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Reference No: SG 146/09

Title:	**The use of water immersion for labour and/or delivery**		
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Ownership:	[redacted] Specialist Hospitals and Women's Health Director		
Approval by:	Specialists Hospitals and Women`s services Standards and Guidelines Committee Trust Policy Committee ExecutiveTeam Meeting	**Approval date:**	05/12/2019 11/12/2019 06/02/2020 12/02/2020
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Key words:	Waterbirth, Immersion, Midwifery led care, GAIN Guidelines		
Links to other policies	BHSCT Intrapartum Continuous Electronic Fetal Monitoring/ Cardiotocograph (EFM CTG) Guideline (2018) SG 09/08 BHSCT Guideline intermittent auscultation of the fetal heart Vaginal birth after previous caesarean section (2009) SG 135/09		

Date	Version	Author	Comments
25/03/2018	1.1	[redacted]	Initial draft
09/05/2019	2	[redacted]	Amended

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

This Guideline will give clear guidance to all midwives involved in providing care for women who choose to labour or give birth in water

1.2 Purpose

- To assist staff to correctly advise and care for women who chose to labour and /or deliver in water.
- Maintenance of maternal and fetal safety throughout labour and birth.
- To facilitate increased maternal choice and satisfaction with her birth experience

Make reference to any other policies, procedures or guidelines which should be read in conjunction with this policy – these policies/procedures/guidelines should be listed below with their relevant codes:-

1.3 Objectives

This guideline will provide a clear evidenced based framework for all midwives in the management and care of women who chose to labour and /or deliver in water [8]

2.0 SCOPE OF THE POLICY

This Guideline will give clear guidance to all midwives involved in providing care for women who choose to labour or give birth in water

3.0 ROLES/RESPONSIBILITIES

It is the responsibility of all midwives involved in caring for women who labour/give birth in water to adhere to this guideline

4.0 KEY POLICY PRINCIPLES

4.1 Definition Of Waterbirth:

A baby born fully submerged into water. The baby's head must remain submerged until the body is born, then the baby is brought immediately to the surface.

Aims of Guideline:

- Midwives and medical staff will be able to care safely for women who use water submersion during all stages of their labour and birth.
- To provide women with increased maternal choice for type of birth
- It provides greater maternal satisfaction with the birth experience [1]

RATIONALE:

- The use of water during birth provides a woman with an alternative option for comfort, mobility and privacy, thereby increasing the opportunity for a deeply satisfying experience.
- Water offers a labouring woman an environment where she can behave instinctively and feel in control. When a woman feels in control during childbirth, she experiences a higher degree of emotional well-being in the postnatal period.
- Labouring in water is recognised as a pain relieving agent [1,2]
- The buoyancy of water enables a woman to move more easily than on land Thus alleviating pain which in turn optimises the progress of her labour [2]
- Evidence that birth in water reduces perineal trauma or blood loss is inconclusive [2]
- .There is no evidence that perinatal mortality and morbidity, including admissions to special care nurseries for babies born into a warm water environment, is significantly different to babies born out of water [3]

4.2 Key Policy Statement(s)

All healthy women with an uncomplicated pregnancy at term should have the option of waterbirth available to them [4]
A woman may be excluded from using the pool for labour/ birth if any of the following factors are present:

- <37 weeks gestation
- previous significant obstetric history
- Multiple pregnancy
- Pre-eclampsia
- Insulin dependent diabetes
- Poorly controlled epilepsy
- Known HIV positive
- Mobility/skeletal problems that may inhibit entry/exit to/from the birthing pool
- Any presentation other than cephalic
- Intrauterine growth restriction
  - Current risk factors or history of shoulder dystocia
- Thick meconium stained liquor
- Febrile or evidence of infection (maternal temperature >37.8, or 2 high readings 2 hours apart)
- Fetal heart rate abnormalities
- Intrapartum haemorrhage
- Opoid analgesia used within the last 3 hours
- Epidural analgesia
- Induction of labour requiring oxytocin (. Mothers who labour following prostin only induction and have no other risk factors may still be considered for a waterbirth)

Situations requiring special consideration:

- Group B Streptococcus positive
- Rupture of the membranes > 24 hours
- Intravenous antibiotics should be prescribed and administrated as per guidelines.
- Timely entry/ exit of the pool/bath will facilitate administration. A waterproof plaster is used to cover the puncture site

Vaginal birth after caesarean section(VBAC):

- Very little evidence is available on this birth method although small scale audits indicate that water VBAC has no adverse effect on maternal and neonatal outcomes(10). and water immersion does not appear to be contraindicated for women undertaking VBAC.(11) All mothers undergoing this type of labour delivery should be advised to have continuous electronic fetal monitoring for the duration of the entire VBAC commencing at the onset of regular uterine contractions (12)

4.3 Policy Principles

ESSENTIAL EQUIPMENT:
In addition to **standard delivery items**, the midwife/doctor should ensure that the following are in readiness for a birth in water:

- Water thermometer
- Waterproof Doppler
- Gloves of sufficient length as required by the attendant
- Sieve to enable debris to be removed.
- Sheet/net/hoist to assist emergency exit from the pool [9]
- Kneeler pads, cushions, low stool and birthing balls should be provided for health and safety of midwives and birth companion
- An attached shower facility over the bath should be considered whenever practicable for additional maternal comfort to ease backache [2,6]

Procedural Guidelines:

- There should be a midwife present at all times while the mother is labouring in the birthing pool.
- The mother should be assisted in and out of the pool using the step provided.
- Midwives caring for women in the pool should adapt their body positions should maintain an ergonomic posture.
- The Sister co-ordinating the shift in Delivery Suite should be made aware the mother has entered the pool.
- The pool room floor should be kept free of accidental water spillages.
- The woman can leave the pool any time she wishes.
- The woman will be asked to leave the pool should complications arise and is expected to comply with the request.
- The midwife must record the times that the woman enters and leaves the pool
- Vaginal examinations may be performed under water if deemed necessary.

Level of water:

The depth of the water should be up to the mother's breasts when she is in a sitting position. This aids buoyancy and will promote free movement in the pool and should be adjusted depending on the mother's position.

The woman's vulval/ perineal area must be completely submerged for the birth. This will prevent premature entry of air during delivery of the baby's head.[4]

Temperature regulation:

- In the first stage of labour, the recommended range of temperature of the water is between 34 – 37 degrees centigrade.
- In the second stage of labour the water temperature should be 37- 37.5 degrees centigrade.
- All midwives should understand the physiological basis of maternal and foetal hyperthermia.
- Maternal, core water and room temperatures should all be checked and recorded regularly 1/2 hourly
- Keep the room temperature between 22 – 28 degrees centigrade.
- Maternal temperature should be checked on entry to the pool to provide a baseline and then ½ hourly. A rise greater than 37.5 0C should result in advice to discontinue use of the pool until temperature returns to normal
- Women should be encouraged to take large amounts of oral fluids while in the pool and to leave the pool to urinate. [4,5]

Observations:

Maternal and fetal well-being are monitored by making certain that all observations are undertaken as for any normal birth in accordance with Guidelines for care of Woman in labour. [1]

Management of second stage of labour:

NB. Two Midwives must be present for delivery.

- The mother should be encouraged to push only as and when she has the urge.

- The delivery should be "hands off', with verbal guidance and encouragement by the midwife.

- It is not necessary to feel for the presence of nuchal cord once the baby's head delivers. It can be loosened and disentangled underwater, in the usual manner as the baby is born. If the cord is around the baby's neck tightly and needs to be cut, the woman should be assisted to stand out of the water so that this can occur safely. The woman remains standing to deliver the rest of the baby.

The cord should never be clamped and cut whilst baby is still under the water:

- The baby should be born completely underwater with no air contact until the baby is raised gently to the surface, with the head emerging first.
- Following the birth of the baby consider resting baby's head above the water, with the baby's body still in the water to prevent hypothermia, at the level of the mother's uterus as this may prevent excessive transfusion to the baby.
- Once the baby's head has come out of the water it must not be submerged again.
- Maintain warmth of baby by skin-to skin contact with its mother. Dry baby's exposed head to reduce heat loss.
- If respiration is not evident within one minute of birth, the cord should be clamped cut and the baby removed from the pool for resuscitation. [1,2]

Management of Third Stage of labour

Each woman should be individually assessed for the most appropriate type of third stage management.

Active management of third stage will not exclude women from delivering in water.

- A Physiological third stage should be the method of choice. Both physiological and active management is conducted out of water (the seat in the pool is very useful).
- Skin to skin contact can be maintained.
- The newly delivered mother should not be left unattended while in the pool.
- Suturing of perineal tears should be delayed for at least 1 hour to allow for water retention in the tissues to dissipate (unless bleeding profusely).
- Postnatal observations of mother and baby should be completed as per any other normal birth [1]

Infection control:

- Keep water as clean as possible (disposable emesis bowls with holes are usually adequate.)
- If necessary ask the mother to leave the pool and refill it
- **Cleaning protocol:**
- Following each delivery the pool is rinsed of debris,
- The pool is then cleaned with a detergent (Antichlor) using a disposable cloth.
- The pool should be filled with cold water and a solution of a chlorine releasing agent (Antichlor plus–Tabs 75) Giving a chlorine concentration of 1000, parts per million i.e. one Actichlor Tab tablet to 1litres of water. The pool is left fallow for 30minutes. Rinse and dry the pool thoroughly.
- Mirrors, torches, should be clean appropriately. [6]
- (Chlorine releasing agents are recommended because they are effective against HIV, Hepatitis B and C)

Labour or Birth complications occurring in the pool environment.

NB. IN EMERGENCY SITUATIONS THE WOMAN IS HELPED OUT OF THE POOL TO A SUITABLY PREPARED AREA IN THE ROOM

A personal hoist can be used if available [9]

If there are any incidences of deviation from normal, the mother should be assisted to leave the pool and maternal and fetal wellbeing assessed [4,5]

Specific incidents: [9]

Evacuation of a collapsed mother from the birthing pool

Summon help (minimum 6 persons)

One person should co ordinate the commands and moving and handling activity.

One person must support head and maintain airway

Pool water emptied (less than 3 minutes)

Bring bed into position beside pool and at the same level

A lifting sheet/net is placed under the mother and a six person manual movement is used to move the mother to the bed where resuscitation can be continued.

Suspected Shoulder Dystocia:

Call for assistance.

Stand mother up and ask her to bend over and grip the side of the pool. With legs wide.

From behind the midwife can then assist the delivery of the shoulders.

In most cases of shoulder dystocia this should be effective. If unsuccessful expedite transfer to delivery bed for continued manoeuvres as per protocol.

Snapped umbilical cord (preventative measures):

Bring baby gradually to the surface of the water.

Check tension of cord regularly

Ensure recommended water level.

Observe for excessive blood loss.

Clamp both ends of cord immediately on discovery.

Baby must be transferred to resuscitaire for assessment and observation.

Paediatric review if necessary

EXCESSIVE BLOOD LOSS:

Blood loss in the birthing pool can be hard to estimate. But any inappropriate loss should be assessed out of the water.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This Guideline will be disseminated to all maternity wards and departments throughout the Belfast Trust. It will be implemented by replacing the existing Guideline. There will be sessions of awareness raising via team meetings and safety briefings for all midwifery staff regarding the implementation of this guideline.

5.2 Resources

None

5.3 Exceptions

None

6.0 MONITORING

7.0 EVIDENCE BASE / REFERENCES

1. NICE Guidelines Care of healthy women and their babies during Childbirth (2007)
2. Burns E, Kitzinger S, (2005) Oxford Centre for Healthcare Research and Development, Oxford Brookes University
3. Cochrane Database of systematic Reviews (2004), Issue1. The Cochrane Collaboration John Wiley and Sons.
4. The Royal College of Midwives London (2000).Position Paper No 1a The Use of water in labour and birth.
5. .Royal college of obstetricians and gynaecologists/Royal college of midwives Joint Statement No1(2006)
6. Zanetti-Dallenbach R,LapaireO, Maertens A, Frei R Holzgreve W and Hoslie (2006a). Water birth : is water an additional reservoir for Group B streptococcus ? Arch Gynecol Obstet,273(4):236-8,epub 6th October 2005
7. Garland D, and Jones K ,(2000) Waterbirth: supporting practice with clinical audit Guidelines for the use of water in labour .
8. Nursing and Midwifery Council (2008) The Code. .Standards of conduct, performance and ethics for nurses and midwives. NMC, London
9. Guidance for safe manual handling during resuscitation Resuscitation Council (UK) 2001
10. McKennaJA; SymonAG. 2014 Jan.Water VBAC:exploring a new frontierfor women`s automony
11. RCOG Birth after previous caesarean birth. Green top guideline45. Oct 2015

8.0 CONSULTATION PROCESS

All relevant stakeholders Delivery Suite Manager Sisters and Midwives and All Supervisors of Midwives

9.0 APPENDICES / ATTACHMENTS

None

10.0 EQUALITY STATEMENT

The Trust has legal responsibilities in terms of equality (Section 75 of the Northern Ireland Act 1998), disability discrimination and human rights to undertake a screening exercise to ascertain if this policy/proposal has potential impact and if it should be subject to a full impact assessment. This process is the responsibility of the policy or service lead - the template and guidance are available on the Belfast Trust Intranet. Colleagues in Equality and Planning can provide assistance or support.
The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact ☒

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities that involve collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 the Trust has to consider the impacts on the privacy of individuals and ways to mitigate against the risks. Where relevant an initial screening exercise should be carried out to ascertain if this policy should be subject to a full impact assessment (see Appendix 7). The guidance for conducting a Data Protection Impact Assessments (DPIA) can be found via this **link**.
The outcome of the DPIA screening for this policy is:

Not necessary – no personal data involved ☐

A full data protection impact assessment is required ☐

A full data protection impact assessment is not required ☐

If a full impact assessment is required the author (Project Manager or lead person) should go ahead and begin the process. Colleagues in the Information Governance Team will provide assistance where necessary

12.0 RURAL IMPACT ASSESSMENTS

From June 2018 the Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans, and when designing and delivering public services. It is your responsibility as policy or service lead to consider the impact of your proposal on people in rural areas – you will need to refer to the shortened rural needs assessment template and summary guidance on the Belfast Trust Intranet. Each Directorate/Division has a Rural Needs Champion who can provide support/assistance in this regard if necessary.

13.0 REASONABLE ADJUSTMENTS ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended), the Trust has a duty to make reasonable adjustments to ensure any barriers disabled people face in gaining and remaining in employment and in accessing and using goods and services are removed or reduced. It is therefore recommended the policy explicitly references "reasonable adjustments will be considered for people who are disabled - whether as service users, visitors or employees.

SIGNATORIES
(Policy – Guidance should be signed off by the author of the policy and the identified responsible Director).

Authors **Date:** 12/02/2020

Director **Date:** 12/02/2020