University Hospitals of Morecambe Bay NHS Foundation Trust

Waterbirth

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1 Introduction

This protocol outlines recommended practice for obstetric and midwifery staff in the management of waterbirth.

Ideally women should be given information on water immersion during the antenatal period, and the guidelines for use of the pool discussed prior to entering the water.

2 Purpose

This policy stipulates the mandatory arrangements for waterbirth.

Implementation of the policy will lead to a:

- Consistent evidenced based approach to management of these women.

3 Duties

3.1 Duties of staff within maternity services are to follow this guideline.

No guideline will apply in every situation; however, it will apply the majority of the time and staff should have an evidence based justification for deviation from the guideline.

The guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient.

4 Policy

4.1 Criteria For Waterbirth

Criteria for use of the pool in labour

- Woman's informed choice.
- 37 weeks gestation, or more
- Singleton fetus with cephalic presentation – engaged.
- Clear liquor, if membranes have ruptured.
- Opiates should not have been administered in preceding 3 hours.

Pool use can be considered for women with

- Uncomplicated induction of labour.
- Requiring prophylactic IV antibiotics in labour.
- Gestational Diabetes – controlled with diet only.
- Otherwise uncomplicated Group B Streptococcus positive women.
- Positive HIV, hepatitis C or hepatitis B result

Exclusion criteria

- Epilepsy
- Severe psoriasis/eczema
- Any obvious genital lesions
- Maternal medical conditions requiring intensive monitoring e.g. severe pre-eclampsia

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If in any concerns discuss with obstetric consultant, telemetry for continuous electronic fetal monitoring may be feasible within the consultant units.

4.2 Management Of Waterbirth

Preparation

- Information regarding immersion in water should be discussed with the woman and her birthing partner prior to entering the water; the discussion must be recorded in the labour record.
- A plan of care should be formulated and documented in the health records.
- The woman must be aware that if, at any stage, a deviation from normal occurs, she will be asked to leave the birthing pool.

Management of labour

- Women should be in established labour (4cm dilated with regular contractions) prior to entering the pool.
- Maternal and fetal observations must be recorded prior to entering the pool.
- The time of entering and leaving the pool must be recorded, including the reason for leaving the pool.

Note: If contractions are strong and pain relief is needed a woman should not be discouraged from entering the pool.

The woman should not be left on her own in the room after entering the pool

First stage

- Water temperature dictated by woman's comfort, between 35-37.5°C, checked and recorded hourly.
- Monitoring of maternal and fetal well-being in accordance with the guideline *LABOUR - FIRST STAGE*.

Whilst in the pool, maternal temperature must be recorded hourly.

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- Encourage fluids to ensure adequate hydration.
- Woman to leave the water to empty bladder.
- Entonox can be used for additional analgesia whilst a woman is in the pool.

Second Stage

- Monitoring of maternal and fetal well-being in accordance with the guideline *LABOUR - SECOND STAGE.*
- Water temperature maintained at 36.5-37.5^{o}C, rising to 37-37.5^{o}C for the birth.
- Water should be kept as clear as possible using a sieve.
- Pushing should be physiological and non-directed.
- Use a “HANDS OFF APPROACH” for delivery of the head; it is not necessary to control the head during crowning.
- Once the baby’s head is delivered, it is not necessary to feel for the presence of nuchal cord. Under no circumstances should the nuchal cord be clamped and cut under water. Standing the woman up if delay in delivery of the body is noted may be sufficient to loop cord over the head and apply two clamps to the cord prior to cutting between them.
- The baby SHOULD DELIVER unaided. Baby should be brought to the surface slowly to avoid undue traction on the cord.
- If the woman raises herself out of the water and exposes the fetal head to air, once the presenting part is visible, she should be advised to remain out of the water to avoid the risk of premature gasping under water. Remember: once the head is out of the water, it must not be allowed to re-submerge - this could be fatal.
- It should be recorded whether the baby was born under water.

Third Stage

- This stage should be conducted in accordance with the guideline *LABOUR - THIRD STAGE*.
- Active or physiological as per maternal choice are acceptable within the pool
- Estimated blood loss should be recorded.

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Complications requiring leaving the pool
• Any complications of labour. • Meconium stained liquor. • Delayed progress of labour, as defined in the *LABOUR - FIRST STAGE* and *LABOUR - SECOND STAGE PROTOCOLS* • *Shoulder dystocia* • *Snapped cord* • Indication of a need for continuous fetal monitoring if telemetry not available, as defined in the *FETAL HEART MONITORING IN LABOUR PROTOCOL*. • Suspicious / pathological CTG • Maternal pulse >100 • Raise in maternal temperature >37.5^{o}C

Suturing

- Waiting one hour before suturing the perineum is recommended due to the tissues being waterlogged.

5 Dissemination and Implementation

5.1 Dissemination

The policy will be distributed and communicated as outlined in the distribution plan on page 8. A copy of the policy will be available to all staff on the Intranet through the Library Service.

5.2 Implementation

It is expected that any policy will be fully operational by the training and implementation dates identified on p8.

6 Document Control

6.1 Library of Procedural Documents

All current approved documents are kept on the Library System which is available through the Trust Intranet.

6.2 Archiving

An electronic archive of strategies, policies, protocols, SOPs and guidelines is maintained by the Library Service.

6.3 Process for retrieving archived documents

Requests for access to archived documents should be made to the Head of Library & Knowledge Service.

7 Monitoring Compliance

Adherence to this policy will be reported as described below.

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7.1 **Standards/ KPIs**

This is not currently a CNST audit. The tool below may be utilised to assess compliance with this protocol.

	Yes	No	Not applicable
Has the guideline been adhered to?			

Requirement	Method	Frequency	Lead	Monitoring Group	Action plan lead	Committee/ group overseeing Action Plan
Adherence to guideline	Audit	Minimum triennial	Audit lead	Maternity audit group	Chair of the Guideline Group	Guideline development group

Adherence to the policy may also be periodically audited by the internal audit department as part of the review of internal controls.

CHANGE CONTROL SHEET

This is a Controlled Document. The definitive version is on the intranet. Printed versions should be verified as valid with the intranet version.

DEVELOPMENT TEAM

Name	**Job Title**
L Cabral-Jackson	Midwife
Val Wilson	Deputy Head of Midwifery

Consultant Obstetricians & Gynaecologists UHMBFT (circulation for comments)
Band 7 and above midwifery staff UHMBFT (circulation for comments)
Non-consultant obstetricians / gynaecology medical staff ST3 and above UHMBFT (circulation for comments

AMENDMENT HISTORY

Revision No.	Date of Issue	Page/Section Changed	Description of Change	Review Date
3	11.10.2012	Complete revision		11.10.2015
3.1	19.12.2012		Change to 'guideline'	11.10.2015

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DISTRIBUTION PLAN

Dissemination lead:	Louise Cabral-Jackson
Is a previous document already being used?	Yes
If yes, in what format and where?	Available on the Intranet
Action to retrieve out-of-date copies of the document:	• Replace document on the Trust Intranet – Policy Library • Remove old paper copies from guideline folders
Actions to communicate the document contents to staff:	The policy will be distributed and communicated via: • E mail communication to staff • Paper copy added to guideline folders on each site. • Highlighting at handover of new guideline publication Upload to Heritage library system for intranet availability

To be disseminated to:	
Library Service	For Policy Library and Archive
Chairperson of approving committee	For information
Maternity staff: midwives & medical	Maternity staff: midwives & medical

TRAINING IMPLICATIONS

Is training required to be given due to the introduction of this policy?	No

Action by	Action required	Implementation Date
N/A		

IMPLEMENTATION ACTIONS REQUIRED

Action by	Action required	Implementation Date
Chair guideline development group	Dissemination as described above	One month following ratification

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EQUALITY & DIVERSITY IMPACT ASSESSMENT TOOL

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination are there any exceptions - valid, legal and/or justifiable?**	No	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
4.a	**If so can the impact be avoided?**	N/A	
4.b	**What alternative are there to achieving the policy/guidance without the impact?**	N/A	
4.c	**Can we reduce the impact by taking different action?**	N/A	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the HR Equity & Diversity Specialist, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the HR Equity & Diversity Specialist, Extension 6242.

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REFERENCES (Include references to all relevant Trust Policies and Guidelines)

Number	References
1	National Institute for Clinical Excellence (2007) Intrapartum Care - care of healthy women and their babies during childbirth London: NICE
2	Alfirevic, Z. (2006) Immersion in Water During Labour and Birth (RCOG/RCM Joint Statement No. 1) London : RCOG
3	Garland, D (2010) Revisiting waterbirth: an attitude to care. London: Palgrave Macmillan.

GLOSSARY and DEFINITIONS

Abbreviation or Term	Definition

SUPPORTING EVIDENCE

Number	Evidence
1	Procedural Documents Policy – Maternity and Gynaecology

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Appendix 1 - Checklist for the Review and Approval of Procedural Documents

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Is the method described in brief?	No	See separate document
	Are individuals involved in the development identified?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are the references cited in full?	Yes	
	Are local/organisational supporting documents referenced?	Yes	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
	If appropriate, have the joint Human Resources/staff side committee (or equivalent) approved the document?	Yes	

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	Title of document being reviewed:	Yes/No/ Unsure	Comments
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	
	Does the plan include the necessary training/support to ensure compliance?	Yes	
8.	**Document Control**		
	Does the document identify where it will be held?	Yes	
	Have archiving arrangements for superseded documents been addressed?	Yes	
9.	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?	Yes	
	Is there a plan to review or audit compliance with the document?	Yes	
10.	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so, is it acceptable?	Yes	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	Yes	

Approval - If the Author and Development Group are happy to approve this document, please sign and date it and forward to the chair of the committee/group where it will receive final ratification.			
Name	*(Author)*	Date	
Signature	Paper copy kept by guideline group		
Committee Approval			
Ratification - If the committee is happy to ratify this document, please sign and date it and forward copies to the Author.			
Name		Date	
Signature	Paper copy kept by guideline group		

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