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1. Introduction and Who Guideline applies to
Nationally, a percentage of births include birth in water or the use of immersion in water during labour. Although immersion in water during labour compared to conventional care has not been shown to reduce the caesarean section rate other significant benefits have been reported. Water immersion for labour and birth is consistently challenged as a practice lacking support from high quality evidence. In National guidance, the lack of Randomised Controlled Trials has led to other forms of evidence and individual opinions being drawn upon which has sometimes resulted in a medical perspective taking precedence.

This guideline is intended for the use of all Midwifery staff involved in the care of pregnant women choosing to labour and/or give birth in water. This guideline applies to all low risk birth settings.

Legal Liability (standard UHL statement):
Guidelines issued and approved by the Trust are considered to represent best practice. Staff may only exceptionally depart from Trust guidelines where such departure is tailored to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgement of the responsible health professional it is fully appropriate and justifiable – such decision to be fully recorded in the patient’s notes.
2. Guideline Standards and Procedures

1. All Midwives involved in the care of a woman choosing to labour and/or give birth in water should ensure that they are competent to care for the woman.

2. Evidence around immersion in water and suitability for a water birth should be discussed with the woman.

3. Consideration should be given as to the timing of entry to the pool.

4. The water temperature should be regulated by the woman’s comfort and should not exceed 37.5°C.

5. Labour and birth should be managed appropriately.

6. Women who have experienced an uncomplicated second stage should be able to choose a physiological third stage as an option. Where active management of the third stage is considered women should be requested to leave the pool for the administration of the oxytocic and management of the third stage.

7. Midwives should be aware of the infection control implications when facilitating a water birth.

8. All Staff caring for women labouring/giving birth in water should be aware of the manual handling implications for the woman and themselves.

Recommendation One:

- All Midwives involved in the care of a woman choosing to labour and/or give birth in water should ensure that they are competent to care for the woman.

- All Midwives should be skilled in caring for women choosing to labour / birth in water.

- All Midwives caring for women choosing to labour and/or give birth in water should make themselves aware of local policies and guidelines.

Recommendation Two:

- Evidence around immersion in water and suitability for a water birth should be discussed with the woman.

- Midwives should discuss during the antenatal period, the use of immersion in water in labour with all women.
Where possible an assessment should be made in consultation with the woman prior to labour and documented in the health record.

Information on immersion and birth in water should be given to women in a form they can understand and in a culturally sensitive fashion, to ensure equity of access to quality services. Such information should include the following:

1. There is good evidence to support immersion in water during the first stage of labour can reduce pain and as such the likelihood of having an epidural.
2. Qualitative studies have shown women who choose to labour and birth in water have a higher sense of control and satisfaction.
3. For women receiving midwifery led care, there is some evidence that shows if water is used during the first or second stage of labour this does not affect the rates of spontaneous birth, instrumental birth or caesarean section.
4. There is no evidence to suggest water immersion effects blood loss or genital trauma.
5. There is some evidence that shows no increased risk of sustaining OASI (obstetric anal sphincter injury), no increase risk in maternal or neonatal infection, or resuscitation or admission to the neonatal unit.
6. There is no evidence evaluating different baths or pools, timing of entry into the pool, or third stage labour management.

Inclusion criteria are:

- Term Pregnancy (37-42 weeks)
- Spontaneous established labour
- Uncomplicated pregnancy suitable for Midwifery Led Care in Labour

When a woman requests a water birth but does not meet the inclusion criteria an individualised care pathway should be made with the multi-disciplinary team. This should be clearly documented in the maternal records.

Women requesting home water births should be advised as to the considerations they should make to ensure their own safety and those of others during labour e.g. positioning of the pool, flooring, electrical safety, quick release valves and implications of flooding in an emergency, accessibility, drowning risks to children and pets. The birth pool checklist should be discussed at 36 weeks or prior to delivery.

**Recommendation Three:**

**Consideration should be given as to the timing of entry to the pool**

- The evidence on timing of entry into water during the first stage of labour is not robust enough to set criteria. There is a common belief amongst practitioners that early entry (when labour is not established), may reduce the length, strength and frequency of contractions, therefore lengthen the latent phase. Early labour could be managed by mobilisation and other activities within a labour room rather than water immersion.

- The working party recommend that the most appropriate time for the woman to enter the pool is when labour is established and the contractions are increasing in length, strength and frequency.

- Women should not enter water (a birthing pool or bath) within 2 hours of opioid administration or if they feel drowsy.

**Recommendation Four:**

The water temperature should be regulated by the woman’s comfort and should not exceed 37.5°C.
• The water temperature should be recorded hourly. The ambient room temperature should be comfortable for the woman.

• Maternal temperature should be recorded hourly if the temperature rises above 1 degree centigrade from the baseline temperature the water must be cooled down or the woman must be asked to leave the pool until her temperature returns to normal. If the woman is using the pool for the analgesic effect in labour, maternal temperature and water temperature should be monitored in the same way, regardless of whether or not she intends giving birth in water.

Recommendation Five:

Labour and birth should be managed appropriately

• The usual maternal observations of low risk women in labour should be performed as per the “Intrapartum Care: Healthy Women and their Babies” guideline

• A maternal temperature of 37.8 or higher should prompt exiting the pool (and then action as per the Pyrexia and Sepsis in Labour guideline)

• The fetal heart should be monitored using waterproof Doppler and in accordance with the “Fetal Heart Rate Monitoring in Labour” guideline

• The woman should be encouraged to leave the pool to empty her bladder at regular intervals

• Frequent drinks should be encouraged to prevent dehydration and isotonic drinks may be more beneficial than water

• Vaginal Examination should be performed out of the water and should include full assessment

• A “Hands off” approach at delivery is recommended. It is not usual to feel for cord – the baby will be born spontaneously

• The baby should be slowly and gently guided to the surface face first. Undue traction on the cord should be avoided

• If there is lack of descent/advancement of the head the woman should be asked to stand out of water

• If the woman raises herself out of the water following delivery of the baby’s head she must not reimmerse herself

• If there are any concerns with restitution and delivery of the shoulders the woman should stand clear of the water and transferred to land

• If it is necessary to clamp and cut the cord the baby must be clear of the water

• If there is evidence of:

  Concerns about progress of labour
  Request for epidural analgesia
  Vaginal bleeding
  Maternal pyrexia on more than 2 occasions
  (as per Intrapartum care: Healthy Women and their Babies guideline)
  Maternal hypertension >140/90mmHg
  (on 2 separate occasions 30 minutes apart)
  Meconium stained liquor
  Fetal heart rate irregularities
  Undiagnosed malpresentation
  Cord prolapse
  Shoulder dystocia
  ANY concerns about maternal or fetal wellbeing

  The woman should be asked to get out of the pool and her care transferred to Combined care
• If there is:
  Maternal request for opioid analgesia → The woman should be asked to get out of the pool and low risk midwifery care should be continued in another low risk environment (unless there are also transfer criteria)
  Heavy contamination of pool →
  Technical difficulties with the pool →

**Recommendation Six:**

Women who have experienced an uncomplicated second stage should be able to choose a physiological third stage as an option. Where active management of the third stage is considered women should be requested to leave the pool for the administration of the oxytocic and management of the third stage.

• Cord bloods for Rhesus negative women who opt for a physiological third stage in the water should not be taken until the placenta is fully delivered and removed from the pool

**Recommendation Seven:**

Midwives should be aware of the infection control implications when facilitating a water birth

• Water should be run through permanent plumbing for two minutes prior to use. If the pool is not used for 24 hours water should be flushed through the system for 2 minutes

• Contamination of any kind may have an effect on the baby. Visible solids should be removed with a sieve. If the midwife feels there is heavy contamination the woman should be advised to leave the pool. Before the woman returns to the water the pool must be emptied, cleaned in accordance with current infection control recommendations and thoroughly dried before refilling

• Disposable Liners: a new liner is essential for each patient when using a portable pool. Used liners must be disposed of in yellow clinical waste bags. Ensure liner is not torn or leaking prior to use

• Where disposable tubing is used this must be discarded after each use. All equipment must be thoroughly cleaned and sterilised after each use

• Women who choose to use water for labour and birth during a planned homebirth should be advised of these measures to reduce the risk of infection. Midwives must decontaminate equipment after a home water birth following ‘UHL Decontamination of portable inflatable home birthing pools Standard Operating Procedure’ which can be found on insite.

**Blood Borne infections:**

Women with BBI must have an individualised care plan by the MDT in place. Although the quantity of water will seriously reduce the risk from blood borne viruses, universal protections should always be taken. Midwives should pay particular attention to transmission via sclera and should wear protective glasses for all types of birth

**Recommendation Eight:**

All Staff caring for women labouring/giving birth in water should be aware of the manual handling implications for the woman and themselves

• Prior to entering the pool the woman must have been assessed and met the clinical criteria as stated in recommendation Two.
• Patient handling risk assessment must be completed on NerveCentre or in the MEOFS assessment booklet where access to NerveCentre is not available.

**Good practice to minimise the risk of manual handling injuries:**

- Antenatal discussion regarding home birth should include the location of the birthing pool to enable good access all around the pool and suitable flooring.
- Any unnecessary manual handling whilst the woman is in the pool should be avoided.
- The woman should be encouraged to position the sonicaid herself, or to raise her abdomen out of the water for the midwife to position it.
- The area around the pool should be kept dry; any spills should be wiped up immediately to prevent any slips.
- The Midwife should not attempt to remove the woman from the pool if she is unable to move herself – she should:
  - Call for immediate assistance
  - Maintain the woman’s safety
  - Consider emptying or filling the pool. This will depend on the clinical situation
  - Follow the ‘Procedure for removal of a woman from the pool if she is unable to do so herself’ (Appendix I).
  - It may be more prudent to stabilise her condition in the pool and then move her when it is safe to do so.

- Women, who develop complications during labour, should be advised to leave the pool while they are still able to do so. Specific transfer criteria are listed in Recommendation Five

### 3. Education and Training

This is a point of registration competency, where practitioners feel they would benefit from a clinical update it is their responsibility as an accountable practitioner to highlight this to their manager so it can be facilitated.

### 4. Monitoring Compliance

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<td>The water temperature should be maintained at and be no higher than 37.5 degrees centigrade</td>
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<td>The woman should be given the choice of physiological management of the 3rd stage if the 2nd stage is uncomplicated</td>
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<td>Where the 3rd stage is managed actively the woman should stand clear of the water or leave the pool</td>
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5. **Supporting References** (maximum of 3)


2. RCM. Midwifery care in labour guidance for all women in all settings. RCM Midwifery Blue Top Guidance. Nov 2018. No.1


5. UHL Decontamination of portable inflatable home birthing pools Standard Operating Procedure’

6. **Key Words**

Waterbirth, home birth, birth centre, intrapartum, low risk

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The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

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<td><strong>Author / Lead Officer:</strong> Original Working party</td>
</tr>
<tr>
<td><strong>Job Title:</strong> Midwives</td>
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<tr>
<td><strong>Reviewed by:</strong> June Burkin, Lorraine Matthews, Ann Buckley and Andrea Dziemianko</td>
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<td><strong>Approved by:</strong> Guidelines Group</td>
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<tr>
<td>Maternity Services Governance Group</td>
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<tr>
<td><strong>Date Approved:</strong> 12.08.13 and 13.08.13</td>
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Appendix I:

PROCEDURE FOR REMOVAL OF A WOMAN FROM THE POOL WHO IS UNABLE TO DO SO FOR HERSELF

Blood loss may be difficult to assess in the pool. If excessive blood loss is suspected or if there are any other concerns the woman should be asked to leave the pool at the earliest opportunity prior to any deterioration in condition.

The aim of this procedure is to remove the woman from the pool in the quickest and safest way possible. Do not initiate this procedure if the woman is able to remove herself from the pool with some assistance.

The degree of urgency will dictate how the woman is removed from the pool.

1. Assess the woman’s condition
2. Call for assistance
3. Pull plug out of pool (if appropriate)
4. Take measures to stabilise the woman’s condition
5. Remove the woman from the pool when it is safe to do so
6. If using the hoist, empty the pool first
7. If using a specifically designed net to remove the woman, fill the pool first to aid buoyancy