



Womens & Newborns Health Network

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

Superseded by
MP 004917

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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 reduces the use of epidural/spinal analgesia. There is limited information for other outcomes related to water use during the 1st and 2nd stages of labour, due to intervention & outcome variability. There is no evidence of increased adverse effects to the fetus/neonate or woman from labouring in water or waterbirth. The fact that the use of water immersion in labour and birth is now a widely available care option for women threatens the feasibility of a large multicentre randomised controlled trial.” (p2)

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 ;
- Agreement to the use of water immersion needs to be obtained and documented after discussion with the woman preferably during the antenatal period [4,5,6] (see Appendix 4);
- The midwife or medical practitioner must be confident and competent to facilitate a woman's labour and/or birth in water [4,5,6];
- The midwife or support person must remain with the woman at all times to maintain safety whilst she is immersed in water; and
- Clinical outcomes are to be recorded and monitored using the *Stork* database.
- Each maternity service that offers immersion in water for labour and/or birth should undertake periodic audit and evaluation to ensure adherence to the guidelines. (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 [1,5,6,7];
- Singleton pregnancy [1,6,7];
- Cephalic presentation [1,6,7];
- At least 37 completed weeks pregnant [1,6,7];
- Not a carrier of / infected with HIV, Hepatitis B or Hepatitis C virus; and
- Body mass index equal to or less than 35.0 pre-pregnancy or at booking visit [8,9]

Special circumstances

- Positive Group B Streptococcus vaginal swabs during pregnancy are not a primary contraindication for water immersion provided that antibiotics guidelines are adhered to (10,11).
- Women with ruptured membranes for more than 18 – 24 hours may utilise immersion in water during labour and birth provided that the recommended intravenous antibiotics are administered [5,10,11].

Intrapartum

In the intrapartum period the following additional criteria must 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;
- Clear amniotic fluid in the presence of a reassuring fetal heart rate; and
- Has not received narcotic analgesia within 4 hours.
- The woman is required to leave the water if an intrapartum risk factor develops or is detected [5];



FIRST STAGE OF LABOUR

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
WATER	
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. [2,4,5].
Run taps on full for several minutes before filling bath/pool.	Reduces risk of transmission of pseudomonas [10].
The water level should be to the maternal breast level when sitting [4, 5].	To facilitate comfort and complete immersion of the baby if born into the water.
The woman should be comfortable with the water temperature. This should not exceed 37.5°C [12]. Check and record water temperature hourly [5,12].	Promote comfort and prevent maternal pyrexia and fetal tachycardia [5].
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 [4].
Additional equipment should include; Long gloves; kneeler pads, cushions, water thermometer and a bed/mattress. Evacuation equipment should be readily available.	Promotes comfort and safety for woman and staff.



(Table continued)

FIRST STAGE OF LABOUR

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
OBSERVATIONS	
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 [5].
It is advisable for a woman's labour to be established before entering the water. (cervical dilatation \geq 4 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.	A rise in maternal temperature may indicate that the water temperature is too hot and may result in fetal tachycardia [13].
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 (14).	Provides opportunity for body temperature to return to normal. Reassess maternal and fetal wellbeing prior to returning to the water.
If the maternal temperature is greater than 37.6°C on 2 occasions, the woman should leave the water [4,13]. Complete a full assessment of maternal and fetal wellbeing and consult or refer if indicated.	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.	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.
Fetal heart rate must be monitored using an aqua doptone	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 [4, 15].	To minimise contamination and reduce risk of infection. Facilitates clinical assessment of



	hydration.
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 [4,7].	Nitrous Oxide & Oxygen should not affect the woman's capacity to leave the water if requested.

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SECOND STAGE OF LABOUR

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 36-37°C and not more than 37.5°C [1, 3,4,13].	Cooler temperatures may trigger initial respirations while the baby is still submerged [16].
Fetal heart rate monitoring should be undertaken as per normal guidelines. In a situation where the midwife identifies any abnormality of the fetal heart rate, then the woman is required to leave the water.	Reduce the risk of a potentially compromised infant being born into water.
Encourage physiological pushing when the urge is sustained, i.e. non-directed pushing.	Non-directed pushing is associated with improved neonatal outcomes [16].
Control of the head is unnecessary. Progress can be observed with a mirror. 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 [16].
If the baby's head is exposed to air at any time, ensure the woman remains out of the water.	Exposure to air may stimulate premature breathing [16].
The cord must not be clamped and cut under water. If necessary loosen/disentangle the cord [4].	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 gently and immediately following birth. The baby's head must not be re-submerged under water once it has surfaced.	Total submersion prevents initiation of respiration [16]. 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	Snapped umbilical cord is a rare but possible complication associated with birth



ensure that it has not snapped. The midwife should be prepared for this eventuality and have cord clamps ready.	underwater. Cord snapping at a water birth is not an emergency if it is recognised promptly [17]. Paediatric review is needed if the umbilical cord snaps.
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 [4].
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 [18].
Neonatal resuscitation equipment must be readily available. Should the baby require resuscitation the cord is to be clamped and cut immediately and the baby removed to an environment to facilitate resuscitation. The woman can then be assisted from the water by the second midwife in a calm and safe manner.	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.

THIRD STAGE OF LABOUR

What additional care is required, to that routinely provided, when healthy women choose to use water immersion during the <u>third stage</u> of labour?	
Recommended Care	Supporting Information
<p>The woman is required to leave the water for active management of the third stage of labour.</p> <p>Two people must be present to assist the woman and the baby when they leave the water.</p> <p>The administration of an oxytocic drug is 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 [14].</p> <p>To facilitate a safe environment where the principles of active management of the third stage can be safely applied.</p> <p>The administration of an injection underwater is not recommended,</p> <p>The time of oxytocic administration needs to be noted.</p> <p>A delay in administering oxytocic may lengthen 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 unclamped. 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 [18].</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>

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FOURTH STAGE OF LABOUR (1st hour after birth)

What additional care is required, to that routinely provided during the <u>fourth stage</u> 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 as close to 36-37⁰ C as possible 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>

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References

Evidence has been classified according to the NH&MRC guidelines:

- LEVEL I** Evidence is obtained from a systematic review of all relevant randomised controlled trials.
- LEVEL II** Evidence is obtained from at least one properly designed randomised controlled trial.
- LEVEL III-1** Evidence is obtained from well-designed pseudo-randomised controlled trials (alternate allocation or some other method).
- LEVEL III-2** Evidence is obtained from comparative studies with concurrent controls and allocation not randomised (cohort studies), case-control studies, or interrupted time series with a control group.
- LEVEL III-3** Evidence is obtained from comparative studies with historical control, two or more single-arm studies, or interrupted time series without a parallel control group.
- LEVEL IV** Evidence is obtained from case series, either post-test or pre-test and post-test.

	<i>Level of Evidence</i>
1. Cluett E R, & Burns E E (2009) Immersion in water in labour and birth. The Cochrane Database of Systematic Reviews. Issue2. Art No.:CD000111. DOI: 10.1002/14651858. CD000111. pub3.	<i>Level I</i>
2. Gilbert R E, Tookey P A (1999). Perinatal mortality and morbidity among babies delivered in water: surveillance study and postal survey. <i>British Medical Journal</i> 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. Southern Australia Department of Health, (2010) – First Stage Labour and Birth in Water Policy.	(clinical guideline based on a range of evidence)
5. 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)
6. Royal Australian and New Zealand College of Obstetricians and Gynaecologists (2011) Warm water immersion during labour and	(clinical guideline based



birth. College Statement No. C-Obs 24

on a range of evidence)

7. 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)

8. Department of Health, Western Australia. (2012) Home Birth Policy and Guidance for Health Professionals, Health Services and Consumers, Perth, Health Networks Branch, Department of Health, Western Australia

(policy based on a range of evidence)

9. Swann, L., & Davies, S. (2012) The role of the midwife in improving normal birth rates in obese women. *British Journal of Midwifery* 20 (1) 7-12

Level IV

10. Department of Health, Western Australia (2004) **Prevention of Early Onset Group B Streptococcal Disease (GBS) in Neonates and Identification of Mothers who are Group B Streptococcal Carriers**

(operational directive based on a range of evidence)

http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=11852

11. Cohain, J.S. (2010) Water birth and newborn GBS diseases *Midwifery Today* (4) 9-10

Level IV

12. National Collaborating Centre for Women's Health (2007) Intrapartum care of healthy women and their babies. RCOG Press: London

(clinical guideline based on a range of evidence)

13. Harper B J (2003) Taking the plunge: re-evaluating waterbirth temperature guidelines. *MIDIRS Midwifery Digest* 12 (4) pp506-508

Level II

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

Level I

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

(clinical guideline based on a range of evidence)

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

(clinical guideline based on a range of evidence)

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

Level IV

18. Rogers J, Wood J, McCandlish R, Ayers S, Truesdale A, Elbourne

Level II



D (1998) Active vs expectant management of the third stage of labour: The Hitchinbrooke randomised controlled trial. *Lancet* 351:693-9

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Appendices

Appendix 1: Infection Control

- Standard Infection Control Guidelines to prevent cross infection or contamination must be followed.
- Where equipment is not personal use only (i.e. client's own pool at home) Infection Control staff should be involved in the selection of equipment and cleaning procedures for birthing pools.
- Equipment that can not be thoroughly cleaned must be single use.
- 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.
- Ensure drain outlet can be cleaned thoroughly.
- Running water with taps fully opened for several minutes to flush pipes and/or hose reduces the risk of pseudomonas transmission from taps.
- In the hospital environment a separate hose should be used for siphoning the pool to empty.

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.

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Appendix 2: Manual Handling

Back care

Carry out risk assessment prior to any hazardous manual task

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

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, e.g. utilize secured, appropriate step/stool to assist in and out of bath/pool.
- 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 prior to the woman entering the pool.
- A non-slip surface 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 and choice of evacuation equipment must be developed by each health service.
- Adherence to the maternity facilities' "Minimal Handling" policy is vital to protect the ergonomic integrity of the staff (Code of practice Manual tasks 2010)
http://www.commerce.wa.gov.au/worksafe/PDF/Codes_of_Practice/Code_manual_handling.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, (based on a risk assessment).
- 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 an e-learning or self-directed learning package on the use of water immersion during labour and water birth as directed /arranged by the maternity facility.

The WNHN in collaboration with the Statewide Obstetric Support Unit has developed an e-learning package, the content of which was based on the study days offered by the Australian College of Midwives, WA Branch and KEMH. Available at:

<http://www.kemh.health.wa.gov.au/services/SOSU/education.php?PHPSESSID=da6c7e414e0a106cf06bae664f1d20bf#waterbirth>

- Observation and facilitation under supervision of 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.

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Appendix 4: Information Agreement

Available at: http://www.healthnetworks.health.wa.gov.au/projects/water_birth.cfm

Use of water for birth and/or labour agreement (Example only)

The provision of water birth is available to women who are assessed as being low risk at the time they wish to enter the pool. The continuation of immersion in water will be provided on the basis of ongoing risk assessment by the midwife/doctor.

It is essential that you find out as much as possible in order to reach a fully informed decision. The latest Cochrane review provides a full overview of all the latest research and information.

Link: <http://www.thecochranelibrary.com>

- This Cochrane library review (2009) has identified eleven trials that were of an adequate quality to include in this review. Of these, six reported that water immersion during the first stage of labour significantly reduced epidural/spinal analgesia requirements, without adversely affecting labour duration, operative delivery rates, or neonatal wellbeing. There is limited information for other outcomes related to birth in water and no trials that assessed immersion in water during the third stage of labour.

- *Therefore, there remains some controversy regarding its safety for the baby during the second stage of labour, i.e. birth itself, and it is for this reason that the paediatricians at King Edward Memorial Hospital do not endorse water births at this hospital or at the Family Birth Centre. (An equivalent of this section needs to be decided by each health service as this wording relates only to KEMH)*

I confirm that:

- I have received and read the leaflet “Labour and birth using water” (WNHS 2009), link: <http://wnhs.health.wa.gov.au>, and have had the opportunity to discuss this with a midwife and/or doctor.
- I understand I am accountable and responsible for myself and my unborn baby if I choose to use immersion in water for birth.
- I understand both the benefits and risks of utilising water for birth for myself and my baby.
- *I understand that the paediatricians at King Edward Memorial Hospital do not support the use of water for birth at this hospital, or at the Family Birth Centre and*



that I will not be able to birth in water if I need to be transferred to the main hospital Labour and Birth Suite. (Needs to be specific to health service as noted above)

Signed:

Date:

Current gestation and Expected Date of Birth:

Witness:

Date:

Designation:

36 weeks/3rd trimester consultation (if applicable).

I have had the opportunity for further discussion on the use of immersion in water for birth with my midwife/doctor. I am re-confirming the statements as above, and have had the opportunity to access sufficient information and research to make a fully informed decision.

Signed:-

Date:

Current gestation and Expected Date of Birth:-

Witness:

Date:

Designation:

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

Patient ID sticker

To be completed by accoucheur for every woman choosing immersion in water for labour and/or birth during an audit period.

Woman fully informed of benefits and risks of waterbirth	Yes	No	
Criteria for inclusion all met	Yes	No	
Waterbirth competent accoucheur	Yes	No	
Did the woman demonstrate she could leave the water unassisted on request?	Yes	No	

During First Stage

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?

- for vaginal examination
- FHR concerns
- Maternal pyrexia
- Other maternal observations abnormal (pulse, BP)
- Vaginal bleeding

Was the midwifery consultant/ doctor informed if the woman was asked to leave the water (other than for cervical assessment)?	Yes	No
---	-----	----

Did the woman return to the water?	Yes	No
------------------------------------	-----	----

Was the water temperature comfortable for the woman?	Yes	No
--	-----	----

Was the temperature between 36-37c?	Yes	No
-------------------------------------	-----	----

Was the water temperature recorded?	Yes	No
-------------------------------------	-----	----

During Second stage (if still immersed)

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?

- for vaginal examination
- FHR concerns
- Maternal pyrexia
- Other maternal observations abnormal (pulse, BP)
- Vaginal bleeding

Was the midwifery consultant/ doctor informed if the woman was asked to leave the water (other than for cervical assessment)?

Yes No

Did the woman return to the water?

Yes No

Was the water temperature comfortable for the woman?

Yes No

Was the temperature between 36-37c?

Yes No

Was the water temperature recorded?

Yes No

Was the fetal heart within a normal range during 2nd stage? Yes No

Were 2 staff present for the birth?

Yes No

Was a 'hands poised approach' used

Yes No

Was there a reason to check for nuchal cord?

Yes No

Did the baby remain fully immersed for the birth?

Yes No

Did the cord snap?

Yes No

If yes, what action was taken? _____

During Third Stage

Was the third stage actively managed?

Yes No

Estimated blood loss _____ mls

Perineal status _____

What were the baby's 1 minute and 5 minute APGAR scores?

1 minute _____

5 minute _____

Was the baby's temperature maintained in a normal range? Yes No

Was the Neonate admitted to NICU? Yes No

Comments, including specific issues for women or accoucher not included above

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in alternative formats on request for a
person with a disability.