Hull University Teaching Hospitals NHS Trust

188 – Waterbirth In Hospital And Community Guideline

Broad Recommendations

Assessment Risk

Low Risk Inclusion criteria for the Pool

- Singleton pregnancy
- Cephalic presentation
- Gestation from 37 to 41+6 completed weeks at onset of labour
- No significant medical conditions ref guidance for consultant referral
- [redacted]
- Guidance for care in labour [redacted]
- BMI less than 35kg/m² at booking
- Primigravida women in established labour
- Multigravida women contracting regularly
- SROM less than 24 hours at onset of Labour
- Otherwise uncomplicated women who require IV antibiotics for Group B Haemolytic Streptococcus to be given outside of the pool
- Induction: cervical balloon or ARM only and T+13 or less at onset of labour
- Must be able to get in and out of the pool unaided
- Previous PPH less than 1000mls.

High Risk - Exclusion criteria for the pool

- Malprestentation
- Para 5 or above
- Multiple pregnancy
- Previous complicated labours
- APH (of a significant degree)
- Confirmed IUGR
- Significant Meconium stained or blood stained liquor
- Any mother requiring a continuous IVI
- Positive Hep C result.
- Gastroenteric pathogens, such as Salmonella, Campylobacter.
- Multiple skin lesions

High Risk Women who could use Labour Ward Pool with Consultant Discussion

- Previous LSCS - Women have birthed using water for labour and birth without reported problems but the woman should discuss her choices with a consultant obstetrician prior to labour in the hospital or at home. A midwife will support the woman with the informed discussions for this choice.
- Women who are induced via Balloon/prostaglandins or ARM who commence labour without IV Oxytocin. If continuous EFM is required then Telemetry EFM could be used with consultant agreement.
- Women who do not fit the inclusion criteria for Midwifery Led Care – who request to use the birth pool during pregnancy, must have a discussion with their named consultant and a midwife regarding a documented plan of care for birth, this would include the use of water/pool, being mobile in labour and any fetal monitoring requirements. If continuous monitoring is required this can be facilitated with the use of the Telemetry machine. The birth plan must be clearly documented in the hand held records. If these discussions have not occurred in the Antenatal period, then there must be a discussed documented plan with the consultant/senior registrar on call on labour ward.

Consultant Referral

Consultant discussion with documented and agreed plan of care to use abour Ward Birth Pool

Use of pool on labour ward not advised

Care in Labour

Pool Filling & Temperature

- Pool should be filled to the women's armpits
- Water temperature range for the first stage of labour 36-37.5°C
- Water temperature in the second stage of Labour 37.0° - 37.5° to be recorded every 15 minutes
- Water and maternal temperature checked and recorded hourly(first stage)

Care in first Stage of Labour

- Labour should be established for Primigravida women – multigravida women should be contracting regularly
- Try different positions in the pool
- No essential oils or other should be added to the pool
- Maternal and fetal heart rate observations and documentation as per Trust Guideline 236 *care of women in labour*
- If contractions decreasing, encourage mobilisation out of the pool
- Encourage -oral – fluids which MUST be documented on the partogram , and for the woman to exit the pool regularly to void urine every 4 hours and documented on the fluid balance chart .
- Remove faecal contamination, if heavily soiled consider emptying pool and refilling
- Birth partners to wear swim wear when in the pool
- Midwife to wear fitted gloves

Second Stage of Labour

- Maternal and fetal heart rate observations and documentation - as per Trust guideline 236- *care of women in labour*
- The woman may choose to birth in or out of the pool

Birth

- Hands off technique
- The progress of the head must be view with a mirror and a water proof light source
- Episiotomy not to be performed in the pool
- It is not necessary to feel for the presence of nuchal cord.
- Once delivered the baby is gently brought to the surface by the woman/Partner/Midwife
- Place baby skin to skin, with -- face out of the water and body submerged
- Babies do not always cry at birth, - spontaneous breathing can take up to 3mins to establish. If baby has good tone, blue in colour, a heart rate over 100bpm, - resuscitation is not required. If - parameters deteriorate, commence resuscitation.
- Rest the baby at about the level of the mothers uterus – head at breast height
- If -a shoulder dystocia is evident, follow Trust Guideline 184 *Shoulder Dystocia*
- The umbilical cord should be checked immediately following birth of the baby to ensure that it has not snapped

Reasons for requesting the woman to leave the pool

- Use of the toilet
- Vagina examination to assess progress of Labour
- If there is any difficulty in hearing, or any abnormality in the fetal heart rate
- Any concern over maternal well-being
- To administer analgesia other than Entonox , paracetomol and codeine
- If the labour is not progressing as expected
- If the water becomes heavily contaminated with faecal matter or blood

Third stage

Consider the following:-

- Women's choice for placental delivery
- Previous third stage issues
- Antenatal history and haemoglobin levels
- Length of stages of labour Inc. latent phase. **If the woman chooses active management she is required to leave the pool. If MLC and Antenatal HB between 90g/dl and 105g/dl consider active management and discuss with the woman**
- Repair of the perineum should be delayed for up to 1 hour following delivery unless bleeding
- Syntometrine or oxytocin may be given in the deltoid if a Post Partum haemorrhage (PPH) is identified

188 - WATERBIRTH IN HOSPITAL AND COMMUNITY

1 BACKGROUND

This guideline has been developed in response to increasing women centred demands for the option to use immersion in water for labour and/or birth. It supports the advice on care given to women who wish to labour in a pool at home or in the hospital

This guidance is intended to ensure the safety, as far as possible for women choosing the option of immersion in water for labour and/or birth for themselves and their unborn/newborn babies.

Aim is to provide a process to enable midwives to support women who choose to labour and/or deliver in the birthing pool.

- To define the risk assessment for suitability for a waterbirth
- To have a clear pathway of care to support the women with this choice

All healthy women with uncomplicated pregnancies at term should have the option of waterbirth available to them and should be able to proceed to a waterbirth as a choice - Written documentation of any discussion is essential, preferably in the antenatal period.

The Fatima Allam Birth Centre is the alongside Midwife Led Unit within this trust and women who fit the inclusion criteria for Midwifery Led care may use the pool's available on the Birth Centre. There may be situations where women choose and are able to use the Birthing pool on the Labour Ward.

Most of the available evidence, both randomised and observational is restricted to healthy women with uncomplicated pregnancy at term. (If there are any concerns, discuss with the Labour Ward coordinator and the obstetric team).

2 GUIDELINE DETAILS

Inclusion Criteria for Water Birth on the Fatima Allam Birth Centre

- Singleton pregnancy
- Cephalic presentation
- Gestation from 37+0 to 41+6 completed weeks at onset of labour
- No significant medical conditions that have required Consultant care in pregnancy.
- Uncomplicated pregnancy.
- BMI less than 35kg/m² at booking
- Primigravida women to be in established labour contracting 3:10 and cervix equal to or greater than 4 cms dilated. Multigravida women must be contracting regularly, i.e. 3 contractions in 10 minutes
- SROM less than 24 hours at onset of labour.
- The woman should have the ability to leave the pool in an emergency or if fetal compromise occurs.
- Otherwise uncomplicated women who require IV antibiotics for **Group B Haemolytic Streptococcus**. Initial antibiotics are to be given prior to first entry to the pool and subsequent doses given out of the the pool. Cannula must be removed or covered with a waterproof dressing or a water proof glove prior to entry to the pool and kept out of the water.
- Previous PPH of less than 1 Litre. Active management of the 3rd stage of labour should be encouraged.
- Women who have had previous extensive perineal trauma can use the pool for labour and birth, following a discussion with a consultant, and FABC manager

- Women who fit into Appendix B of Care in labour Guideline no.236 following consultant discussion and agreement
- Women with previous 3rd degree tear with consultant agreement. Women must have been counselled regarding mode of delivery and if consultant agrees can use the pool, it may be a possibility to use the pool for labour but get out to birth on land with a hands on approach.

Women who could consider use of the pool on the Labour Ward.

Women must have had a consultant discussion and an agreed plan in order to use the birthing pool if they are not under Midwifery Led Care.

- Previous LSCS – Women who have birthed in previous pregnancies prior to LSCS should discuss her choices with a consultant obstetrician prior to labour in the hospital or at home. A midwife will support the woman with the informed discussions for this choice.
- Women who are induced via Balloon/prostaglandins or ARM who commence labour without IV Oxytocin. If continuous EFM is required then Telemetry EFM could be used with consultant agreement.
- A woman who does not fit the criteria for Midwife Led Care but who has consultant agreement to labour or birth in water. If continuous Electronic Fetal Monitoring (EFM) is required in labour Telemetry EFM could be facilitated on the Labour Ward if agreed by the consultant.

If a CTG prior to entry to the pool is part of the obstetric management plan, this must be for a minimum of 20 minutes with a review of the CTG to inform continuing obstetric and midwifery management.

Exclusion criteria for Water Immersion in Labour and Water Birth

- Malprestentation
- Para 6 or more
- Multiple pregnancy
- Previous complicated labours
- APH (of a significant degree)
- Confirmed IUGR
- Significant Meconium stained or blood stained liquor
- Any mother requiring a continuous IVI
- Positive Hep C result.
- Gastroenteric pathogens, such as Salmonella, Campylobacter.
- Multiple skin lesions

USE OF THE POOL

Depth and Temperature of Water

- The depth of the water should be to the women's armpits when she is in a sitting position in the pool. This is to aid buoyancy and maternal movement. The woman may get too hot if the water level is higher and it may lead to a feeling of loss of control.
- Recommended water temperature range for the first stage of labour is comfortable for the mother between the range 36-37.5°C
- The water and maternal temperature should be checked and recorded hourly on the Partogram in the Birth Notes. If the woman feels too hot she should be encouraged to leave the pool until she has cooled down.

- Recommended water temperature range for the second stage of labour 37.0° - 37.5° to be monitored every 15 minutes and recorded on the Partogram in the Birth Notes.

Coping methods that can be used alongside water submersion

- Relaxation techniques
- Diversion therapy
- Hypnotherapy
- Entonox
- No Opiate use within the last 2

First stage of labour – plan of care to be documented in the Birth Notes.

- Labour should be established.
- Once she has entered the pool the woman should not be left alone and should be accompanied by a Midwife, Maternity assistant or birth partner at all times.
- The woman can be encouraged to try different positions in the pool, such as squatting, kneeling and all fours.
- Aromatherapy – women can have aromatherapy via inhalation on cotton wool placed on the edge of the pool in one of the plastic pots if they wish no essential oils should be added to the pool.
- Routine maternal observations and fetal heart rate in the first stage of Labour should be performed as per **Hull University Teaching Hospital NHS Trust guideline no; 108 Intrapartum assessment of fetal wellbeing** and documented accordingly in the Birth Notes.
- If contractions appear to decrease in strength and frequency, then the woman should be encouraged to leave the pool and mobilise until contractions return.
- The woman should be encouraged to drink plenty of water whilst in the pool to prevent dehydration and this should be documented on both the fluid balance chart and partogram .
- Women should be encouraged to leave the pool to empty their bladder every 4 hours .
- With consent, vagina examination should be performed in accordance with the Hull University Teaching Hospital NHS Trust guideline for the care of women in labour no: 236.
- Faecal contamination should be removed using a disposable sieve as E. coli is a potential source of infection. If there is heavy contamination, consider emptying and refilling the pool with clean water.
- Birth partners to wear swimwear when in the pool
- Midwife to wear fitted gloves

Second Stage of Labour – plan of care to be documented in the labour record

- Routine maternal observations and fetal heart rate in the second stage of Labour should be performed as per **Hull University Teaching Hospital NHS Trust guideline no; 108 Intrapartum assessment of fetal wellbeing** and documented accordingly in the Birth Notes.
- As the second stage of Labour approaches the woman may choose to birth in the pool or out of it, or as planned in the antenatal period in conjunction with the Trust guideline 236 *Care of women in labour* guideline.

Birth

- Hands off technique as traditional control of the head during crowning are noted to be unnecessary and may promote early respiration.
- Progress of the emerging head must be observed with a mirror and a water proof light source.
- Episiotomy not to be performed in the pool
- It is not necessary to feel for the presence of nuchal cord. It can be loosened and disentangled as the baby is born in the usual manner. Under no circumstances should a nuchal cord be clamped and cut under water
- Once delivered the baby is gently brought to the surface by the woman/partner/midwife, the head should leave the water first.
- The baby must be born completely under water with no air contact until it is brought to the surface head first.
- If for any reason the baby's head comes into contact with air before the body is delivered the head should remain out of the water and the birth should then be completed in air NOT water.
- Once delivered the baby should be placed skin to skin, with baby's body submerged under the waterline to maintain its temperature.
- These babies do not always cry at birth, so spontaneous breathing can take up to 3mins to establish. If it has good tone, blue in colour, and has a heart rate over 100bpm, it does not require resuscitation if any of these parameters deteriorate, clamp and cut the cord and commence resuscitation.
- Rest the baby at about the level of the mothers uterus in order to prevent excess transfusion to the baby
- Breathing movements should be observed once established
- If there is a shoulder dystocia ask the woman to stand up and raise her leg onto the side of the pool and attempt to deliver. If not delivered to exit the pool and commence the HELPERR pneumonic following guidelines/management of shoulder dystocia.
- The umbilical cord should be checked immediately following birth of the baby to ensure that it has not snapped.

Third Stage of Labour NICE recommendations

Issues to be considered when assessing women's choice for physiological versus active third stage are:

- Women's choice
- In or out of the water, since the early theoretical risk of water embolism has been dispelled (risk assessment in relation to access to medical aid prior to delivering the placenta in water at a home water birth)
- The women's antenatal history together with the latest haemoglobin
- Previous third stage problems
- Length of labour both latent and active phases
- Nature of the contractions in the second stage
- Recommendation for delayed cord clamping
- **If the woman chooses active management she needs to leave the pool prior to the administration of Syntometrine or oxytocin and the use of Controlled cord traction unless a Postpartam haemorrhage is identified than oxytocin/syntometrine can be given in the deltoid**

Examine the perineal area and vagina for trauma. Repair of perineum should be delayed for up to 1 hour following delivery, as perineal tissues may be water saturated and need time to revitalise. If trauma is bleeding do not delay the repair.

Reasons for requesting the woman to leave the pool

- Use of the toilet
- If there is any difficulty in hearing, or any abnormality in the fetal heart rate
- Any concern over maternal well-being
- To administer any analgesia, other than Entonox .
- If the labour is not progressing as expected, e.g. decreased uterine activity, poor decent of fetal head on pelvic palpation
- If the water becomes heavily contaminated

Home water birth

Pump advice

Public health England (PHE) and NHS England have temporarily advised that pools filled in advance of Labour and where the temperature is then maintained by the use of a heater and pump should not be used in the home setting until definitive advice on disinfection and safety is available.

There are no concerns regarding pools which are filled from domestic hot water supplies at the onset of labour, provided that any pumps are used are solely for pool emptying.

Suggested advice for the woman and her family preparing for a home waterbirth
It is the family's responsibility to ensure the equipment you use is safe and appropriate.

- Certain companies make and hire pools for women who wish to labour at home in a pool. It is advised that you use one of these companies.
- It is advised that you use a pool rather than the bath as you can move more freely, and is easy to access, in an emergency.
- Check with home insurance company and a landlord (if appropriate) that cover will be provided for use of the pool at home
- It is important to consider the room you will use for the pool birth.
- Will the floor hold the weight of a full pool? The ground floor is recommended.
- Ensure a warm room, that is draft free but ventilated and any heat sources are away from the pool
- Ensure electric sockets are covered if not in use and well away from the pool
- Checked the boiler is large enough to provide enough hot water to fill the pool. It is recommended you have a trial run before labour commences
- The pool should be assembled following the manufacturer's instructions
- Your partner will be responsible for heating and emptying of the pool so close access to the hot water supply and drain is required, consider how they will achieve this.
- Have a bed, futon, sofa, within the room that you can use after the birth
- Public Health England (PHE) and NHS England have temporarily advised that pools filled in advance of labour and where the temperature is then maintained by the use of a heater and pump, are not used in the home setting until definitive advice on disinfection and safety is available. There are no concerns regarding pools which are filled from domestic hot water supplies at the onset of labour provided that any pumps are used solely for pool emptying.

- You will also require a sieve and a baby bath thermometer

3 PROCESS FOR MONITORING COMPLIANCE

As identified from any risk management safety or quality issue

4 REFERENCES

- Nice Institute for Health and Clinical Excellence (2017) Intrapartum Care. London. NICE.
- Patient Safety Alert. Legionella and Heated Birthing Pools filled in advance of labour in the home setting. Public Health England June 2014.
- Taha M. (2000) The effects of water on labour: a randomised controlled trial: (Doctoral thesis) Rand Afrikaans University South Africa. Cited in Cluett ER, Nickodem VC, Mccandish RE, Burns EE, (2005).
- Immersion in water in pregnancy, labour and birth. The Cochrane Database of Systematic Reviews 2004 Issue 1. The Cochrane collaboration John Wiley and Sons.
- Nursing Times. 91(11): 38-40.
- Hull University Teaching Hospital NHS Trust standard precautions policy http://intranet/policies/policies/178.pdf
- Plumb, J., Holwell, D., Burton, R. and Steer, P. (2007) Water birth for women with GBS: a pipe dream? The Practicing Midwife. 10(4):25-8.
- RCM (2018) Evidence based guidelines for Midwifery-Led care in labour Immersion in water for labour and birth. Accessed 16/6/17: https://www.rcm.org.uk/sites/default/files/Immersion%20in%20Water%20%20for%20Labour%20and%20Birth_0.pdf
- RCOG (2015)The Management of Third- and Fourth-Degree Perineal Tears Green-top Guideline No. 29 June 2015
- RCOG (2017) Prevention of early-onset Neonatal Group B Streptococcal Disease, Green-top Guideline No. 36. September 2017.
- NMC (2015) The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates Nursing and Midwifery Council: London

5 APPENDICES

- Appendix A – Duties
- Appendix B – Definitions
- Appendix C – Emergency Procedures
- Appendix D - Hospital Pool Cleaning
- Appendix E - Water Births at Home
- Appendix F – COVID – 19 Risk assessment

Document Control			
Reference No:	188	**First published:**	January 2008
Version:	5.1	**Current Version Published:**	November 2020
Lead Director:	Medical Director	**Review Date:**	November 2023
Document Managed by Name:	[redacted]	**Ratification Committee:**	Health group Governance
Document Managed by Title:	Clinical Governance Midwife	**Date EIA Completed:**	
Consultation Process			
Electronic via email to all lead midwives and senior obstetricians for discussion and consultation with midwives and obstetric medical staff.			
Key words (to aid intranet searching)			
Water birth			
Target Audience			
All staff	**Clinical Staff**	**Non-Clinical Staff**	
Managers	**Nursing/Midwifery Staff**	**Medical Staff**	

Version Control			
Date	**Version**	**Author**	**Revision description**
October 2020	5.1	[redacted]	Review and Update
January 2018	5	[redacted]	Review and Update
June 2017	4	[redacted]	Update
July 2015	3	[redacted]	Full review
May 2011	2	[redacted]	Full review
January 2008	1	[redacted]	New guideline

Appendix A

DUTIES

Title	Duties
Midwife	• Recognised as a responsible and accountable professional who can conduct a water birth on her own responsibility and provide care for the newborn. • The midwife enables the woman to make a decision about a water birth based on her individual needs by discussing this choice. • In cases were a woman's choice of a waterbirth may be challenging the midwife can contact a professional midwifery advocate for midwife support in supporting the woman. • Ensuring the pool has been cleaned prior to supporting a woman using the pool for labour and birth • A course of Hepatitis B vaccination must have been completed and immune status should be demonstrated • Staff should have no open cuts, abrasions or other skin conditions
Consultant Obstetrician	• As the senior medical professional lead, will provide a consultation with the woman if requested or indicated to discuss any evidence which indicates a waterbirth will be a risk to her or her baby. This should take place antenatally. • Will become the lead professional for management of care if the women require transfer out of the pool for medical reasons following an identified deviation from the norm which is outside the midwives sphere or practice.
Midwifery Support Worker	• Has a duty of care to ensure this guideline is followed when cleaning the pool
Ward Hygienist	• Will ensure this guideline is available to support with the cleaning of the pool
Parent's duties relating to home water birth	• It is the responsibility of the woman and her birthing partner to arrange the private hire of the birthing pool and its assembly and maintenance. • The filling, emptying and maintaining the temperature of the pool is also the responsibility of the woman and her birth partner. • Care should be taken to ensure that the pool is not near any electrical equipment or sockets and that the floor is able to support the weight. • Any damage sustained by the use of the pool is the responsibility of the parents.

Appendix B

DEFINITIONS / GLOSSARY

Term	Meaning
APH	Antepartum haemorrhage
ARM	Artificial rupture of membranes
BMI	Body Mass Index
IVI	Intravenous Infusion
LSCS	Lower Segment Caesarean Section
PPH	Postpartum haemorrhage
PROM	Prolonged rupture or membranes
SROM	Spontaneous rupture of membranes
EFM	Electronic Fetal Monitoring

Appendix C

EMERGENCY PROCEDURES

Emergency Procedure for Removing a Woman from a Birthing Pool at Home

At home the woman should have the ability to leave the pool either unaided or aided with the help of her partner, as the midwives are unable to assist should an emergency situation occur.

Emergency Procedure for Removing a Woman from a Hospital Birthing Pool

This procedure relates only to those emergency situations when it is necessary to get the woman completely out of the pool before any medical intervention can be undertaken.

All staff must practice this technique annually, this training to be recorded.

1. The attendant midwife must activate the emergency buzzer, and support the woman's head, above the water to prevent possible drowning.
2. The next staff member(s) to enter the room operate the taps (from the window side of the room) to raise the water level to approximately 50mm from the top of the pool; this will take approximately 90 seconds. Do not allow water to flow over edge of pool. Whilst the pool is being 'topped off', the Evacuation net is to be slid under the woman.
3. The third member of staff to enter the room assists with pulling the net under the woman and places a gel pad between the woman's back and the net.
4. Subsequent members of staff will move the bed/emergency trolley to the end of the pool – see Figure 2, ensuring equal numbers of staff either side of the bed (preferred number 3 each side), and adjust the bed height to be level with the top of the pool. Ensure that the brakes are applied.

Figure 1 - Start Position

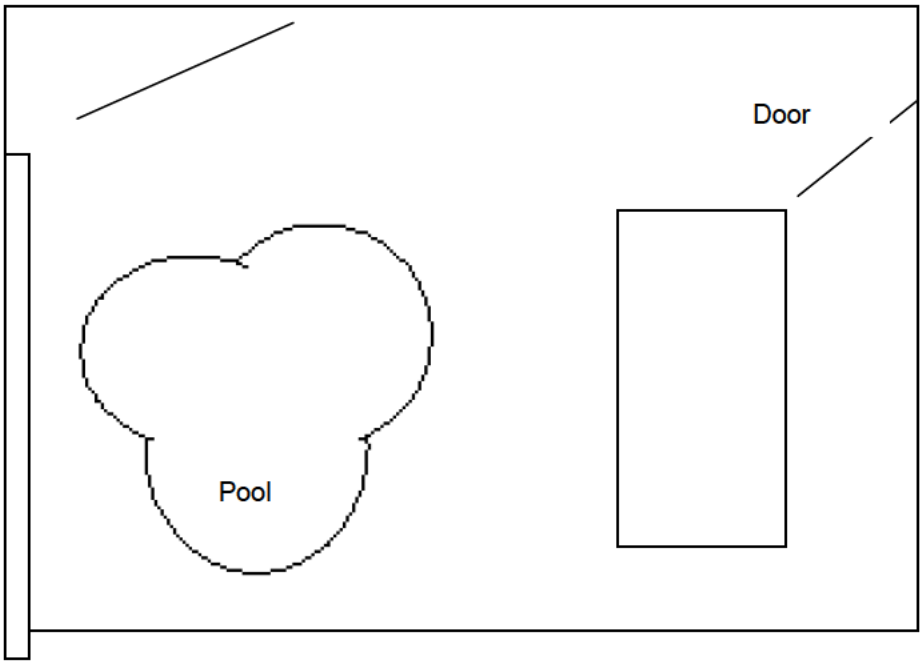
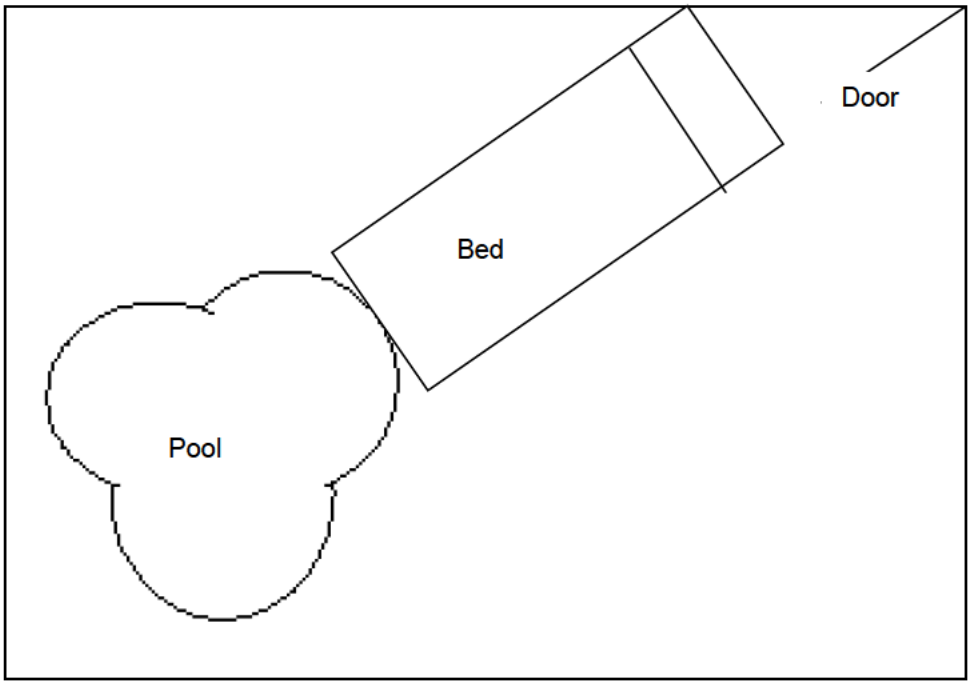


Figure 2 – Finish Position



5. Place the Patslide on the bed, placing the end of the slide on the rim of the pool.
6. With all staff equally spaced along both sides of the net, the net can be gently pulled towards the side of the pool, raising the woman out of the water (head to be supported throughout).
7. The attendant midwife now gives a clear command and all staff 'side step' to move the woman out of the bed and along the length of the bed.
8. Emergency medical procedures can now be undertaken.

Specific Watch Points

- Do not lift, slide
- Ensure firm grip on the net
- When raising the woman out of the pool pull the net by rolling the edges
- The floor may be wet so extra care is needed
- Give clear commands
- Ensure that there are a minimum of 6 staff

Appendix D

HOSPITAL POOL CLEANING

Introduction

Several reports have identified the risk of bacterial contamination of the birthing pool and associated equipment. During a pool birth amniotic fluid, blood and faeces may contaminate the pool. This could possibly lead to an increased risk of neonatal and/or postpartum infection, as well as increasing the risk to attendant staff. Gram-negative organisms thrive in wet areas and bacteria such as Pseudomonas aeruginosa and Klebsiella pneumoniae have been isolated from various sites in birthing pool systems. It is essential that the procedures used are those, which will minimise the risk of infection.

Equipment

- Chemicals used in association with the water birthing pool and ancillary accessories should be in accordance with the manufacturer's advice and the relevant COSHH data obtained
- The pool should be rinsed before use for 2 minutes
- Any equipment, for example sieve, thermometer, jug, cleaning brush should be single use only
- The manual handing net for the collapsed patient, following use must be rinsed in tap water and then sprayed with its own specialist spray (Clean Guard IPA 70)

Decontamination of the Pool

- Thorough cleaning of the pool is essential
- The birthing pool should be cleaned as soon as possible after its use, using warm water and a neutral detergent, followed by disinfection. A single use brush may be used to remove any stubborn soiling
- The pool should then be disinfected using Tristel Fuse diluted solution, ensuring that all surfaces are wiped over with the product. Particular attention should be paid to the drainage outlet pipe. An appropriately sized brush or disposable wipe should be used to clean the inner lumen of the pipe.
- The manufacturer's guidelines for the cleaning and maintenance of the water birthing pool should be followed. If the above information does not comply with these guidelines, verification should be sought from the Infection Prevention and Control Team.

Prior to Pool Entry

- The Trust legionella flushing regime should be followed
- The mother should shower before entering the pool if possible
- Personal clothing worn in the pool should be fresh and cleanly laundered
- Birthing partners who wish to enter the pool must also observe the above Infection Prevention and Control precautions.

Microbiological Assessment

Microbiological sampling is not necessary as a routine practice, but may be requested in exceptional circumstances at the discretion of the Infection Prevention and Control Team.

PROCEDURE	RATIONAL
Apron, gloves and eye/face protection must be worn.	To ensure personal protection
Taps should be run for two minutes.	To reduce the risk of contaminated water that may have remained static in the water pipes.
All surfaces of the pool should be cleaned with neutral detergent and warm	To remove grease and soiling

water. A single use brush may be used to remove any stubborn soiling	
The pool should be rinsed well with tap water.	To remove detergent.
The pool should be disinfected using Tristel Fuse diluted solution, ensuring that all surfaces are wiped over. The pool then needs to be thoroughly rinsed following with water. Particular attention should be paid to the drainage outlet pipe. An appropriately sized brush should be used to clean the inner lumen of the pipe.	To ensure adequate decontamination and to minimise the risk of infection.
Waste should be disposed of in accordance with Trust policy.	To comply with National and Local guidelines.
The sluice gate on the drainage outlet pipe should be left in the closed position when the pool is not in use.	To prevent any potential contamination occurring from the main drainage system
The pool should be rinsed with tap water prior to its use.	To remove any traces of disinfectant.

All health care workers who are involved in the cleaning and maintenance of water birthing pools should have followed the above guideline.

Appendix E

WATER BIRTHS AT HOME

Discussion with:
Name
Date
Midwife
Address

SUBJECT	DISCUSSION	RATIONALE	COMMENTS
Reason for request	Previous knowledge/experience Other influences	To assess influencing factors, attitudes and beliefs	
Understanding of events	Inclusion/exclusion criteria Maternal and fetal observations during labour Assessment of progress in labour Birthing baby underwater/out of water Management of third stage	To ascertain parents understanding of the sequence of events surrounding the birth To assess parents preferences and to discuss practical issues	
Role of partner	Discussion about the role of the birth partner	To establish the role of the partner and plan for participation	
Birth plan	Written documentation essential to inform midwives and medical staff	To aid the understanding between the mother/ partner, midwife	
Infection control	Method of removing faeces (maternal/fetal) from the pool	Midwives should use universal precautions and follow local trust infection control guidelines.	Ref guideline for Maternity Staff undertaking water Birth deliveries
Health & safety	Floor covering (if at home) Evaporation and necessary ventilation	Health and safety for the mother, partner, carers and midwives.	**Positioning and weight of pool to be considered**
Electrical safety	For heated tub a trip fuse must be fitted. (use of these pools not currently recommended PHE and NHS England) The pool must be the required distance from electrical sockets Ensure no water spillage near existing plugs Use of waterproof Doppler	To ensure health and safety for the mother, partner, carers and midwives.	
Water temperature	Recommended water temperature is: □□36.0 -37.5° C during the first stage □□37° - 37.5°C during the second stage.	To ensure the water is maintained at the correct temperature, to avoid overheating of the mother/baby and to avoid the baby gasping at delivery if the water is too cold	**Birth partner to take responsibility for maintaining pool water temperature**
SUBJECT	**DISCUSSION**	**RATIONALE**	**COMMENTS**

Midwifery cover	Two midwives to attend birth	All community staff to be informed of home waterbirth by use of home birth lists	
Theory and practice for midwives	All midwives should ensure that they are competent to care for a woman who wishes to have a water birth and should make themselves aware of local policies and guidelines. Apart from emergency drills, training should also include emergency management of cord rupture at birth.	Midwives and managers should ensure that training in caring for a woman who wishes to have a water birth is undertaken by midwives who undertake intrapartum care.	
Medical cover	Ensure labour & Delivery Suite coordinator aware of home waterbirth when woman in labour	To enable direct contact if necessary	**Emergency contact** [redacted]
Coping mechanisms	Relaxation techniques Diversional therapy Self-administered inhalation analgesia	Full discussion and inclusion in birth plan	
Monitoring mother/baby	Maternal and fetal observations frequency and type	As per guideline	
Episiotomy	Implications of episiotomy and midwifery clinical judgement	Indication to birth on land if required	
Management of cord	Clamping and cutting cord and management if cord round neck	Alert to the possibility of occult cord rupture and be sensitive to any undue tension on the cord	
Handling of baby under water	Minimal handling of baby,	To prevent baby breathing under the water	
Resuscitation of the baby	Need for resuscitation Use of Ambubag/oxygen		
Transfer to Women & Children's Hospital	Discuss possible reasons for transfer	Discuss possible reasons for transfer Ensure communication when woman in labour with L&D coordinator to facilitate transfer if necessary	

Risk Assessment appendix F

Site	Department
HRI	Maternity

Date completed	Review date
29.4.20	29.4.22 (or end of COVID-19 pandemic)

Risk assessor:	Job title:
[redacted]	Midwifery Sister

NB: All assessments should be reviewed once every ***two*** years (or sooner) if:

- An incident highlights that the assessment needs changing;
- There are any ***changes*** in the working environment or with the tasks or procedures being carried out which may alter the risk.

What is the Hazard? (i.e., what is it that has the potential to cause harm)

Risk of transmission of COVID-19 during use of the birthing pool

Who could be harmed by this hazard?

Staff	☒	Visitors	☒	Patients	☒	Contractors	☐

How might harm be caused?	What are we already doing to prevent harm?
The potential transmission of COVID-19 through droplets and/or faecal matter when using birthing pool for labour and/or delivery. Nb WHO have reported no cases of faecal-oral transmission of COVID-19 NHSE, WHO and RCM believe it is still acceptable to continue to offer low risk women who are not suspected or confirmed COVID-19 the option of pool for labour and delivery in hospital or at home if appropriate risk assessment has been undertaken	**When women contact the hospital to say they are in labour or need to come in, they are asked routine questions about symptoms for COVID-19.** **Women in labour who are suspected or known COVID-19 are to be on Labour Ward, not the Fatima Allam Birth Centre or at home.** **Birthing pool is not an option on Labour Ward at present, as this is part of the COVID contingency plan on Labour Ward.** **Midwives and other staff attending women in birthing pools to wear appropriate PPE – water resistant surgical mask, apron, water resistant if not waterproof gown, gloves. Long gauntlet style gloves are to be worn if needing to do close work with hands in the birthing pool** – ***please note that at present these gloves are not available in a latex free option therefore women who have latex allergies may not be able to use a birthing pool.***

	Staff who are wearing the above PPE are encouraged to ensure the room is not overheating and that they have comfort breaks for water when required. Under the PPE, they are encouraged to wear scrubs/light weight uniform in the hospital and light weight uniform in the homebirth setting. Shower facilities are available at the hospital for staff. **In labour, women are advised to adopt a position out of the water, such as standing, for auscultation of the fetal heart in labour. If this is not possible, such as in the second stage, midwife to wear appropriate gloves for this.** **If a pool becomes contaminated with lots of faecal matter that cannot be easily removed, women to be assisted out of the birthing pool and pool to be cleaned as per instructions. Women can get back in the pool if this cleaning is possible and midwife feels it is appropriate.** **Midwives are advised to only have their hands directly in the water if absolutely necessary and are encouraged to use the larger mirrors that can be held partially out of the water.** **If possible for the birth, women are encouraged to adapt a position for the birth whereby they can easily reach the baby themselves. If this is not possible, midwife to do this as quickly as possible wearing appropriate PPE.** **For the third stage, women are encouraged to get out of the pool.** **Birthing partners are not to be in birthing pool as well.** **Birthing pools to continue to be cleaned appropriately (as per our routine standards with Tristel). WHO state that there is no evidence that COVID-19 is passed human-human through the use of pools and hot tubs if they are cleaned appropriately.** **If pools are hired for homebirths, manufacturer instructions for cleaning and safe disposal of lining to be adhered to by woman.**

What is the remaining risk?

(Please use the matrix below by: simply multiplying the potential severity (**S**) of the hazard by the likelihood (**L**) of it causing this then gives the Risk (**RR**).

Hazard	S		L		RR
Transmission of COVID-19 to staff caring for women in birthing pool	3	x	2	=	6
		x		=	
		x		=	
		x		=	

NB: Further guidance can be found later in this assessment.

Are there any additional actions needed to manage this risk?

Please remember to identify 'by whom' and 'by when'.

Birth centre manager to continue to await any further updates regarding transmission of COVID-19 via birthing pools. This will be reviewed weekly and risk assessment updated accordingly.

Although it is appreciated COVID-19 infection could lead to catastrophic consequences, the risk is overall "low" due to measures in place as per this risk assessment

Manager:
It is the Manager's responsibility to ensure that all risk assessments are completed to a satisfactory standard.

Managers are also responsible for the monitoring of assessments and ensuring staff have read and understood such assessments.

Staff:
You are required to familiarise yourself with the content of the risk assessment and if further advice is needed please speak to your manager.