Sherwood Forest Hospitals
NHS Foundation Trust

TITLE: BIRTHING POOL - LABOUR AND BIRTH IN A BIRTHING POOL GUIDELINE

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Lead Division:	Women and Children's
Lead Specialty:	Maternity
Lead Author:	Sharon Parker – Midwife Kate Duignan -Midwife
Sponsor:	Head of Nursing and Midwifery

	Name the documents here or record not applicable
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Consultation Undertaken:	Natalie Potts consulted with the authors of the guideline and then went to Maternity and Gynaecology Governance
Template control:	v1.4 November 2019

CONTENTS

1 INTRODUCTION / BACKGROUND

The benefits of labouring in water for a healthy woman with an uncomplicated pregnancy are well documented. Both the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives support labouring in water for healthy women with uncomplicated pregnancies.

The evidence to support water birth is less clear but complications are seemingly rare. It is therefore felt to be safe for women at low risk of complications should be given the opportunity to labour and/or give birth in water. Labouring in water during the first or second stage of labour does not affect rates of spontaneous birth, instrumental birth, or caesarean section. There is no evidence of the effect of water immersion on blood loss or genital trauma.

Evidence suggests that water birth empowers women, enabling them to make choices for themselves. Women who use water immersion during labour have increased maternal satisfaction and sense of control, less painful contractions, shorter labours, less need for augmentation, less need for pharmacological analgesics particularly epidural anaesthesia, more intact perineum and fewer episiotomies, thus promoting more positive childbirth experience and a greater emotional wellbeing postnatally.

2 AIMS / OBJECTIVES / PURPOSE (Including related Trust documents)

The aim of this guideline is to support Midwives who are caring for women who choose to use the pool during labour and birth.

This clinical document applies to:

Staff group(s)
- Midwives

Clinical area(s)
- Community Midwifery
- Sherwood Birthing Unit

Patient group(s)
- Women in labour

Related Trust Documents

- Guideline for the care of women in normal physiological labour
- Intrapartum fetal monitoring Guideline

3 ROLES AND RESPONSIBILITIES

Roles and responsibilities are written within the main body of this guideline for both Community and Hospital based Midwives.

4 GUIDELINE DETAILS (including flowcharts)

Practitioners should assume that all women may wish to use the birthing pool. Women who do not meet the inclusion criteria require consideration on an individual basis, in order that a plan can be made. This may be done in liaison with the Community Midwife, Consultant Obstetrician, Senior Midwife and Infection control team as appropriate.

Inclusion Criteria

- Women in labour who have experienced problem free pregnancy are 37 to 42 weeks gestation with a singleton pregnancy with a cephalic presentation.

- The woman is able to enter and leave the pool unaided.

- Use of the pool by women who have had Maternity Team Care but express a desire to labour in water should be discussed on an individual basis including risk assessment by all concerned in their care.

- Refer also to the Sherwood Forest Hospitals guideline for *"Care of Women in Normal Physiological Labour (March, 2021)".*

Exclusion Criteria

- Meconium staining of the liquor
- BMI >40/ weight >100kgs (although there is some limited evidence that allowing clinically obese women to labour and birth in a pool reduces the likelihood of Caesarean Section).
- Any deviation from normal in the maternal or fetal observations

Group B strep

If a woman is known to be Group B Streptococcus (GBS) positive this does not necessarily exclude her from using the pool, providing there are no other risk factors. A decision will be made on an individual basis. Intravenous antibiotics can be administered providing a waterproof dressing protects the cannula.

An on-going risk assessment should be performed throughout the labour to ensure that it remains safe to continue to labour/birth in the pool

Preparation of area and pool

- If the birth is to take place at home the Community Midwife should visit the home to undertake a risk assessment at 34-36 weeks gestation. Ensure discussion is documented on the home birth risk assessment paperwork.

- If it is a homebirth then the woman's birthing partner should take responsibility for assembly, filling and emptying the birthing pool. They should also ensure that the room is adequately ventilated and furnished for comfort, health and safety of the woman, family and staff. Refer to birthing pool hire agreement.

- Ensure room is clean at all times with all the necessary equipment for water and land birth in the room.

- An alternative area for birth out of the pool must be prepared nearby if the mother does not intend to birth in the water and in case of emergency.

- Normal tap water should be used and no chemicals or salt should be added, as there is no proven benefit. An adequate supply of hot water must be available at all times during labour and birth to ensure correct water temperature is maintained. Water temperature should not exceed 37.5 degrees for 1st stage and should be maintain around 37 degrees for the second stage (RCOG 2001).

- A single-use pool liner may be required for home births.

- Fill pool to 2/3 depth full. This should be deep enough to cover the woman's abdomen when sitting and sufficient to facilitate mobility.

- A sieve and accurate water thermometer must be available.

- Warm towels, blankets and robes should be available for the mothers use when out of the pool and to wrap the baby in following birth, to maintain normal body temperature for both mum and baby.

- The Midwife responsible should have had prior training in the safe evacuation of the pool.

First Stage of Labour

- Women may use the pool in the latent phase of labour for pain relief.

- If opiates have been administered, then allow a minimum of 4 hours until not adversely affected or drowsy before entering the pool

- Once in the pool the woman should not be left unattended and always have another competent adult, which may be her birthing partner, in the room with her.
- Encourage involvement of the birthing partner.

- Oral fluids should be encouraged in order to avoid dehydration and possible maternal hyperthermia.

- The water temperature should not exceed maternal body temperature but must not exceed 37.5 degrees. The water temperature should be checked hourly and documented on the partogram. The temperature should be taken from the middle or bottom of the pool.

- Maternal pulse and temperature should be checked hourly and recorded on the partogram. A maternal temperature of more than 37.5 degrees, is an indication assisting the woman from the pool as this can alter the oxygen transfer to the baby and lead to associate fetal compromise.

- Fetal heart rate should be recorded every 15 minutes for a full minute following a contraction using a waterproof sonicaid and recorded in the handheld notes and on the partogram as single figure. The trend should be observed for a rise in baseline.

- Document any accelerations if heard or fetal movements if palpated as these are reassuring of fetal wellbeing.

- Please use an Hourly Risk Assessment sticker for Intermittent Auscultation. Please follow the link to the associated guideline in regards to fetal monitoring and hourly risk assessment/fresh eyes. The Intrapartum fetal monitoring guideline

- If any problems are identified during auscultation then the woman should be advised to leave the pool for monitoring. If occurs at a home birth, the Coordinator of SBU should be made aware and transfer into is required for CTG monitoring. If the electronic fetal monitoring is subsequently reassuring following a 20 minute monitoring, she may return to the pool if she wishes and continue intermittent auscultation unless the woman asks to stay on continuous cardiotocography. Please refer to the Intrapartum Fetal Monitoring Guideline for Intermittent Auscultation

- Vaginal examinations can be performed in the water if the woman wishes. Long gauntlet gloves should be available in the pool room.

- Entonox may be used in the pool under supervision.

- Continue to check blood pressure 4 hourly.

- Monitor urine output as in normal labour.

Second Stage of Labour

- A midwife should be present throughout the second stage.

- Water temperature must be checked every 15 minutes and maintained at 37 degrees C. This is essential in preventing the baby's initial gasp and subsequent inhalation of water. This should be documented either on the partogram or with the free text of the intrapartum notes.

- The fetal heart should be auscultated every 5 minutes for a full minute after each contraction using a waterproof sonicaid and recorded in the handheld notes and on the partogram as single figure

- Wherever possible a 'hands off' approach should be maintained for the birth. This minimises stimulation to the baby. Traditional control of the head during crowning is unnecessary.

- It is not necessary to palpate for the presence of the cord once the head is born. It can be loosened and disentangled once the baby is born. If it is not possible to disentangle the baby from the cord then ask the mother to stand. The cord should never be clamped and cut with the baby still under the water.

- The baby should be born completely underwater. He/she is then brought face up, immediately and gently to the surface. Avoid traction on the umbilical cord as the

baby's head is brought to the surface. Following the birth the baby should be held skin to skin by the mother, head above the water with the body submerged to prevent hypothermia.

Third Stage of Labour

- Third stage should be conducted in accordance with the care of women in normal physiological labour guideline.

- The third stage can be conducted in the pool or out of the water depending on the women's wishes and clinical condition. If the third stage is conducted in the pool, physiological management is recommended. For active management then the woman should be asked to leave the pool prior to giving oxytocin.

- The estimation of blood loss in the pool is difficult due to dilution. It is therefore recommended that the blood loss be estimated as either more or less than 500mls.

- The perineum should be examined and repaired as necessary. This should be done out of the water. If suturing is required then it may be delayed for up to 1 hour, to allow perineal tissues to revitalise from immersion in water, unless excessive bleeding is noted.

Record Keeping:

- Accurate contemporaneous records should be kept, as usual. In addition, times of entering and leaving the pool should be clearly documented, including the reason for leaving the pool, if appropriate. It is important that it is recorded clearly whether the baby was born under water.

Emergencies

- In emergency or abnormal situations then the mother will be asked to leave the water in order to reassess the situation or expedite birth. The woman will be transferred to a prepared dry area close to the pool and the appropriate action initiated.

- In case of maternal collapse the woman will be removed from the pool using a predetermined plan in accordance with current moving and handling and health and safety guidelines.

- In the event of an emergency at a home pool birth the evacuation procedures should have been discussed at the birth plan.

Pool Cleaning

<u>Hospital Births</u>

- Pool surfaces should be damp dusted daily.

- Clean the interior surface of the pool first of all with detergent if visibly dirty and then with Hypochlorite solution 1,000 parts per million solution and allow drying to occur naturally.

- The thermometer, bucket, mirror and inflatable should be cleaned with Hypochlorite 1,000 parts per million solution.

- The sieve should be single use and disposed of as clinical waste.

- Chlorine does leave a residual powder and so it is necessary to rinse with water afterwards.

Home births

- After each use empty using the pump into the plumbed outlet and remove the liner and dispose of as clinical waste.

- Pools used in the community setting have single use outlet tubing which should be disposed of in the clinical waste).

- Chlorine does leave a residual powder and so it is necessary to rinse with water afterwards.

- The responsibility of dismantling the pool at a homebirth should be the support person/people, following instructions from the hire company.

5 EDUCATION AND TRAINING

No formal education or training is required; however midwives need to feel competent to support women to labour/birth in water.

6 MONITORING COMPLIANCE AND EFFECTIVENESS

No monitoring is required for this guideline

7 EVIDENCE BASE/ REFERENCES

- RCOG 2006 Immersion in Water During Labour and Birth RCOG/Royal College of Midwives Joint Statement No. 1

- The RCOG (2001) recommend that temp should never exceed 37oc, Royal College of Obstetricians and Gynaecologists – waterbirth recommendations(www.rcog.org.uk/medical/birth.html)

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- NICE (2017) Intrapartum care: care of healthy women and their babies during childbirth (Updated). London NICE.

- Charles C (1998) 'Fetal hyperthermia from warm water immersion'. British Journal of Midwifery, Vol 6, (March) No 3, pp 152-156.

- Johnson P (1996) Birth underwater to breathe or not to breathe, British Journal of Obstetrics and Gynaecology vol 103 (March) pp 202-208.

- Harper B (2006) Guidelines for a safe waterbirth. Waterbirth International.

8 EQUALITY IMPACT ASSESSMENT

- Guidance on how to complete an Equality Impact Assessment
- Sample completed form

Name of service/policy/procedure being reviewed: Birthing pool – labour and birth in a birthing pool management guideline			
New or existing service/policy/procedure: Existing			
Date of Assessment: 31/3/21			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?	b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?	c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality
The area of policy or its implementation being assessed:			
Race and Ethnicity:	None	N/A	N/A
Gender:	Female only	N/A	N/A
Age:	None	N/A	N/A
Religion:	None	N/A	N/A
Disability:	None	N/A	N/A
Sexuality:	None	N/A	N/A
Pregnancy and Maternity:	None	N/A	N/A
Gender Reassignment:	None	N/A	N/A
Marriage and Civil Partnership:	None	N/A	N/A
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation):	None	N/A	N/A

What consultation with protected characteristic groups including patient groups have you carried out? None
What data or information did you use in support of this EqIA? None
As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments? None

Level of impact From the information provided above and following EqIA guidance document, please indicate the perceived level of impact: Low Level of Impact For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment:
Signature: Sharon Parker
Date: 31/3/21