to entering pool (baseline observations, abdominal palpation)
 - b. times of entering and leaving the pool
 - c. reason for leaving the pool, if appropriate
 - d. record of hourly maternal temperature, pulse, pool temperature and 4 hrly BP, with baseline readings taken prior to entering the water
 - e. a clear record of whether the baby was born underwater.
3. All midwives should ensure that they are:
 - a. competent to care for a woman requesting a water birth
 - b. aware of how to manage cord rupture at birth
 - c. able to evacuate a woman from the pool on Delivery Unit (DU) and MLBU in the event of an emergency.
4. Staff cleaning the pool should be aware of the recommended method for pool disinfection.
5. In relation to water birth, accurate contemporaneous record-keeping should reflect:

1 Scope

Local: This guideline is applicable within Maternity Services in the home and hospital setting.

- It applies to low-risk women in labour under midwifery-led care.
- Where high-risk factors are present, midwives should refer to [appendix 1](#).

2 Purpose

- To provide information and advice to midwives caring for low-risk women who wish to participate in a water-based labour and/ or birth.
- To make recommendations for midwifery practice.
- To outline the practical aspects of caring for women requesting the use of water for their labour and/ or birth.

3 Introduction

In a joint statement produced in 2006, both the Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Midwives (RCM) support labouring in water for healthy women with uncomplicated pregnancies. Whilst the evidence for underwater birth is less clear, complications are seemingly rare. However, causality cannot be inferred, on current evidence, to directly link reported case studies of rare adverse outcomes with water birth.

There is therefore nothing to suggest that the use of water for labour and birth should not be made available to women if good practice guidelines are followed in relation to infection control, management of cord rupture and strict adherence to eligibility criteria. Support for this choice is also endorsed in the Maternity National Service Framework (NSF).

4 Background

Lying in warm water gives a sense of relaxation, but whether it actually reduces pain is less certain. A perception of relaxation, pain relief, ease of movements and more holistic experience made labour in water a popular choice during the 1980s. This concept has been extended to include actual birth under water following widely quoted experience from France.

In response to public demand, the Winterton Report recommended that all maternity services provide women with the option to labour and/ or give birth in water, and more recently, this has been endorsed by National Institute for Health and Clinical Excellence (NICE) (2007) and the joint statement by the RCM/RCOG (2006).

B

5 Benefits of pool use from randomised clinical trials (RCTs)

Most of the evidence, both randomised and observational, is restricted to healthy women with uncomplicated labour at term, although induction of labour (IOL) and vaginal birth after caesarean section (VBAC) have been managed in using water for labour and birth without reported problems.

For labour in water (rather than birth), evidence, to date, shows that:

- women report less painful contractions in labour
- women feel more relaxed and in control
- labour is possibly shorter
- women report more satisfaction with pushing in the second stage

and there is/ are:

- less use of pharmacological pain relief, particularly epidural
- fewer deflexed heads when labouring in water
- fewer obstetric interventions
- greater maternal satisfaction in the pushing stage
- no difference in:
 - assisted vaginal delivery rates
 - perineal trauma

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- caesarean section
- maternal infection
- overall, no adverse effects for the mother.

For birth in water, there may be rare, but clinically significant, risks for the baby born underwater. These include respiratory problems (including the possibility of fresh water drowning), cord rupture with haemorrhage, and waterborne infections. However, studies have found no differences in neonatal outcomes (Apgar score <7 at 5 mins, Neonatal Unit (NNU) admissions, neonatal infection rates) although it is recommended by the Cochrane reviews that further research is needed to assess the effect of immersion in water on neonatal and maternal morbidity.

No studies have evaluated the third stage in water.

6 Risk assessment

Water immersion is suitable for women with uncomplicated pregnancies. If a woman wants to use the pool during labour and delivery, the midwife should carry out a risk assessment on admission. See low risk guideline 1.6: [criteria for referral for obstetric-led care \(or obstetric opinion\) by midwives](#).

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The midwife should discuss progress of labour with the woman as well as her ability to use the pool.

For mothers using a pool at home, it is appropriate for the mother and midwife to assess the risk prior to labour and to reassess at the time of labour. In the home situation it is important that a safe environment is fostered with areas for:

- the mother to labour safely outside of the pool
- neonatal resuscitation should it become necessary.

In all birth settings, midwives should discuss with the mother any risk factors which mitigate against a safe pool birth and document such conversations.



In addition, when conducting a home water birth, it is advisable to inform the parents (at the birth discussion in a manner that is not alarmist) that, in the case of an emergency, the mother should understand that a midwife cannot lift her out of the pool. If a problem arises, there must be expectation that she can/ will get out if the midwife is concerned.



7 Criteria for use of pool

- Maternal request.
- Uncomplicated pregnancy and labour at 37+ weeks.
- Established labour (good regular contractions, descent of the presenting part and a dilating cervix). A VE should be offered if appropriate to confirm a dilating cervix of ≥ 4 cms.
- Fetal heart rate auscultated and within normal parameters.
- Normal baseline temperature, pulse, blood pressure and urinalysis

C

- Cephalic presentation (confirmed on VE if necessary)
- Pool availability
- SRM < 48hours.

8 Contraindications for pool use

- Use of systemic opioids at any time in labour (a drug-free labour is important for the successful initiation of the infant's diving reflex at birth underwater).
- Pre-existing fetal/ maternal conditions.
- Pre-labour spontaneous rupture of membranes (SROM) at term, more than 48 hours without labour onset.
- The use of syntocinon.
- Irregularities of fetal heart rate.
- Meconium stained liquor.
- Multiple births.
- Breech presentation.
- Positive status for hepatitis B, C or HIV.






(A positive result of Group B haemolytic streptococcus is **not** a contraindication to pool use when no other contraindications exist.)

Water immersion/ birth may be beneficial for women with certain risk factors (see [appendix 1](#)).








If women with known risk factors wish to use the pool, discussion between the woman, midwife and consultant obstetrician/ senior specialist registrar (SpR) (4-5) should occur prior to the woman entering the pool. Ideally, such a discussion would take place in late pregnancy and a care plan drawn up. A midwife may also wish to discuss the issue with a Supervisor of Midwives.

9 Care of mother and baby during labour – practice issues

- The pool should be filled to the level of the mother's breasts when sitting in the pool. 
- Water temperature during first stage should be self regulated at maternal request depending on maternal comfort. The neutral comfort zone (NCZ) is 35-36°C. This is the optimum temperature when the sweat glands or the heat formation mechanisms are activated. If the midwife is concerned that the water temperature requested is too high, it should be adjusted. Water temperature should not exceed 37.5°C particularly in second stage. Fetal temperature is 1°C higher than maternal core temperature. 
- The temperature of the water should be recorded using the temperature probe placed deep into the water and documented hourly on the partogram/ in the notes, along with hourly maternal temperature. 

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- If the maternal temperature rises 1°C above her baseline reading or above 37.5 °C on 2 occasions, the woman should be asked to leave the pool until her temperature returns to normal. If a further reading in another hour is still raised, then she should be advised to transfer to Delivery Unit, if elsewhere. A persistent pyrexia should be investigated. 
- The ambient room temperature should be at the neutral thermal comfort zone that is around 26-28°C. Ensure adequate ventilation.
- Other fetal and maternal observations should be monitored as per procedures for practice for low risk women (see low risk intrapartum guideline 2.2: [admission assessment and general care principles for the care of low risk women in labour](#)). 
- Oral fluids should be encouraged to prevent dehydration.
- Sometimes it may be advisable for a woman to use showers and baths for pain relief in early labour. Entering the pool in the early stages of labour may diminish the contractions, so leaving the pool periodically should be encouraged. Contractions should resume within 30 minutes after leaving the pool.
- The fetal heart should be monitored using an underwater Doppler and undertaken in accordance with low risk intrapartum 2.6 [fetal monitoring in low risk labour guideline](#). 
- As far as possible, faecal contamination of the pool should be removed. In the event of the pool becoming heavily contaminated it may be necessary to ask the woman to leave the pool temporarily whilst it is cleaned.
- Wherever possible, a 'hands off' physiological non-directed birth supported by verbal encouragement by the midwife should be practised. 
- The baby should be born completely underwater, with no air contact until the baby is raised, head first, to the surface of the water immediately following delivery. If the mother raises her vulva 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. 
- Lift the baby gently to the surface of the water with the face being delivered first.
- Avoid undue traction on the umbilical cord as the baby's head surfaces the water to reduce the risk of the cord rupture in the event of a short cord. Cord clamps should be readily available; midwives need to be alert to the possibility of occult rupture and be sensitive to any undue tension on the cord. 
- Third stage management may be physiological. Physiological third stage can be either in the pool or outside it according to maternal needs. Physiological management of the third stage should be as per the low risk intrapartum guideline 2.10: [physiological management of](#) 

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[the third stage of labour](#). If the mother wants active management of the third stage this must be conducted on dry land.

- Blood loss should be recorded as 'estimated as' less or greater than 500mls in the notes as it cannot be accurately measured. PROTOS will require a figure in millilitres but it can only be an estimate.
- If there are any concerns about fetal or maternal wellbeing, the mother should be advised to leave the pool and an opinion sought from an obstetrician or other suitably qualified person, if appropriate.



9.1 In the event of an emergency situation

In an emergency, the mother should be asked to leave the pool immediately. If necessary, a hoist may be used. There is fixed apparatus in the pool room on the Delivery Unit (DU). See [appendix 2](#) for further details. The Rosie Birth Centre (RBC) should adhere to locally agreed procedures. There is an emergency lifting balloon and airflow cushion on the RBC to assist midwives in getting a woman out of the pool or bath who is unable to get out herself; midwives working in the RBC should be competent to use this device, if needed.



10 Infection control

10.1 Cleaning the pool

10.1.1 Between use cleaning

- **Step 1:** Residual organic matter (eg blood, faeces) must be cleaned from all surfaces of the pool before it is disinfected. This should be undertaken using the steam cleaner on Delivery Unit by trained personnel adhering to universal precautions. Using the steam cleaner aids the user with manual handling. If the steam cleaner is not available then detergent can be used ensuring all surfaces are visibly clean and free of debris.
- **Step 2:** The pool should be wiped around with sodium hypochlorite solution 1:10 solution (or tablets) which should be allowed to dry on the bath surface.

Alternatively, steps 1 and 2 can be replaced by:

- Chlor-Clean (in the standard dilution of 1000ppm) which contains both a detergent and hypochlorite disinfectant. It should also be allowed to dry on the surface.

10.1.2 Gap between use

Bath needs to have been emptied and cleaned. Allow to become dry and leave for 10 minutes before being refilled.

10.1.3 Low use procedure

If pool is not used for one week or more, then the taps are to be run for five minutes before the bath is filled.

10.1.4 Equipment

- Sieves used need to be disposable or autoclaved between each use.
- All other equipment used (such as mirrors and thermometers) should be thoroughly cleaned (eg with Chlor-Clean) and dried after every use.

11 Monitoring compliance with and the effectiveness of this document

The use and effectiveness of this guideline will be monitored through the following processes:

- Risk management process – the obstetric risk manager will collect incident forms relating to any adverse birth outcomes following labour and/ or delivery in water including the incidence of any cord rupture (if it occurs), and reasons and rates of neonatal admission to the NNU. These will be reported monthly to the Perinatal Governance Committee; any agreed action will be taken by the nominated person(s) within midwifery.
- Audit - via any planned ad-hoc local or national audit into water-birth. Local audit standards are given below.
- Midwifery supervision – Supervisors of Midwives (SoMs), together with the Head of Midwifery and Consultant Midwife, will assist midwives to gain the knowledge and skills needed to undertake water births and encourage midwives, where needed, to seek additional training as required.
- Practice development – the practice development team and consultant midwife will advise the head of midwifery on the training and education requirements for midwives in relation to water birth and ensure appropriate learning opportunities are made available to them.
- Data collection by the maternity information systems midwife on the numbers of water births conducted monthly, including those on the Delivery Unit, at home and on the Rosie Birth Centre. The data will be presented monthly to senior staff and any significant trends will be identified and reported to the obstetric risk manager.
- Individual patient case reviews (including those for women who seek to use water when there are recognised risk factors), user/ clinician feedback, patient complaints and staff meetings will also contribute to this monitoring and compliance process.

Any changes to this guideline will be facilitated by the research and development midwife.

12 References

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13 Associated documents

- LR1.6: [criteria for referral for obstetric-led care \(or obstetric opinion\) by midwives guideline](#)
- LR2.2: [admission assessment and general care principles for the care of low risk women in labour guideline](#)
- LR2.6 [fetal monitoring in low risk labour guideline](#)
- LR2.10: [physiological management of the third stage of labour guideline](#)

Equality and diversity statement

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Document management

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Appendix 1: Water birth and risk factors

This section has been added in response to women requesting water-births in certain situations, where labour is not entirely 'low-risk' ie spontaneous in onset, at term, with no medical or obstetric complications. The recommendations below have been made after local discussion and agreement. It should be noted however that the majority of the literature on water birth relates to low risk women and the national recommendations recommend only the use of water for women with **uncomplicated** pregnancies.

General advice

Although water births continue to be the subject of much audit and research, there is a dearth of evidence concerning their safety in particular situations, where one or more certain high-risk factors are present. It is important that women are made aware of this lack of evidence and that any recommendation can only be made on the basis of current beliefs and limited evidence. 

It is preferable that, for any women requesting a pool birth in these situations, the request is ideally discussed with a midwife or obstetrician **antenatally**, so that a plan can be documented prior to admission in labour, and followed when the woman is in labour.

It is also important to consider:

- what factors place the woman into the high risk category
- the implications of the high-risk factor(s)
- why labour differs from being 'normal'
- how this affects intrapartum care.

At all times, the wishes of the mother should be respected. There should be an open and frank discussion of the reasons for (and the possible consequences of not) receiving interventions recommended for a particular risk factor. Midwives should document their discussions with women concerning the risk and benefits of pool use where risk factors are present, giving explicit advice where appropriate, whilst respecting the choice of the mother. It should be emphasised that women have the choice and right to opt for water-birth when high risk factors are present. Midwives have a duty to provide ongoing care, even if the woman chooses to proceed with a birth in water which is not recommended.

A Positive group B strep (GBS) vaginal swab or positive urine culture in pregnancy

The risk associated with maternal carriage of GBS is transmission to the baby in-utero, and particularly in labour. Although there is no evidence to support this, there **appears** to be no theoretical reason why GBS transmission should increase when women are in the pool during labour. Intravenous administration of antibiotics should continue as per the GBS protocol ([HR 2.4: management of Group B streptococcal colonisation in](#)



[pregnant women and prevention of early onset GBS infection in newborn infants](#)) and the mother's hand, where the cannula is sited, kept dry.

It is important to remember that up to 30% of mothers will be GBS carriers, and GBS status for the majority of women will not be known.

B Post-term pregnancy

The risks associated with post-term pregnancy are significantly increased after 42 weeks. Refer to the Trust's guideline high-risk antenatal 1.41: [women declining IOL who wish to continue beyond 42 weeks of pregnancy](#) for the risk of stillbirth at different gestations. A policy of induction after 41 weeks is designed to reduce this perinatal mortality.

Recommendations for practice are therefore as follows:

Women may use the pool if in otherwise normal **spontaneous** labour and the gestation is more than 41 weeks, but not greater than 42 weeks, as women over 42 weeks are considered high risk.

However, women being **induced** in an otherwise uncomplicated pregnancy at 41 weeks plus are a slightly different group. Again, there is no evidence to support or refute water births in this situation although some other units in England do allow such practice. The issues in this situation include:

- **Fetal monitoring** - The National Institute for Health and Clinical Excellence (NICE) considers that risk factors that indicate the need for continuous electronic fetal monitoring (EFM) in labour are:
 - post-term pregnancy >42 weeks
 - oxytocin augmentation
 - induced labour.
- However, NICE also states that continuous EFM is not needed if there are other risk factors present. Where the pregnancy has been uncomplicated, normality should be confirmed with a cardiotocograph (CTG) and then the assessment of fetal wellbeing in labour may take place via intermittent fetal heart rate monitoring.
- **Prostin/ artificial rupture of membranes (ARM)** – By the very nature of administering prostin or performing an ARM, labour is no longer 'normal' or 'physiological.' Some would argue that this is reason alone not to use the pool.

It is therefore difficult to support a policy of encouraging pool use during induction of labour, since this precludes continuous fetal monitoring and labour is no longer entirely 'normal' or 'physiological.' Therefore, no firm recommendations for induced post-term women can be made; clinicians will need to decide on an individual basis in conjunction with the woman, particularly considering other risk factors.

For women who request a water birth in this situation, there should be a documented discussion of the risks, benefits and alternatives. If the pool is



used, there should be a normal post-prostin/ Propess® CTG and discussion between the woman, midwife and consultant obstetrician/ senior SpR (4-5), if appropriate, prior to the woman entering the pool. A Supervisor of Midwives may also be contacted.

The use of oxytocin to augment or induce labour is a definite contraindication to pool use.

C Use of water in labour following previous caesarean section (CS) and water birth and VBAC

Increasingly, the use of water and/or water birth is being requested by women undergoing a VBAC, including those wanting a home birth. There are several case reports of women successfully giving birth in water following CS.

In the light of current evidence and national recommendations, a water birth following a previous CS cannot be actively encouraged:


- previous CS is listed in the NICE *guideline on intrapartum care* (2007) as a reason for continuous fetal monitoring in labour and scar rupture may be suggested by a suspicious/ pathological CTG
- there may be difficulties getting the woman out of the pool if scar rupture is suspected, particularly if this must be undertaken with some speed.

Risks and benefits should be explained and documented. The telemetry CTG may be available in this situation if the woman choose this option, although its availability to women cannot be guaranteed.

Ideally, antenatally, there should be a discussion of the risks and benefits of labouring/ delivering in water following a CS. However, if a woman presents in labour requesting this, there should be appropriate professional discussion with the woman as described above. The midwife should inform the shift coordinator and the on-call senior obstetric SpR, if the mother is on DU. She/he may also wish to seek the support of a supervisor of midwives, particularly for a planned home birth.

A plan for care in labour should be agreed with the woman. This may include, for example:

- an admission CTG
- intermittent CTGs throughout labour
- insertion of an intravenous cannula for labour.

Safe parameters for getting out of the pool should also be agreed with the woman. 

D Women positive to HIV, Hepatitis B or C

Women who are hepatitis B or C positive and undergoing normal labour may sometimes request use of the pool in labour and/or for birth.

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- Women with a known infection risk from blood-borne pathogens – hepatitis B virus (HBV), hepatitis C virus (HCV) or human immunodeficiency virus (HIV) – present a potential risk to staff and other patients, through contact with blood and other body substances.
- Care in labour should follow that described in the Trust's [Infection Control procedures](#).
- Labouring in a pool would seem to increase the infection risk to staff as midwives frequently need to place their hands in the water. Some hospitals that offer water birth insist that women should be tested for blood-borne viruses before its use: HBV and HIV are offered as part of routine antenatal screening; hepatitis C screening is also recommended as about 1 in 200-300 women from the general population are carriers.
- Women with known HIV, HBV or HCV infection should **not** use the pool. The reasons for its exclusion should be explained and documented.



Appendix 2: Emergency evacuation of pool on DU

The probability of a woman collapsing and being unable to get herself out of the pool is very low due to the strict criteria applied to the selection of women suitable for the birthing pool. However, it is foreseeable that the situation could occur and so it is vital that all staff likely to be involved in caring for women using a pool are familiar with emergency evacuation procedures.

The first aim should be to avoid the event of a woman collapsing in the pool, therefore:

- if the midwife has any concerns that this is a possibility then he/she should ask the woman to leave the pool
- in the event that the woman is unable to leave the pool unassisted (eg she has lost consciousness) help will be required.

Evacuation of static pool

Equipment required

- Mobile sling hoist.
- Sling (net).

Number of handlers required

Minimum 5.

Method

The midwife in attendance will summon help by pressing the emergency call bell. She/ he will take responsibility for maintaining the woman's airway to ensure her face is held clear of the water.

- **Do not drain the pool.** The buoyancy offered by the water will assist staff to position the sling and to support and turn the woman.
- Staff member to fetch the hoist and sling.
- Staff member to assist the midwife to turn the woman so that her back is resting on the step of the pool (if the woman is sitting on the step then leave her in this position).
- Staff member will prepare the bed/ trolley to receive the woman. The overhead hoist only transfers the patient to the Bradbury cushion. The normal delivery bed does not fit between the pool and the Bradbury cushion. The Arjo standing hoist is more suitable to use for emergency transfer to a delivery bed.
- Two members of staff will position the sling under the woman.
- The midwife should move to one side of the woman but remain in charge of the airway.
- Staff members (hoist must always be used by two members of staff) to bring the hoist into position behind the woman. The brakes should never be engaged on a hoist when in use. Two people attach the sling to hoist (the woman should be lifted in a semi recumbent position by

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attaching the longest loop at the shoulder and a shorter loop at the leg).

- The woman is lifted in the hoist and moved to the bed (two members to manoeuvre the hoist, another midwife to support the woman).
- Staff to remove the hoist from the room once the woman is on the bed.

Duties and responsibilities

Midwife

- Summon help.
- Maintain the woman's airway during the procedure.

Helpers

- Prepare bed to receive mother. If necessary call for crash team and collect emergency trolley.
- Fetch hoist and sling.
- Assist midwife to position the woman in the pool.
- Position hoist at birthing pool, brakes off.
- Two to position sling on the woman.
- Minimum of two to operate hoist.
- Manoeuvre hoist to bed.
- Support patient as hoist is moved to the bed.
- Remove hoist from room when woman is on bed.
- Keep the patient warm with towels, dry the mother utilising bed linen, make sure wet bed linen is removed.