

# Women's & Newborns' Health Network

## WA Labour & Birth in Water Clinical Guidelines

October 2009

**Clinical guidelines for women requesting immersion in water for pain management during labour and /or birth.**



Government of **Western Australia**  
Department of **Health**



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## Background

This guideline has been developed in response to increasing consumer demand in Western Australia for the option to use immersion in water for labour and/or birth.

The guideline 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.

It should be noted that the Women's and Newborns Health Network does not necessarily advocate 'Water Birth' but recognises that women have a right to choose to labour and or birth in water.

A Cochrane review [1] provides the most recent evidence on water births stating that,

“Water immersion during the first stage of labour significantly reduces epidural/spinal analgesia requirements and reported maternal pain, without adversely affecting labour duration, operative delivery rates, or neonatal wellbeing. Immersion in water during the second stage of labour increased women's reported satisfaction with pushing” (pp. 1-2).

Water births are associated with low risks for both the woman and baby when best practice guidelines are followed [2,3].

This guideline has sections that relate to each stage of labour. The content relating to the first stage of labour is suitable for those requesting immersion in water for pain relief only.

## Aim

- To enable midwives and medical practitioners to provide care that is as safe as possible for healthy pregnant women who choose to use immersion in water as a pain management strategy during labour and/or for birth.



## Key Points

- These guidelines describe the additional care that is required, to that routinely provided, when healthy women choose to use water immersion during labour and/or birth;
- Staff must be trained in, and have practiced emergency drills in the correct procedure to assist the woman leave the water in an emergency situation (see Appendix 3);
- If a woman is considering the use of immersion in water during labour and/or for birth, this should be discussed with the woman and her support people during pregnancy to enable the woman to make a fully informed decision [4];
- Consent needs to be completed and documented after discussion with the woman preferably during the antenatal period [5-7] (see Appendix 4);
- The midwife or medical practitioner must be confident and competent to facilitate a woman's labour and/or birth in water [6,7];
- The midwife or support person must remain with the woman at all times to maintain safety whilst she is immersed in water; and
- Each maternity service that offers immersion in water for labour and/or birth should undertake ongoing audit and evaluation to ensure adherence to the guidelines and monitor outcomes using the supplied audit tool (see Appendix 5).

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## Inclusion Criteria

### Antepartum

The following women may be offered the option of being immersed in water during labour and/or birth:

- Healthy women with no medical or obstetric risk factors [1,6-10];
- Singleton pregnancy [1,6];
- Cephalic presentation [1,6];
- At least 37 completed weeks pregnant [1,6];
- Not a carrier of / infected with HIV, Hepatitis B or Hepatitis C virus; and
- Body mass index less than 35 at term.

### Special circumstances

- Positive Group B Streptococcus vaginal swabs during pregnancy are not a primary contraindication for water immersion [11]
- Women with ruptured membranes for more than 18 - 24 hours may be offered the option of being immersed in water during labour and birth, after commencing the recommended course of intravenous antibiotics [6,7,11].

### Intrapartum

In the intrapartum period the following additional criteria need be taken into consideration.

- There is no contra-indication to the use of intermittent auscultation of the fetal heart
- All maternal and fetal observations remain within normal range;
- The woman is required to leave the water if an intrapartum risk factor develops or is detected [9];
- Clear amniotic fluid in the presence of a reassuring fetal heart rate; and
- Has not received narcotic analgesia within 4 hours.



<b>What additional care is required, to that routinely provided, when healthy women choose to use water immersion during the <u>first stage</u> of labour?</b>	
<b>Recommended Care</b>	<b>Supporting Information</b>
<b>WATER</b>	
Fill the bath/pool with pure tap water (no additives).	There is some evidence that additives, especially bath oils, in the water may be detrimental to the baby. [2, 7,12].
Run taps on full for several minutes before filling bath/pool.	Reduces risk of transmission of pseudomonas [11].
The water level should be to the maternal breast level when sitting [4, 5, 7].	To facilitate comfort and complete immersion of the baby if born into the water.
The woman should be comfortable with the water temperature. This would be expected to be between 35-37°C [4,5]. Check and record water temperature hourly [5,7,8,12,13].	Promote comfort and prevent maternal pyrexia and fetal tachycardia [6].
Keep the water as clean as possible using a sieve.	Minimise faecal contamination and reduce risk of infection. If the water becomes heavily contaminated ask the woman to leave the water so that it can be cleaned and refilled [5].
Additional equipment should include; Long gloves; kneeler pads, cushions, water thermometer and a bed/mattress. Lifting equipment should be readily available. Weight limits for the lifting equipment must be considered.	Promotes comfort and safety for woman and staff.

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(Table continued)

What additional care is required, to that routinely provided, when healthy women choose to use water immersion during the <u>first stage</u> of labour?	
Recommended Care	Supporting Information
<b>OBSERVATIONS</b>	
Times of entering and leaving the water should be clearly documented, including the reason for leaving, if appropriate.	Clear concise documentation reflects quality care delivery [6].
It is advisable for a woman's labour to be established before entering the water (> 5 cm).	If labour is not established, progress may be delayed [1].
Assess maternal and fetal observations prior to the woman entering the water.	This ensures a baseline for continued assessment
Maternal temperature should be recorded at hourly intervals and should remain within normal range.  If the woman feels too hot or her temperature becomes raised then she should leave the water until she has cooled down. Check the water temperature and add cold water if necessary and re-check the woman's temperature within 30 minutes.  If the maternal temperature is greater than 37.6°C on 2 occasions, the woman should leave the water [7]. Complete a full assessment of maternal and fetal wellbeing and consult or refer if indicated.	A rise in maternal temperature may indicate that the water temperature is too hot and may result in fetal tachycardia [14].  Provides opportunity for body temperature to return to normal. Reassess maternal and fetal wellbeing prior to returning to the water.  A rise in maternal temperature may also indicate dehydration or infection.
Fetal heart monitoring should be undertaken as per the standard guidelines for a healthy woman and her fetus during a normal labour and birth.  Fetal heart rate must be monitored using an aqua doptone	If, during intermittent fetal heart rate monitoring, the midwife detects a deviation from normal, the woman is required to leave the water and both maternal and fetal conditions should be reassessed. Consultation and/or referral should be undertaken as deemed appropriate to the situation.  To prevent accidental electrocution.
Encourage the woman to drink.	Maintain hydration and minimise effects of a warm environment.
Encourage the woman to leave the water to urinate [5, 7,15].	To minimise contamination and reduce risk of infection. Facilitates accurate record keeping.
The woman is usually asked to leave the water if and when a vaginal examination is required. This is dependent on the Midwife's ability to perform this procedure under these circumstances – the woman should leave the water if findings are not certain.	Facilitates the gathering of all appropriate information in a situation where an assessment is deemed appropriate. Ensures appropriate back care for midwife.
Nitrous Oxide and Oxygen can be used by the woman in the water [5,7,8].	Nitrous Oxide & Oxygen should not affect the woman's capacity to leave the water if requested.



What additional care is required, to that routinely provided, when healthy women choose to use water immersion during the <u>second stage</u> of labour?	
Recommended Care	Supporting Information
If a woman chooses to birth in the water two health professionals (midwives, medical practitioners) should be in attendance.	To maintain safety and provide assistance in the event of an emergency
Check water temperature continuously and document every 30 minutes during the second stage of labour. The optimum water temperature is 37°C and not more than 37.5°C [1,3,5,6,8,17].	Cooler temperatures may trigger initial respirations while the baby is still submerged [5].
Fetal heart rate monitoring should be undertaken as per normal guidelines. In a situation where the midwife identifies variable decelerations, assumed to be related to cord compression/traction, then the woman is required to leave the water.	Reduce the risk of a potentially compromised infant, with cord entanglement, being born into water.
Encourage physiological pushing when the urge is sustained, ie non-directed pushing.	Non-directed pushing is associated with improved umbilical artery pH and Apgar scores in the newborn [16].
Traditional control of the head is unnecessary. Progress can be observed with a mirror [17]. Avoid unnecessary touching of the head and await spontaneous restitution and birth of the body to minimise tactile stimulation of the baby.	Immersion in water appears to facilitate slow crowning of the head. "Hands Poised" birth minimises stimulation of the baby underwater [17]
If the fetal / newborn's head is exposed to air at any time, ensure the woman remains out of the water.	Exposure to air may stimulate premature breathing [17].
The cord must not be clamped and cut under water. If necessary loosen/disentangle the cord [7].	Clamping/cutting of the cord while the baby is still submerged may stimulate respiration.
At birth the baby should be completely submerged and brought to the surface, head first and face down <b>gently but immediately</b> following birth. The baby's head must not be re-submerged under water once it has surfaced.	Total submersion prevents initiation of respiration [17]. Babies born under water do not initiate respiration until they come into contact with cool air. Care should be taken to avoid undue traction on the cord and prevent cord snapping [1].
The umbilical cord should be checked immediately following birth of the baby to ensure that it has not snapped. The midwife should be prepared for this eventuality and have cord clamps ready.	Snapped umbilical cord is a rare but possible complication associated with birth underwater. Cord snapping at a water birth is not an emergency if it is recognised promptly [18]. Paediatric review is needed if the umbilical cord snaps.
Record whether the baby was born under water and assess the condition of the baby at birth.	The first Apgar score should be assessed one minute from the time the baby is exposed to the air [7].
Maintain warmth of the baby by skin to skin contact, drying the head and keeping the rest of the body under water. Encourage and facilitate early breastfeeding.	Prevent hypothermia of the baby. Promote maternal infant connection and establishment of lactation, and assist with uterine contraction for separation of the placenta in the third stage [19].
Should the baby require resuscitation the cord is to be clamped and cut immediately and the baby placed in a warm, dry environment to facilitate resuscitation. The woman can then be assisted from the water by the second midwife in a calm and safe manner. Neonatal resuscitation equipment must be readily available.	A safe environment is necessary to enable effective neonatal resuscitation and assessment to be performed. There must be a suitably qualified person available to resuscitate the baby if needed.



**What additional care is required, to that routinely provided, when healthy women choose to use water immersion during the third stage of labour?**

Recommended Care	Supporting Information
<p>The woman is required to leave the water if <u>active management of the third stage</u> of labour is indicated.</p> <p>Two people must be present to assist the woman and the baby when they leave the water.</p> <p>Injections of any kind must not be given while the woman is in the water. The administration of an oxytocic drug may be delayed until the woman has safely left the water.</p>	<p>Active management of the third stage of labour reduces the risk of maternal postpartum haemorrhage and shortens the third stage [20].</p> <p>To facilitate a safe environment where the principles of active management of the third stage can be safely applied.</p> <p>Special care must be taken to ensure the safety of the baby where the placenta is still in situ and the cord is unclamped and the baby and the woman exit the water together.</p> <p>It is unsafe to administer injections while the woman is immersed in water. The time of oxytocic administration needs to be noted as this will influence the length of completion of the third stage.</p>
<p>For women requesting a <u>physiological third stage</u>. The woman may wish to leave the water however, there is no evidence to contraindicate birthing the placenta in water in physiological management of the third stage. The cord is left <b>unclamped</b>. Once pulsation of the cord has ceased, the placenta and membranes are expelled spontaneously by the woman into the water.</p>	<p>Clamping of the pulsating cord disturbs the physiology and can predispose postpartum haemorrhage and or retained placenta [19].</p> <p>The uterus is not stimulated prior to expulsion of the placenta and membranes as it interferes with the physiological process</p>
<p>The estimated blood loss should be recorded as accurately as possible recognising that this may be difficult with dispersion/ dilution in the water</p> <p>The woman must be assisted to leave the water immediately if there is any evidence of physical compromise or if postpartum haemorrhage is suspected.</p>	<p>Recording blood loss accurately is difficult. Assessment of the woman's physical wellbeing is therefore vital.</p> <p>It is important to remember that the woman may not show signs of physical compromise until a significant blood loss has occurred.</p>
<p>Suturing should be delayed up to 1 hour after the woman leaves the water.</p>	<p>Perineal tissues need time to revitalise following prolonged immersion in water.</p>



**What additional care is required, to that routinely provided during the fourth stage of labour, when a healthy woman and her baby choose to remain in the water?**

Recommended Care	Supporting Information
<p>Both mother and baby should be kept warm following the birth.</p> <p>Hats are recommended for the baby and wet wraps should be regularly changed.</p> <p>The temperature of the water must be maintained while mother and baby remain in the bath.</p> <p>The baby's temperature must be checked regularly during this time.</p>	<p>Prevent hypothermia.</p> <p>Keeping the baby's head dry and warm promotes thermoregulation in the newborn.</p>
<p>Observations of the woman and baby must be completed and documented as usual where the woman chooses to remain in the water following the birth of the baby.</p>	<p>Timely identification of maternal and/or infant compromise.</p>
<p>The woman and baby must be fully assisted when leaving the water.</p>	<p>The wet floor, possible physiological maternal hypotension or sudden blood loss on standing may cause the woman to become unstable on her feet.</p>

Superseded By  
OD 0417110



## References

	Level of Evidence
1. Cluett E R, Nikodem V C, McCandlish R E, Burns E E (2004) Immersion in water in pregnancy, labour and birth. The Cochrane Database Systematic Review. (2):CD000111	Level I
2. Gilbert R E, Tookey P A (1999). Perinatal mortality and morbidity among babies delivered in water: surveillance study and postal survey. British Medical Journal 319:483-7.	Level IV
3. Geissbuehler V, Stein S, Eberhard J. (2004) Waterbirths compared with landbirths – an observational study of nine years <i>Journal Perinatal Medicine</i> 32:308-14	Level III-2
4. Burns E, Kitzinger S (2001) <i>Midwifery Guidelines for Use of Water in Labour</i> . Oxford Centre for Health Care Research and Development, Oxford Brookes University.	(clinical guideline based on a range of evidence)
5. Government of South Australia, (2005), Policy – First Stage labour in Water, Department of Health.	(clinical guideline based on a range of evidence)
6. Royal College of Obstetricians and Gynaecologists / Royal College of Midwives (2006); Immersion in Water during Labour and Birth. Joint statement No.1	(clinical guideline based on a range of evidence)
7. Government of South Australia, (December 2005), Policy – Birth in Water, Department of Health.	(clinical guideline based on a range of evidence)
8. Maternity Services, Obstetric and Gynaecology Directorate (2006) Antenatal women requesting immersion in water for pain relief in labour and or childbirth Norfolk and Norwich University Hospital, NHS Trust, United Kingdom.	(clinical guideline based on a range of evidence)
9. Woodward J, Kelly S (2004) A pilot study for a randomised controlled trial of waterbirth versus land birth. <i>BJOG: an International Journal of Obstetrics and Gynaecology</i> , Vol 111, 537-545.	Level II
10. Bodner K, Bodner-Adler B, Wierrani F, Mayerhofer K, Fousek C, Niedermayr A, Grunberger W (2002) Effects of water birth on maternal and neonatal outcomes <i>Wiener Klinische Wochenschr.</i> 114 (10-11): 391-5.	Level II
11. Zanetti-Dallenbach R, Lapaire O, Maertens A, Frei W, Holzgreve I (2006) Water birth: is the water an additional reservoir for group B Streptococcus? <i>Archive of Gynaecology and Obstetrics</i> 273:236-38.	Level IV
12. Women's and Children's Health. (2006) <i>The use of baths during labour</i> . The Canberra Hospital, Australian Capital Territory, Australia	(clinical guideline based on a range of evidence)
13. Women's and Children's Health Unit. (2004) Guidelines for warm water immersion for labour and birth. Cheshire Medical Centre, Keene, Northampton, England, United Kingdom.	(clinical guideline based on a range of evidence)
14. Harper B J (2003) Taking the plunge: re-evaluating	Level II



waterbirth temperature guidelines. *MIDIRS Midwifery Digest* 12 (4) pp506-508

15. College of Midwives of British Columbia (2000). Guidelines for the use of water in Labour and Birth. British Columbia, Canada; <http://www.cmhc.bc.ca/>.

**(clinical guideline based on a range of evidence)**

16. Enkin M, Keirse M, Nielson J, Crowther C, Dudley L, Hodnett E and Hofmeyer J (2000). *A guide to effective care in pregnancy and childbirth*. Oxford: Oxford University Press pp. 316-317

**Level II**

17. Johnson P (1996) Birth under water - to breathe or not to breathe. *British Journal of Obstetrics and Gynaecology* Vol: 103 pp 202-208.

**Expert opinion**

18. Cro S, Preston J (2002) Cord snapping at Waterbirth delivery. *British Journal Midwifery* 10(8)494-7

**Level IV**

19. Rogers J, Wood J, McCandlish R, Ayers S, Truesdale A, Elbourne D (1998) Active vs expectant management of the third stage of labour: The Hitchinbrooke randomised controlled trial. *Lancet* 351:693-9

**Level II**

20. National Institute for Clinical Excellence. Intrapartum care. Care of healthy women and their babies during childbirth. London:2007

**Level I**

Superseded By  
OD 0417113



## Appendices

### Appendix 1: Infection Control

- Standard Infection Control Guidelines to prevent cross infection or contamination must be followed.
- Evidence suggests there is no increased risk of infection from using water for labour and/or birth. Routine infection control procedures are recommended, including removal of faecal contamination from the water and appropriate cleaning after use [1-5].
- The suggestion that bath/pool water provides a perfect condition for bacteria to reproduce has been refuted by Garland and Jones [6].
- Running water with taps fully opened for several minutes reduces the risk of pseudomonas transmission from taps [11].

#### Cleaning of bath/pool

- The cleaning agent should be a neutral detergent recommended for use by the organisation.
- If a spa bath is used, the cleaning regimen should include jets, drain pumps, hoses and filters. They should be well maintained, free draining and flushed through with a chlorine solution after each use.
- The bath/pool must be allowed to air dry before it is used again;
- The bath/pool must be regularly maintained.
- Routine Legionella testing of the hospital water supply should occur in accordance with State/National recommendations.
- If a portable pool is to be used, use a disposable liner.

#### Clothing

- Long arm gloves should be used to avoid contact with maternal blood and body fluids in the bath/pool water, as per National Infection Control Guidelines.
- Any breaks in skin integrity are to be covered with a waterproof dressing.
- Personal protective clothing including eye protection should be worn as appropriate.

#### Equipment

- Cleaning of baths/pools should take place with long handled equipment, adjusted to the correct length to allow cleaning of all bath walls.
- Where possible single pieced equipment is required for use as it can be more effectively cleaned and sterilised.

#### Contamination

- If the water becomes heavily contaminated, the woman should be asked to leave the bath/pool temporarily until the water can be changed and the bath/pool cleaned.
- After use, the bath/pool and sieve must be thoroughly cleaned and allowed to air dry before next use.



## Appendix 2: Manual Handling

### Back care

- Kneeler pads, cushions, low stool and birthing balls should be provided for health and safety of midwives/doctors and birth companions [6,7].
- Correct back care for the midwife/doctor should be maintained.
- The bath should be cleaned without forward bending, twisting or over-reaching.
- The back should be kept in a position to maintain normal spinal curves with all activities including cleaning.

### Safely assisting the woman in/out of the water

- Ensure the woman is able to enter (and, when appropriate, exit) the bath/pool without placing herself in physical danger.
- Ensure that the temperature of the water is appropriate.
- Assess the placement of electrical appliances to avoid close proximity of the bath/pool.
- Provide guidance to the woman's birth partner on how to best help the woman in and out of the bath/pool.
- A non-slip mat should be available.
- A supply of dry towels or linen should be in close proximity in order that the woman (and, following birth, her baby) does not become cold.

### Assisted evacuation out of the water

- If the woman becomes unconscious, immediate emergency procedures must be enacted to remove the woman from the water. Hospitals, health services and non government organisations should each develop their own emergency procedures in conjunction with their chosen method of patient lifting/transfer device.
- A guideline and training schedule in the use of the maternity facilities choice of evacuation equipment must be developed.
- Adherence to the maternity facilities "Minimal Handling" policy is vital to protect the ergonomic integrity of the staff (National Code of Practice for Manual Handling [http://www.ascc.gov.au/NR/rdonlyres/86BD7C06-48F5-48C6-ACB6-BD761EF0A508/0/manualhandling\\_cop2005\\_1990.pdf](http://www.ascc.gov.au/NR/rdonlyres/86BD7C06-48F5-48C6-ACB6-BD761EF0A508/0/manualhandling_cop2005_1990.pdf))
- Staffing levels should be adequate to ensure that the woman can be removed from the bath/pool if she is unable to do so herself.
- Ideally, two or more sides of the bath/pool should be easily accessible.



## Appendix 3: Education

### Requirements for Facilitating Immersion in Water during Labour and/ or for Birth

Women using immersion in water for labour and/or birth should be attended by a registered midwife and/or medical practitioner who is experienced in facilitating this care. There should be two health professionals (midwives/medical practitioners) present at the birth.

Study days related to the use of immersion in water for labour and birth will be offered by Women's and Newborns' Health Service – KEMH, Department of Nursing & Midwifery Education & Research as part of its continuing professional development program for midwives. The WA Branch of the Australian College of Midwives will also be encouraged to repeat previous study sessions on this topic.

Appropriate experience with water birth should include:

- Attendance at an education session/s and/or completion of a self-directed learning package on the use of water immersion during labour and water birth as directed /arranged by the maternity facility.
- Facilitation under supervision, on two or more occasions, the care of a woman who has used water immersion during their labour and/or birth (either as a student or after qualification).
- Trained and practiced in emergency evacuation procedure.
- Confirmation of recent neonatal resuscitation competency update.

Suggested education package topics

- Benefits and risks of using water immersion in labour and/or for birth: The research evidence
- Fetal physiology, the dive reflex and transition to extra-uterine life
- Best Practice
  - Information sharing and informed consent
  - Equipment
  - Criteria, ongoing assessment and monitoring
  - When is the best time to get in the water?
  - When should women get out of the water?
- Giving birth in the water. There are many suitable DVDs to enhance this learning. It is also recommended that women are invited to speak about their waterbirth experiences.
- Management of a physiological third stage
- Assessing and measuring blood loss
- Emergency evacuation of the woman from the water
- Occupational Health and Safety
  - Protection
  - Ergonomic awareness
  - Cleaning





## Learning Resources

### Books

Garland D. (2000). Waterbirth. An attitude to care. (2<sup>nd</sup> ed.). Oxford: Books for midwives

Harper, B. (2001). Waterbirth: Dispelling the myths – embracing the miracle

National Childbirth Trust. (2002). Labour and birth in water – how and why you might use water. London:NCT

Pairman, S., Pincombe, J., Thorogood, C., & Tracy,S. (2006). Midwifery preparation for practice. Sydney:Elsevier

It is recommended that staff read the chapter on the use of water for labour and birth and complete the review questions as part of their professional development.

### Examples of useful DVDs/videos

A guide to waterbirth (1993): Made at the John Radcliffe Hospital in Oxford UK, this straightforward guide offers insights into the value of water for labour and birth, the parent's views about this approach and practical tips for the midwives assisting the labouring woman. We see the birth of a second baby, following a traumatic forceps and episiotomy for the birth of the first baby. This film, now re-released on DVD, would be useful for classes as well as midwifery education.

The Art of Birth (2002): Shows four gentle waterbirths at home and in a Birth Centre.

"Birth in Water" (2006): Made at John Flynn Hospital (Gold Coast). This DVD takes you on an extraordinary journey documenting the use of water immersion during labour and childbirth. It reveals the benefits of water birthing, both physical and emotional. There are 5 births, filmed at the John Flynn Hospital on the Gold Coast, with Dr Andrew Davidson.

Testimonials from parents give you insight as to what to expect.

55 minutes.



## Appendix 4: Information Sharing and Consent

### Consent

Informed consent refers to the process of firstly sharing non-biased information with a woman, within the context of her feeling able to openly ask questions, seek clarification and share her own views. Secondly the process involves obtaining her consent for a health practitioner to provide a specific care option and/or treatment.

RANZCOG [8] recommends that “Institutions are encouraged to obtain consent in writing from women who choose to use warm water immersion for labour and/or delivery, prior to the onset of labour” (p4.)

Women should sign a standardised ‘consent form’ when choosing or requesting to use water immersion for labour and/ or birth. The process of informing a woman about this option should be undertaken in conjunction with the presentation of a consumer information brochure.

The informed consent process should include:

- Discussion with the woman about whether she would be considered suitable for immersion in water during labour and/or birth (refer to Guideline Inclusion Criteria).
- Benefits & risks associated with immersion in water for labour and/or birth (refer to the evidence included in the Guideline).
- Discussion re circumstances that would require the woman to leave the water.
- Obtaining the woman’s consent.

Further information on Western Australia’s Department of Health consent policy can be retrieved from the following address:

[http://www.safetyandquality.health.wa.gov.au/docs/consent/Consent\\_Policy](http://www.safetyandquality.health.wa.gov.au/docs/consent/Consent_Policy)

### Information that could form the basis of a consumer leaflet / brochure

Water immersion during labour and/or birth provides pregnant women with a non-invasive option for managing the pain of labour.

#### **Benefits**

Water immersion during labour and/or birth can enhance relaxation, reduce perceptions of pain and promote supportive care. There are many studies that focus on the benefits of water for women [9].

These studies suggest that entering the water in the first stage of labour can:

- Promote comfort
- Enhance mobility
- Facilitate relaxation
- Alleviate stress (decrease catecholamines and increase oxytocin and endorphins)
- Increase a woman’s confidence in her own ability to manage her labour which in turn promotes feelings of control over the process

Labouring women who use water immersion are less likely to require;

- chemical forms of pain relief
- drugs to accelerate labour
- episiotomy and/or perineal stitches for tears



Labouring women who use water immersion are more likely to;

- achieve a natural spontaneous birth
- be satisfied with their birth experience

Women must leave the water for assessment in the following circumstances;

- If they have temperature
- The fetal heart rate pattern is abnormal
- A vaginal examination is indicated
- The woman requests pain relief in the form of a narcotic analgesic or epidural anaesthetic

### **Choosing to birth in water**

Evidence suggests that the clinical outcomes for babies born into water are not significantly different to those not born in water [9,10].

The risk of the baby breathing water into its lungs, while extremely low, is more likely to occur when the baby is not well. A woman whose baby is assessed to be compromised must leave the water for further assessment.

Routine monitoring in labour does not always detect when a baby is compromised. Observations can be completely normal and a baby be born in an hypoxic state. Such babies are those most at risk of gasping and inhaling water during a water birth.

The risks associated with giving birth in water are reduced when good practice guidelines are followed in relation to:

1. Ensuring staff have the appropriate education and skills to assist a woman give birth in the water;
2. There are guidelines to direct practice which include criteria for using water immersion;
3. Appropriate infection control policies and procedures are in place; and
4. Evacuation procedures and management of emergencies are clearly documented.

### **Examples of Consumer Information Brochures**

Department of Health South Australia, Labour & Birth in Water (2005)

<http://www.health.sa.gov.au/ppg/portals/0/WaterBirthLeaflet.pdf>

Midirs Informed Choice - Do you want a waterbirth?

<http://www.choicesforbirth.org/booklets.php?id=11>

Brochure being developed for use in WA by Women's and Newborns' Health Service on behalf of the Women's and Newborns' Health Network.



**Appendix 5: Audit tool for the use of water during labour and/or birth at hospitals and health services in Western Australia.**

To be completed by accoucheur for every waterbirth, including intended.

<b>Record Identification no.:</b> _____	<b>Date:</b> ____/____/____
<b>Facility:</b> _____	

Woman fully informed of benefits and risks of waterbirth Yes No

Is the woman of ethnic minority? Yes No

What ethnicity is she? \_\_\_\_\_

Did the woman wish to use water immersion but did not meet the criteria?  
Yes No

Why was she unable to do so? \_\_\_\_\_

Criteria for inclusion all met Yes No

Experienced accoucheur Yes No

Entered the bath/pool in early labour < 4cms Yes No

Entered the bath/pool in established labour ≥ 4cms Yes No

Did the woman demonstrate she could leave the water unassisted on request?  
Yes No

Did the woman choose to leave the water? Yes No

If yes, why? \_\_\_\_\_

Was the woman asked to leave the water? Yes No

If yes, why? \_\_\_\_\_

Did the woman return to the water? Yes No

What was the outcome of the investigation that required her to leave the water?  
\_\_\_\_\_

Was the midwifery consultant/ doctor informed if the woman was asked to leave the water?  
Yes No

If no, why not? \_\_\_\_\_

Was the water temperature comfortable for the woman? Yes No

Was the temperature between 35-37c? Yes No

Was the water temperature recorded? Yes No

If no, why not? \_\_\_\_\_

Was the fetal heart within a normal range whilst the woman was immersed?  
Yes No

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**During second stage**

Was spontaneous pushing supported? Yes No  
 Was a 'hands off approach' used Yes No  
 Was the fetal heart within a normal range during second stage? Yes No  
 Did the baby remain fully immersed for the birth? Yes No  
 If no, why not? \_\_\_\_\_

Were 2 staff present for the birth? Yes No  
 If no, why not? \_\_\_\_\_

Was there a reason to check for nuchal cord? Yes No  
 If yes, what was the reason? \_\_\_\_\_

Was the baby's temperature maintained in a normal range? Yes No  
 Did the cord snap? Yes No  
 If yes, what action was taken? \_\_\_\_\_

**During 3<sup>rd</sup> Stage**

Was the 3<sup>rd</sup> stage Actively managed? Yes No  
 If yes, why? \_\_\_\_\_

Did the woman get out of the water for the placenta? Yes No  
 If so, why? \_\_\_\_\_

Estimated blood loss \_\_\_\_\_mls  
 Perineal status \_\_\_\_\_  
 What were the baby's 1 minute and 5 minute APGAR scores? 1 minute: \_\_\_\_\_  
 5 minute: \_\_\_\_\_

What was the woman's expression of her experience of water immersion for pain management during labour and/or for birth?

Comments \_\_\_\_\_

Was the Neonate admitted to NICU? Yes No  
 For what reason? \_\_\_\_\_

**Once you have completed this form please send a copy to the Women's and Newborns' Health Network via one of the three methods:**  
**E-mail:** [healthpolicy@health.wa.gov](mailto:healthpolicy@health.wa.gov)  
**Fax:** 08 9489 2833  
**Post to:** Women's and Newborns' Health Network, Health Networks Branch, PO Box 8172, Perth Business Centre, PERTH WA 6849



## Appendix 6: Pools

### Types of pools available for reference

Birth Pool in a Box

Website [www.birthpoolinabox.co.uk](http://www.birthpoolinabox.co.uk)

La Bassine Birth Pools

Website <http://www.simplybirth.com.au>

Febromed

Website [http://www.febromed.de/html\\_englisch/novarelay\\_english.htm](http://www.febromed.de/html_englisch/novarelay_english.htm)

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