GUIDELINE FOR THE MANAGEMENT OF WATERBIRTH

Introduction

The RCM & RCOG provided a joint statement supporting labour in water for healthy women (2006). Birthing pools and other aids are highly valued by women to support different birthing positions with evidence of their flexibility, space and comfort of how the environment may help facilitate straightforward low intervention labour and birth documented in the RCM Blue top guideline (2018).

A systematic review of 15 randomised controlled trials including 3663 women, found no increased risk of infection for neonates following waterbirth (Cluett et al, 2018).

Pregnancy

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 water birth if they wish.

Labour

General advice

1. The pool should be filled to the level of the pregnant woman's breasts when sitting in the pool.
2. The temperature of the water should be maintained at 37 degrees Centigrade. The water temperature should be measured and recorded every 30 minutes. If the baby is born into water at this temperature it will not breathe while still under water. If the baby is born into water which is not 37 degrees centigrade then it may initiate respiration whilst still under water.
3. The woman should be able to move and to explore different positions in the pool at any time during labour and birth.
4. The woman should be encouraged to drink plenty water whilst in the pool as the temperature can contribute to her becoming dehydrated more readily.
5. As far as possible faeces which is passed in the second stage of labour should be removed from the pool. Disposable sieves are provided to aid this process.
6. The usual recordings of maternal temperature, pulse rate and blood pressure should be performed.

Monitoring the Fetal heart

1. Intermittent auscultation is the normal practice to monitor fetal heart during labour and birth in the pool environment.
2. A woman with previous caesarean section requests the use of pool, the waterproof telemetry equipment can provide a continuous fetal heart trace (in line with NICE guidance re continual monitoring during labour and scar rupture).
3. The fetal heart should be monitored using a waterproof doptone.
4. The fetal heart rate should be auscultated every 15 minutes in the first stage of labour and every 5 minutes in the second stage of labour. Listen to the fetal heart for one minute following a contraction. (do not attempt to listen before, during and after a contraction)
5. Record the fetal heart rate in the woman's electronic notes.

Delivery

1. Pushing should be physiological (non-directed) that is, the woman should be encouraged to push when she has the urge and should not be hurried.
2. A waterbirth should be a "hands-off" birth supported by verbal guidance from the midwife. Under NO circumstances should an episiotomy be performed when a woman is birthing in the pool environment.
3. After the baby's head is delivered, do not perform any manipulation to deliver the shoulders. This manual stimulation may cause the baby to breathe under water. Allow the shoulders and trunk to deliver unaided.
4. It is not necessary to feel for the presence of nuchal cord. The umbilical cord can be loosened and disentangled after the baby's head has surfaced.
5. The baby should be born completely under water, with no contact with the air until it is raised to the surface gently after the birth.
6. Following the birth of the baby, consider resting its head above the water at the level of the pregnant woman's uterus.
7. The woman should leave the pool or it drained of all water for delivery of the placenta and membranes. Physiological third stage is an option. Blood loss should be recorded as 'greater than' or 'less than' 500mls.
8. After use, the birthing pool should be promptly rinsed of debris. The entire pool and the area around the taps etc, should be cleaned using a solution of a chlorine

releasing agent 10,000ppm. The deck scrubber with disposable head should be used to thoroughly clean the bottom of the pool without exposing the midwife to health and safety issues with regards to moving and handling. Rinse and dry the pool thoroughly. All disposable items should be discarded appropriately and any other equipment, (Doppler, thermometer) should be cleaned with the same strength chlorine releasing solution.

Complications in labour and delivery

If there are any complications in labour or delivery you must recommend the woman leaves the pool environment. Please ensure you fully inform the woman of the reasons you wish her to leave and document in her electronic notes. Such complications include:

- Fetal distress
- Intrapartum haemorrhage
- Maternal pyrexia
- Hypertension
- Delay in first stage of labour
- Delay in second stage of labour

COVID – 19

The RCM recommends the following:

- Practice should be guided by all emerging evidence through the pandemic.
- The current evidence does not suggest that there should be a blanket cessation on the use of water in labour or waterbirth for all women.
- Midwives should be familiar with the up to date UK wide infection prevention and control guidance, and have access to the appropriate PPE at all times when providing care.
- Midwives already make professional judgements about their own safety and the safety of the women they care for and they should continue to use the same decision-making process flexibly. 'The Health & Safety at Work Act' (H&SAWA) 1974, puts a legal duty on employers to conduct risk assessments based on both the environment in which a worker operates and the tasks they undertake. They also have a duty to tell workers about the risks and the preventative measures they are

taking. Whatever the circumstances, though, the employer has a responsibility to assess the risks and mitigate them.

- Individualised risk assessment about the appropriateness of providing labour or birth care in the pool room should be undertaken for each woman by the midwifery team providing care, based on the woman's individual presentation and the pool environment within the labour setting. For example, if a pool room is very small and does not allow for social distancing by the midwife from the woman during labour, or if there is no facility to ensure adequate ventilation of the room, the midwife may make a clinical judgement in relation to the safety of proceeding.
- If the pool becomes contaminated with faecal matter during the labour or birth, the midwife should assess the risk of contamination presented. If the faecal matter cannot be removed using normal methods such as a sieve, it may be necessary for the midwife to ask the woman to leave the pool (Jinyamg et al 2020).

Burns et al (2020) recommends the use of pool births for women risk assessed suitable for low risk care as the birth pool environment presents a natural barrier between the woman and her midwife. Supporting women in the water reduces droplet, aerosol and faecal contamination, presenting a low risk transmission activity for the Coronavirus.

Emergency procedure for assisting the pregnant woman out of the birthing pool.

If the woman loses consciousness in the birthing pool adopt the following procedure:

1. Summon help.
2. Don't empty the pool.
3. Support the woman's head and neck.
4. Place the body support around the woman's waist.
5. Raise the water level by opening the taps.
6. Remove the end of the bed and bring the bed to the edge of the pool. Place a glide sheet over the bottom of the bed (the height of the bed should be slightly lower than the edge of the pool.
7. Place net underneath the woman and with aid of glide sheet, slide her onto the bed.

References

Burns E; Feeley C; Venderlaan J; Hall P; Roehr C (2020) Coronavirus COVID – 19 Supporting healthy pregnant women to safely give birth. Oxford Brookes University. 29 April 2020.

Cluett ER; Burns E; Cuthbert A (2018) immersion in water during labour and birth (Cochrane review). The Cochrane database of Systematic Reviews, Issue 5 16 may 2018.

RCM (2020) RCM clinical briefing: Waterbirth – COVID 19. Royal college of Midwives April 2020

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