



Care of women using the Birthing Pool for labour and delivery

Clinical Director



M. P. WYLES MA FRCOG

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Directorate Manager



J. Payne
Date: 09/01/2012

Clinical Guideline, care of women using the Birthing Pool for labour and delivery

Meta Data

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Revision History

Version No.	Date of Issue	Author	Reason for Issue
1	January 2007	M. Dobson E. Whapples	Merger
2	January 2012	M. Dobson J. Crighton	Review / addendums p.4 – changes to flowchart to reflect guidance and SBU p.5 – Disabled women using birthing pool. Management of GBS & PROM p.6 – reduction from 4 to 2 hours to enter pool post opioid (as per NICE recommendations). Levels of competency & supporting staff. p.7 - VBAC in the birthing pool & potential neonatal concerns when delivering in water

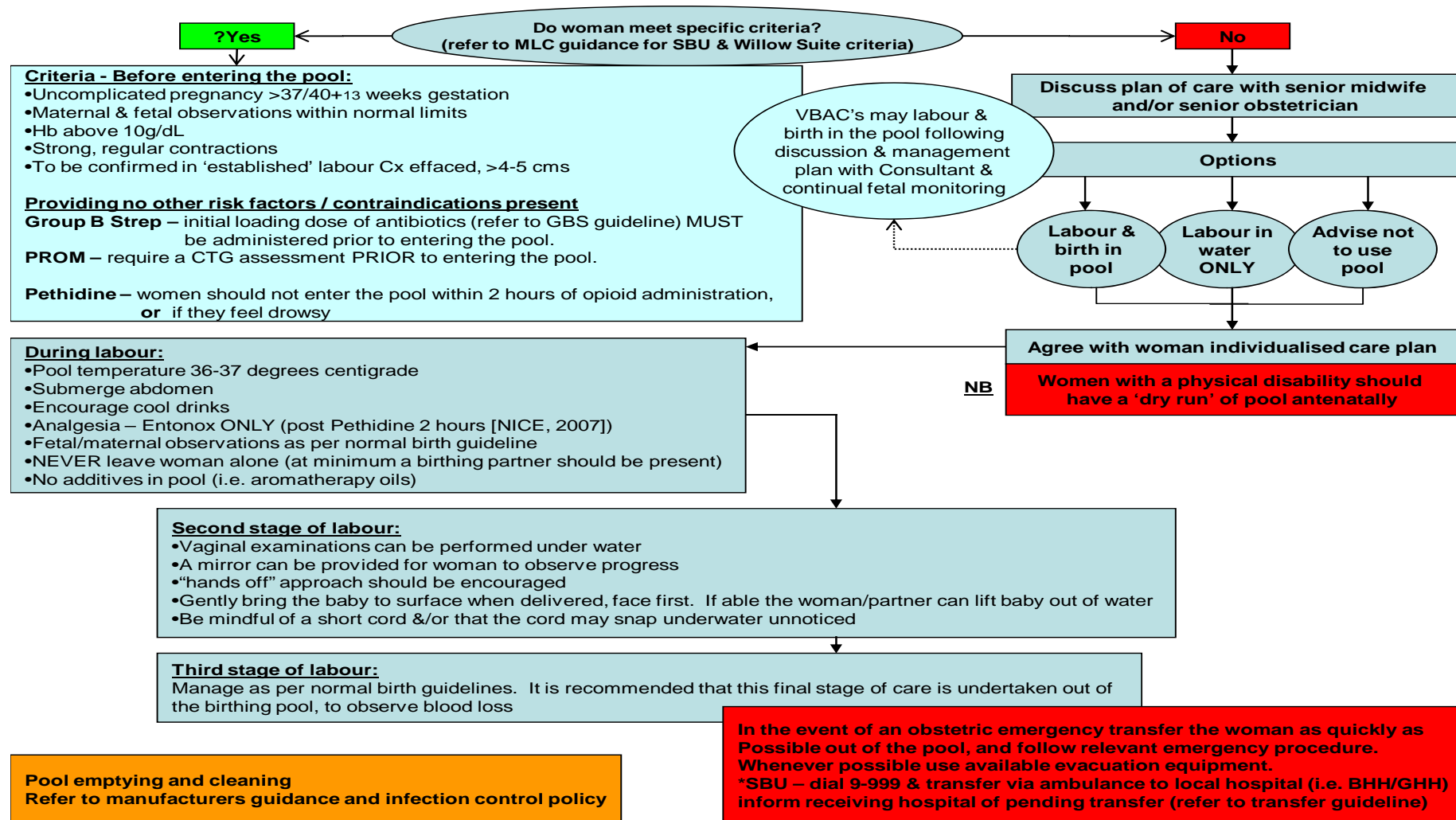
Clinical Guideline, care of women using the Birthing Pool for labour and delivery

Contents & Page Numbers:

1	Flowcharts	
	Flowchart 1 – Waterbirth (management)	4
2	Overview / Introduction	5
3	Objectives of the Guideline	5
4	Body of the Guideline	
	Criteria for entering the Birthing pool	5
	Contraindications	5
	Relative Contraindications	6
	Role of the Delivery Suite Co-ordinator	6
	Role of the Midwife	6
	Filling and maintaining the Birthing pool	6
	Intrapartum care	6
	VBAC using the Birthing Pool	7
	Third Stage management	7
	Potential neonatal concerns	7
5	Reason for developing the Guideline	7
6	Methodology	7
7	Implementation	8
8	Monitoring	8
9	Application of the Guideline	8
10	References / Bibliography	8
11	Appendices	
	Appendix 1 – Launch and Implementation	10
	Appendix 2 – Appraisal Checklist	11
	Distribution listing	12

1 Flowcharts

1.1 Flowchart 1 – Waterbirth



Clinical Guideline, care of women using the Birthing Pool for labour and delivery

2 Overview / Introduction

Water is a natural method of pain relief whilst ensuring the safety of the woman and the fetus is maintained throughout the use of the pool. Benefits of using the birthing pool also include:

- The buoyancy of water enables a woman to move more easily than on land
- Alleviates pain and optimises the progress of her labour
- Maternal relaxation, less painful contractions, shorter labours, less need for augmentation, less need for pharmacological analgesics, and a reduction in perineal trauma
- Water offers a labouring woman an environment where she can behave instinctively and feel in control and is becoming increasingly in demand by informed women (Richmond, 2003).
- A greater degree of control for the woman during childbirth, giving her an experience of higher degree of emotional well being postnatally

3 Objectives of this Guideline

To reduce the risk of maternal and neonatal mortality and morbidity.

4 Body of the Guideline

Criteria for entering the birthing pool (also refer to Booking appointment & risk assessment pathway)

- a. uncomplicated pregnancy between **37 - 40+13 weeks** gestation
- b. Maternal and fetal observations within **normal** limits
- c. Hb above **10g/dL**
- d. Strong, regular **contractions**
- e. to be confirmed in '**established**' labour (4-5cms dilated), **unless** using pool as analgesia
- f. **GBS** initial loading dose of antibiotics **MUST** be administered prior to entering the pool. Providing no other contraindications present (refer to GBS guideline)
- g. **PROM** providing no other risk factors/contraindications present i.e. fetal tachycardia, maternal pyrexia/tachycardia - **IN THIS CASE A CTG ASSESSMENT PRIOR TO ENTERING THE POOL IS REQUIRED.**

NB. f & g NOT appropriate for home delivery at SBU and Willow Suite (refer to MLU guidelines)

Contraindications

- known maternal/fetal complications, for example maternal epilepsy and fetal compromise (anomalies)
- open wounds
- indication for continual fetal monitoring, unless facility available

NB. Whenever possible use available emergency evacuation equipment, i.e. Gantry hoist. Good Hope hospital has the use of a CTG to provide continuous fetal monitoring while in a birthing pool.

Clinical Guideline, care of women using the Birthing Pool for labour and delivery

Relative contraindications:

- use of opioid or epidural analgesia (use of nitrous oxide only provided). Women should not enter water (a birthing pool or a bath) within 2 hours of opioid (Pethidine) administration or if they feel drowsy (p.108 NICE, 2007)
- physical, maternal disability that may prevent her from leaving pool quickly, unless a 'dry –run' proves evacuation can be achieved without risk

Role of delivery suite co-ordinator

- To approve use of the pool for analgesia, birth or both, taking into consideration staffing levels and labour ward admissions
- Ensure the Midwife assigned to the pool delivery is adequately trained (refer to midwives role). It is the responsibility of the Delivery Suite co-ordinator to ensure that a second Midwife, or Maternity Support Worker (MSW) will be available for delivery. The designated MSW is to be deemed as capable of supporting the midwife and has a clear understanding of the correct procedure to take should an emergency situation arise.
- Receive regularly updated on progress of labour

Role of the midwife

- To provide information to all women during the antenatal period of the risks and benefits of a pool birth
- Midwives should have witnessed care and delivery in the birthing pool at least **once** and has also cared and delivered at least **once** under supervision (ideally two deliveries), before considered as competent for future deliveries. Caring for women in the pool for the sole purpose of analgesia is NOT to be considered as a competence.
- Two staff members must be present for delivery, one of which a midwife
- Is wholly responsible for filling pool and maintaining appropriate temperature
- Ensure that a resuscitaire has been placed outside the pool room in time for delivery and checked as appropriate.

Filling and maintaining the birthing pool

- If it is necessary to leave the room while the pool is filling the tap must be switched off, even in the cases of an emergency bell
- General maintenance of the pool is expected routinely, i.e. cleaning appropriate equipment and discarding of any 'disposable' equipment following a pool delivery.
- For home deliveries the family should take full responsibility for setting up of pool

Intrapartum care

- Pool temperature to be checked hourly and maintained at 36-37°C during 1st stage of labour and 37-37.5 °C during 2nd stage of labour
- Fetal observations as per guideline
- Maternal observations, including: blood pressure and pulse to be recorded every 4 hours, and temperature 2 hourly
- **Artificial Rupture of Membranes (ARM)** – is not routinely carried out unless at the maternal request and documented in action plan (page 19 intrapartum notes)
- **Transitional stage** – it is not unusual for the woman to request leaving the birthing pool during this stage; however the use of coping strategies such as breathing through the contractions may enable the woman to have her pool birth. However, the transitional stage requires the midwife to make a decision of judgement as to how the woman is coping, and facilitate the woman if she wishes to leave the pool.
- **Delivery** – encourage the woman to keep her bottom in the water during delivery to ensure baby's head is delivered underwater

Clinical Guideline, care of women using the Birthing Pool for labour and delivery

- **Cord** – it is not necessary to feel for the cord at delivery of the head, but the cord can be unravelled as the baby delivers while still underwater if necessary. Be mindful that the cord may snap under water unnoticed.

NB please refer to shoulder dystocia guideline for actions to be taken if such an obstetric emergency occurs in the birthing pool

Vaginal birth after caesarean section (VBAC) using the birthing pool

Women with a history of ONLY ONE C/S may be considered for the birthing pool. It is not routine to offer delivery in water to anyone who has had a caesarean section (C/S), and should only be considered following discussion with a Consultant Obstetrician. . Facilities to care for a woman requiring a pool delivery following a C/S are available at GHH not at BHH & SBU.

Inform the woman:

- of the associated risk (albeit small) of scar rupture and the possible consequential effect on baby and mother
- that a CTG trace will be undertaken before entering the pool to assess fetal well-being, and continual CTG monitoring will occur while in the pool
- that her maternity notes will be reviewed by a Consultant Obstetrician for the final decision
- Of the need for group & save/cannulation, dependant on professional judgement. (cover cannula over with water resistant material while in pool)

Third stage management

Physiological or active management can be undertaken according to maternal wishes, however, it is recommended that this final stage of care is undertaken out of the birthing pool to observe blood loss.

***All discussion and plan of care must be clearly documented in the hospital and hand-held notes, including Consultant decision.**

***All midwives and MCA's caring for women in the birthing pool must have appropriate competencies.**

Potential neonatal concerns:

Still births/neonatal mortality	Respiratory Distress
Drownings	Hyonatramic seizures
Hypoxic ischemic encephalopathy	Infections
Ruptured umbilical cords	Tachycardia
Temperature irregularities (related to water temperature)	

Any concerns should be referred to a neonatologist for review

5 Reasons for developing the Guideline

The guideline provides information to all clinicians as to the most appropriate management of women using the birthing pool for analgesia in labour, or when using the birthing pool for analgesia and delivery.

6 Methodology

Development of all guidelines adheres to a process of examining the best available evidence relevant to the topic, incorporating guidance and recommendations from national and international reports.

Finalised guidelines will ultimately be approved and ratified by the directorate locally.

Clinical Guideline, care of women using the Birthing Pool for labour and delivery

7 Implementation

Following approval the guideline will be disseminated and available for reference to all members of the multidisciplinary team via the Trust and Obstetric intranet site; also paper copies will be stored in a marked folder within a designated clinical area.

8 Monitoring

Adherence and efficiency of the clinical guideline will be monitored through regular clinical audit.

Following clinical audit of a guideline an addendum to change in clinical practice may be necessary. Any change to a clinical guideline requires that it must be ratified by the directorate locally.

Review dates for guidelines will be set at a period of three years; however this set period can be overridden in light of new clinical evidence.

All unused/previous guidelines will be logged and archived electronically, and in paper format within the trust.

9 Application of this Guideline

This guideline applies to all obstetric patients when using the birthing pool for analgesia in labour, or analgesia and delivery.

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Clinical Guideline, care of women using the Birthing Pool for labour and delivery

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Clinical Guideline, care of women using the Birthing Pool for labour and delivery

11 Appendices

Appendix 1 - Launch and Implementation Plan for Clinical Guidelines

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Action	Who	When	How
If previous document is in use: proposed action to retrieve out-of-date copies of the document (electronic and/or paper)	Maggi Dobson	Upon ratification of new guideline	Logged and archived electronically, and in paper format within each trust
Initiate addition to clinical guidelines Sharepoint	Maggi Dobson	Upon ratification	Trust intranet
Communicate new guideline/changes to guideline	Normal/Active Birth teams across the site Audit Leads Clinical Risk Trust Trainers	Following ratification	Guideline distribution panel will be informed of ratification. Regular updates to be given at audit meeting, directorate meetings, and through mandatory training programmes
Offer awareness training/incorporate within existing training			Through induction and mandatory training programmes
Circulation of document (paper)	Maggi Dobson	Upon ratification	To a designated area within each trust
Circulation of document (electronic)	Maggi Dobson	From draft 1 through to ratification	drafts via core distribution panel and again upon ratification

Clinical Guideline, care of women using the Birthing Pool for labour and delivery

Appendix 2 - Clinical Guidelines Appraisal Checklist

All clinical guidelines must be appraised using this appraisal checklist before submission to the Clinical Standards Committee for formal ratification (adapted from Appraisal of Guidelines Instrument, AGREE Collaboration, 2001).

The appraisal tool will be completed by the clinical guideline Lead or Author with the support and advice of the Directorate of Healthcare Governance.

1. The overall objective(s) of the guideline is (are) specifically described.

Strongly Agree	4	3 <input checked="" type="checkbox"/>	2	1	Strongly Disagree
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2. The patients to whom the guideline is meant to apply are specifically described.

Strongly Agree	4 <input checked="" type="checkbox"/>	3	2	1	Strongly Disagree
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3. The target users of the guideline are clearly defined.

Strongly Agree	4	3 <input checked="" type="checkbox"/>	2	1	Strongly Disagree
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4. The health benefits, side effects and risks have been considered in formulating the recommendations.

Strongly Agree	4	3 <input checked="" type="checkbox"/>	2	1	Strongly Disagree
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5. The recommendations are specific and unambiguous.

Strongly Agree	4 <input checked="" type="checkbox"/>	3	2	1	Strongly Disagree
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6. The different options for management of the condition are clearly presented.

Strongly Agree	4 <input checked="" type="checkbox"/>	3	2	1	Strongly Disagree
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7. Key recommendations are easily identifiable.

Strongly Agree	4 <input checked="" type="checkbox"/>	3	2	1	Strongly Disagree
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8. The guideline presents key review criteria for monitoring and audit purposes.

Strongly Agree	4	3	2 <input checked="" type="checkbox"/>	1	Strongly Disagree
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9. There is an explicit link between the recommendations and the supporting evidence.

Strongly Agree	4	3 <input checked="" type="checkbox"/>	2	1	Strongly Disagree
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10. A timescale for reviewing the guideline is provided.

Strongly Agree	4 <input checked="" type="checkbox"/>	3	2	1	Strongly Disagree
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11. The guideline was consulted with individuals from all the relevant professional groups.

Strongly Agree	4 <input checked="" type="checkbox"/>	3	2	1	Strongly Disagree
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SCORE = 38

(NB a score of at least 33 must be obtained before formal ratification by the Clinical Standards Committee can be obtained)

Clinical Guideline, care of women using the Birthing Pool for labour and delivery

Guideline Distribution listing - core members

Internal reviewers:	Name:
Obstetricians	A-Z listing
Obstetric Consultant BHH & Audit Lead	Barber Katherine
Gynaecology Consultant GHH	Cartmill Richard
Gynaecology Consultant BHH	Chakravarti Swati
Obstetric Consultant BHH/SOL	Griffin Christopher
Obstetric & Gynaecology Consultant GHH	Honest Honest
Obstetric & Gynaecology Consultant GHH	Houghton Susan
Obstetric & Gynaecology Consultant GHH	Howland Elizabeth
Obstetric & Gynaecology Consultant BHH	Hutchon Susan
Obstetric & Gynaecology Consultant BHH	Irani Shirin
Obstetric & Gynaecology Consultant BHH/SOL	Matharu Gurminder
Obstetric & Gynaecology Consultant BHH	Papaioannou Spyros
Obstetric Consultant BHH/GHH	Patni Shalini
Infertility, Gynae Endocrinology & Paediatric Gynaecology	Payne Elizabeth
Obstetric & Gynaecology Consultant BHH	Pradhan Poonam
Obstetric Consultant GHH	Rhodes Cathy
Clinical Governance & Obstetric & Gynaecology Consultant BHH/HEFT	Sunanda Gargeswari
Clinical Director & Obstetric Consultant HEFT	Wyldes Michael
Midwifery	
Antenatal Day Unit Manager GHH & Midwife	Abukhalil Maxine
Delivery Suite Manager GHH & Midwife	Adams Judith
Ward 4 Manager GHH & Midwife	Andrews Elizabeth
Midwife & Midwife Trainer BHH	Austin Clare
Bereavement Midwife BHH	Beesley Clare
Diabetic Specialist Midwife GHH & Supervisor of Midwives	Buckley Helen
Solihull Antenatal Clinic Midwifery Manager	Carbery Vivienne
Midwife & E3 Midwife GHH	Chinn Rebecca
Lactation Specialist Midwife BHH	Clayton Alison
Matron Maternity Clinical Services GHH, Midwife & Supervisor of Midwives	Coleman Maggie
Delivery Suite Matron	Collins Vikki
Midwife SOL SBU	Collins Wendy
Community Midwifery Manager & Supervisor of Midwives GHH	Dean Louise
Clinical Risk Manager HEFT, Midwife & Supervisor of Midwives GHH	Deegan Carolyn
Community Midwife BHH & Supervisor of Midwives	East Paula
Midwife & Supervisor of Midwives BHH	Ebanks Sandra
Bereavement Midwife GHH	Evans Debra
Core Midwife Delivery Suite GHH – High Dependency Unit speciality	Eveson Silja
Delivery Suite Manager BHH & Supervisor of Midwives	Foster Lorna
Midwife & Supervisor of Midwives GHH	Harman Sarah
Community Midwife & Supervisor of Midwives GHH	Hawes Carol
Screening Midwife GHH	James Teresa
Midwife & Midwifery Trainer BHH	Jeffs Denise
Midwife SBU	Lester Sharon
Community/Screening Midwife & Supervisor of Midwives BHH	Lilburn Joan
Community Midwifery Manager BHH & RCM Representative	McGuigan Karen
Community Midwife & Link Supervisor of Midwives GHH	Miner Lisa
Clinical Investigations Advisor, Midwife & Supervisor of Midwives BHH/HEFT	Murray Letitia

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Head of Midwifery HEFT	Payne Joy
Midwife & Supervisor of Midwives GHH	Saunders Suzanne
Clinical Risk Midwife HEFT & Supervisor of Midwives BHH	Stewart Maria
Ward 5 Manager, Midwife & Supervisor of Midwives GHH	Wilson Suzanne
Screening Midwife GHH	Wyatt Tessa
Neonatologists	
Neonatologist Consultant GHH	El-Shimy Nagui
Neonatologist BHH	Fradd Victoria
Neonatologist Consultant GHH	Gandhi Anjum
Neonatologist BHH	Garikapati Vidya
Neonatologist Consultant GHH	Gupta Sanjay
Neonatologist Consultant GHH	Jayaraman Rajesh
Neonatologist Consultant GHH	Kallappa Chetana
Neonatal Unit Manager GHH	Lewis Sheena
Neonatologist Consultant GHH	Meran Joanne
Neonatologist Consultant BHH	Mupanemunda Richard
Neonatologist BHH	Singh Jaideep
Neonatologist BHH	Storey Imogen
Neonatologist BHH	Tiron Irina
Neonatal Nurse Manager BHH	Woodman Catherine
Neonatologist Consultant BHH	Watkinson Michael
Anaesthetists	
Anaesthetic Consultant	Benham Maria
Anaesthetic Consultant GHH	Kelly Gillian
Anaesthetic Consultant GHH	Moore Simon
Anaesthetic Consultant BHH	Osborn Nicola
Anaesthetic Consultant GHH	Thomas David
Anaesthetic Consultant & Anaesthetic lead BHH/HEFT	Walker Liz
External reviewers:	
Outreach Librarian	Clayton Susan
Radiologist Consultant HEFT	Crowe Paul
Radiologist Consultant HEFT	Ganeshan Arul
Clinical Lead, Obstetric Sonographer	Grant Helen
Gynaecology Manager SOL	Greenhill Tracey
Director of Infection Control & Consultant Microbiologist	Gupta Itisha
Formulary Lead Pharmacist & Pharmacy Representative for Clinical Standards Committee	Hingley Theresa
Blood Practitioner Nurse	Khorsandi Jayne
Emergency Medicine HEFT	MacNamara Aidan
Gynaecology Matron BHH	Nash Tracey
Paediatric Consultant, Respiratory Medicine BHH	Ninan Titus
Directorate Pharmacist HEFT – Paediatric & Women’s Health	Pinel Wendy
University Lecturer, Midwife & Supervisor of Midwives	Quarrell Kate
Gynaecology, Clinical Nurse Specialist GHH	Rutter Jacqui
Haematology, Consultant HEFT – Oncology, Transfusion & Laboratory Medicine	Smith Neil
Laboratory Medicine & Blood Transfusion	Taylor James 2

*this list is not exhaustive as relevant specialities will be consulted in relation to guideline, and distribution is often circulated for wider consultation via core members

Title of Guideline: Care of women using the Birthing Pool for labour and delivery

Directorate: Obstetrics and Gynaecology

Clinical Guideline Lead: Dr S. George

Date of Appraisal: 9th January 2012