Standards of Practice, Protocols, Guidelines, & Minimum Practice Requirements

For California Licensed Midwives

Characteristics of Clinical Competency associated with science-based maternity care as provided by professionally-licensed Community Midwives

Reviewed by Clinical and Academic Advisors and Experienced Midwives

Includes:

Standards of Practice

Administrative Obligations

Protocols & Policies

Criteria for Client Eligibility

Physician Consultation, Referral, & Transfer

Minimum Practices Requirements

California College of Midwives

State Chapter of the American College of Community Midwives (ACCM)

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Characteristics of Clinical Competency

Associated with Science-based Maternity Care

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California College of Midwives
State Chapter ~ American College of Community Midwives

Section I - A

Physiological Management of Normal Labor & Birth Defined	

Science-based principles of maternity care for spontaneous labor and normal birth include the following physiologically sound practices:

1. Continuity of care
2. Patience with nature
3. Social and emotional support
4. Full-time presence of the primary caregiver during active labor
5. Mother-controlled environment (place) for labor and birth
6. Provision for appropriate psychological privacy (persons present)
7. Mother-directed activities, positions, and postures for labor and birth
8. Opportunity for an upright and mobile mother during active labor
9. Recognition of the non-erotic but nonetheless sexual nature of spontaneous labor and normal birth
10. Non-pharmaceutical pain management such as walking, one-to-one care, touch relaxation, showers and deep water tubs, other traditional midwifery strategies
11. Judicious use of drugs and anesthesia when needed
12. Absence of arbitrary time limits as long as some progress, mother and baby OK
13. Vertical postures, pelvic mobility and the right use of gravity for pushing
14. Birth position by maternal choice unless medical other factors require otherwise
15. Mother-directed pushing --NO prolonged breath-holding (Valsalva maneuver)
16. Physiological clamping/cutting of umbilical cord-- after circulation between baby and placenta has stopped (approximately 3-5 minutes)
17. Immediate possession and control of newborn by mother and father
18. On-going and unified care and support of the mother-baby during the postpartum/postnatal period.

Physiological management is the science-based model of normal maternity care and is the foremost standard of care for all healthy women with normal pregnancies, regardless of the category of maternity care provider and regardless of the setting for labor and birth (hospital, home or birth center).

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Section I - B

STANDARDS OF PRACTICE

Professionally licensed midwives offer primary care to healthy women and their normal unborn and newborn babies throughout normal pregnancy, labor, birth, postpartum, neonatal, and intra-conceptional periods. Standards of practice, protocols, minimum practice requirements, and detailed guidelines for appropriate physician consultation, referral, transfer of care, and emergency care are contained within the Standards and Guidelines of the California College of Midwives / ACCM.

I. Purpose, Definitions & General Provisions:

A. Standards of practice provide a framework to evaluate the licensed midwife's practice to ensure that it is safe, ethical, and consistent with the professional practice of midwifery in California. The professionally licensed midwife who conforms to these standards and their associated practice requirements is judged to be competent. Sources and documentation for practice requirements include, but are not limited to, the following:

1. The International Definition of a Midwife (International Confederation of Midwives) and international scope of practice
2. Customary definitions of the midwifery model of care by state and national midwifery organizations, including the 2000 LMPA amendment (See language from SB 1479 at end of this section.)
3. Standards of practice for community midwives published by state and national midwifery organizations
4. Philosophy of Care, Code of Ethics, and Informed Consent Policy published by state and national midwifery organizations
5. Educational competencies published by state and national midwifery organizations

B. The California licensed midwife is a competent health care practitioner who maintains all requirements of state certification, keeps current with safe and ethical midwifery practice and who practices in accordance with:

1. The body of knowledge, clinical skills, and clinical judgments described in the Midwives Alliance of North America (MANA) Core Competencies for Basic Midwifery Practice
2. The statutory requirements as set forth in the Licensed Midwifery Practice Act of 1993, all amendments to LMPA and the Health and Safety Code on Birth Registration
3. The standards and guidelines for community-based midwifery practice
4. The protocols of the individual midwifery service/practice

C. The California licensed midwife provides care in clinics, physician offices, client homes, hospitals & birth centers. The licensed midwife provides well-woman services pre- and inter-conceptionally and maternity care to essentially healthy women who are experiencing a normal pregnancy. An essentially healthy woman is without serious pre-existing medical or mental conditions affecting major body organs, biological systems, or competent mental function. An essentially normal pregnancy is without serious medical conditions or complications affecting either mother or fetus.

D. The California licensed midwife must be able to give the necessary supervision, care and advice to women prior to and during pregnancy, labor and the postpartum period, to conduct deliveries, and to care for the newborn infant. This care includes preventative measures, policies and protocols for variations/ deviations from norm, detection of complications in the mother and child, the procurement of medical assistance when necessary, and the execution of emergency measures in the absence of medical help.

E. The California licensed midwife's fundamental accountability is to the women in her care. This includes a responsibility to uphold professional standards and avoid compromise based on personal or institutional expediency.

F. The California licensed midwife is also accountable to peers, the regulatory body, and to the public for safe, competent, ethical practice. It is the responsibility of the licensed midwife to incorporate evaluation of her practice that includes ongoing community input and participation in mortality and morbidity reporting and review processes. The results of these individual evaluations can be distributed to influence professional policy development, education, and practice.

G. The California licensed midwife is accountable to the client, the community, and the midwifery profession for evidence-based practice. This includes but is not limited to continuing education and on-going evaluation of the scientific literature. It may also include developing and sharing midwifery knowledge and participating in research regarding midwifery outcomes.

II. A brief overview of the licensed midwife's duties and responsibilities to childbearing women and their unborn and newborn babies

A. The California licensed midwife engages in an ongoing process of risk assessment that begins during the initial consultation and continues through the completion of care. Within the midwifery model of care, **the licensed midwife's duties** to mother and baby shall include the following individualized forms of care:

1. Antepartum care and education, preparation for childbirth, breastfeeding and parenthood
2. Risk assessment, risk prevention, and risk reduction Identifying and assessing variations and deviations from normal and detection of abnormal conditions
3. Maintaining an individual plan for consultation, referral, transfer of care, and emergencies
4. Evidence-based physiological management to facilitate spontaneous progress in labor and normal vaginal birth while minimizing the need for medical interventions

5. Procurement of medical assistance when indicated
6. Execution of appropriate emergency measures in the absence of medical help
7. Postpartum care to mother and baby, including counseling and education
8. Maintaining up-to-date knowledge in evidence-based practice and proficiency in life-saving measures by regular review and practice
9. Maintaining all necessary equipment and supplies, preparation of documents including educational handouts, charts, informed consent waivers, birth registration, newborn screening, practice protocols, morbidity reports, annual statistics, and other required documentation.

III. Standards of Practice for Community-Based Midwifery

STANDARD ONE ~ The licensed midwife shall be accountable to the client, the midwifery profession and the public for safe, competent, and ethical care.

STANDARD TWO ~ The licensed midwife shall ensure that no act or omission places the client at unnecessary risk.

STANDARD THREE ~ Within realistic limits the licensed midwife shall provide continuity of care to the client throughout the childbearing experience according to the midwifery model of practice.

STANDARD FOUR ~ The licensed midwife shall respect the autonomy of the mentally competent adult woman and work in partnership with her, recognizing individual and shared responsibilities. The licensed midwife recognizes the healthy woman as the primary decision maker throughout the childbearing experience.

STANDARD FIVE ~ The licensed midwife shall uphold the client's right to make informed choices about the manner and circumstance of normal pregnancy and childbirth and shall facilitate this process by providing complete, relevant, objective information in a non-authoritarian and supportive manner, while continually assessing safety considerations and the risks to the client and informing her of same.

STANDARD SIX ~ The licensed midwife shall collaborate with other healthcare professionals and, when the client's condition or needs exceed the midwife's scope of practice, shall consult with and refer to a physician or other appropriate healthcare provider.

STANDARD SEVEN ~ Should the pregnancy become high-risk and require that primary care be transferred to a physician, the licensed midwife may continue to counsel, support, and advise the client at her request.

STANDARD EIGHT ~ The licensed midwife shall maintain complete and accurate health care records.

STANDARD NINE ~ The licensed midwife shall ensure confidentiality of information except with the client's consent, or as required to be disclosed by law, or in extraordinary circumstances where the failure to disclose will result in immediate and grave harm to the

client, baby, or other immediate family members.

STANDARD TEN ~ The licensed midwife shall make every effort to ensure that a second midwife or a qualified birth attendant who is currently certified in neonatal resuscitation and cardiopulmonary resuscitation assist at every birth.

STANDARD ELEVEN ~ The licensed midwife shall order, prescribe or administer only those prescription drugs and procedures as authorized in the Licensed Midwifery Practice Act, Section 2514 and shall do so in accordance with the client's informed consent.

STANDARD TWELVE ~ The licensed midwife shall order, perform, collect samples for, or interpret those screening and diagnostic tests for, a woman or newborn as identified in the Licensed Midwifery Practice Act, Section 2514 and in accordance with the client's informed consent.

STANDARD THIRTEEN ~ The licensed midwife shall participate in the continuing education and evaluation of self, colleagues, and the maternity care system.

STANDARD FOURTEEN~ The licensed midwife shall critically assess evidence-based research findings for use in practice and shall support research activities.

SB 1479 ~ Amendment to the Licensed Midwifery Practice Act of 1993

Section 4 ~ THE LEGISLATURE FINDS AND DECLARES THAT:

(a) Childbirth is a normal process of the human body and not a disease.

(b) Every woman has a right to choose her birth setting from the full range of safe options available in her community.

(c) The **midwifery model of care** emphasizes a commitment to informed choice, continuity of individualized care, and sensitivity to the emotional and spiritual aspects of childbearing, and includes monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle; providing the mother with individualized education, counseling, prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support; minimizing technological interventions; and identifying and referring women who require obstetrical attention.

(d) Numerous studies have associated professional midwifery care with safety, good outcomes, and cost-effectiveness in the United States and in other countries. California studies suggest that low-risk women who choose a natural childbirth approach in an out-of-hospital setting will experience as low a perinatal mortality as low-risk women who choose a hospital birth under management of an obstetrician, including unfavorable results for transfer from the home to the hospital.

(e) The midwifery model of care is an important option within comprehensive health care for women and their families and should be a choice made available to all women who are appropriate for and interested in home birth.

Section I-C

MIDWIFE & CLIENT RESPONSIBILITIES AND RIGHTS

The licensed midwife provides accurate information regarding the standards and scope of midwifery practice, fees, medical consultation arrangements, and the rights and responsibilities of the client.

CLIENT RIGHTS & RESPONSIBILITIES SPECIFIED

A. The client shall receive complete, relevant, objective and, where appropriate, evidence-based information regarding community-based midwifery, including but not limited to:

1. The risks and benefits associated with midwifery services provided in the client's home or freestanding birth center
2. The right of the client to change her mind and seek out obstetrical services or hospitalization
3. A description of the responsibilities for the client and her family, relative to choosing community-based maternity care
4. The client's right to receive full information, including risks, benefits, options, and alternatives, and to provide permission or informed consent prior to the performance of routine procedures of midwifery care or other treatments, procedures, or administration of any drug to mother or newborn
5. The client's right to decline standard or recommended midwifery care. The client's decision to decline recommended care will be made in writing and signed or initialed by the client and kept in the client's chart;
6. Birth-related legal requirements for California residents which include newborn screening for inborn errors of metabolism (PKU/newborn genetic screening), eye prophylaxis, registration of birth and death certificates, and reporting requirements for emergency transports involving mortality or serious complications
7. Information regarding the client's medical conditions and other concerns for which a licensed midwife may need to consult with a physician, refer client to a physician, and/or transfer the client to a physician's care
8. Information and referral of the client to other providers and services whenever requested or if the care required by the client is outside the scope of practice for midwifery or the protocols of the individual licensed midwife
9. The grievance process for client complaints to the Medical Board of California regarding unsatisfactory or unethical care; (Medical Interface form per SB 1479 - see Section I-D)
10. The client's right to have pertinent records in her chart forwarded to other professionals when requested, to obtain copies of her midwifery records and those of her baby
11. The licensed midwife's expectations of the client and the licensed midwife's right to discontinue care

MIDWIFE RESPONSIBILITIES

The principal objective of the midwifery profession is to render service to healthy women and their infants with full respect for human dignity. Licensed midwives should merit the confidence of women entrusted to their care, rendering to each a full measure of service and devotion. Each licensed midwife should uphold the dignity and honor of the profession and accept its self-imposed disciplines. Such disciplines include a responsibility to uphold professional standards, to avoid compromise based on personal or institutional expediency, and to adhere to professional rather than commercial standards in making known the availability of their services.

Client Disclosure and Informed Consent for Community-based Midwifery Services

B. The licensed midwife shall provide a professional disclosure to each client that includes a brief description, either orally or in writing, of the following:

1. The licensed midwife's practice standards, guidelines, protocols and policies
2. The licensed midwife's training and years of experience
3. The licensed midwife's compliance with adult and infant cardiopulmonary resuscitation and neonatal resuscitation certification, continuing and/or special education
4. The licensed midwife's practice statistics, noting the number of clients served annually and the percentage of NSVD at home, of hospital transfers and subsequent operative or instrumental deliveries, and the perinatal mortality rate for her practice
5. Any limitations on the skill, practice, or other special requirements specific to the licensed midwife
6. Care and equipment available and supplies provided
7. How to contact the licensed midwife for routine communication
8. How to reach the licensed midwife in an emergency, including phone numbers for a second-call midwife or backup arrangements if the licensed midwife cannot be reached

C. There shall be a place on the form for the client to attest, by signing her full name, that she has received complete, relevant, objective information on **Client Rights and Responsibilities** and **Midwife Responsibilities** as listed above.

D. The **Disclosure and Consent form shall** include the date, name and signature of the client and, if appropriate, her partner, and become an official part of the client's records.

E. Medical Interface Community-Based Maternity Services & Plans for Emergency Services ~ disclosure statement as required by LMPA / SB 1479

Each licensed midwife shall disclose to a client, in oral and written form:

1. The legal scope of practice for licensed midwives under the LMPA
2. The specific arrangements for the client to access medical services including consultation and transfer of care during the prenatal period, hospital transfer during labor, birth and the immediate postpartum
3. How to obtain appropriate emergency medical services for mother and baby when necessary
4. The professional liability insurance status of the licensed midwife
5. How to inquire about the midwife's licensure status from the Medical Board of California
6. Methods to report unsatisfactory or unethical care to the Medical Board of California

The **Medical Interface "Plan for Emergency Care" form** shall include the date, name and signature of the client and, if appropriate, her partner and become an official part of the client's records.

The **Medical Interface Form,** as developed by the California College of Midwives, is accepted by the MBC as satisfying the requirements of the 2000 amendment to the LMPA.

However, any licensed midwife may develop her own version as long as it includes the same six areas of required information.

F. Midwife Responsibilities & Client Informed Consent Documents ~ Sample forms

1. Sample forms as developed by California midwives are available on line ~ at www.collegeofmidwives.org or in Section 4 of this midwives may use or develop their own version for each form as long as each one includes the necessary information.

a. Professional Disclosure and Informed Consent for routine care
b. Medical Interface and Plans for Emergency Care per SB 1479
c. Information on Group B Strep and Consent/Decline of prenatal GBS cultures
d. Information and Consent /Decline ~ Routine Newborn Ophthalmic Prophylaxis
e. Information and Consent /Decline ~ Routine Administration of Vitamin K
f. Consent for Out Of Hospital Intrapartum Care
g. Special Circumstances-Moderate Risk Wavier // Informed Decline of Standardized Care

Section I-D -

CLIENT DISCLOSURE FORM ~Required by the LMPA
Midwifery Scope of Practice, Medical Interface, Emergency Arrangements, Malpractice Insurance Disclosure, Reporting Unsatisfactory Care to MBC

Informed Consent for Community-Based Midwifery Care

The *Licensed Midwifery Practice Act* (LMPA) requires that each licensed midwife provide information on the scope of licensed midwifery practice in California to clients seeking community-based midwifery care.

The *LMPA* also requires that licensed midwives identify appropriate arrangements for medical consultation and transfer of care during the prenatal period, for hospital transfer during labor, birth and immediate postpartum, and for how to obtain appropriate emergency medical services for mother and baby when necessary.

Medical arrangements must be specific to each client's circumstance, discussed with her, documented in writing and retained in her chart.

In addition, licensed midwives are legally responsible for registering the births of all babies born under their care.

Midwifery Scope of Practice as defined by the LMPA, Sec 2507:

(a) The license to practice midwifery authorizes the holder, under the supervision of a licensed physician and surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the newborn.

(b) As used in this article, the practice of midwifery constitutes the furthering or undertaking by any licensed midwife, under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics, to assist a woman in childbirth so long as progress meets criteria accepted as normal. All complications shall be referred to a physician immediately. The practice of midwifery does not include the assisting of childbirth by any artificial, forcible, or mechanical means, nor the performance of any version.

(c) As used in this article, "supervision" shall not be construed to require the physical presence of the supervising physician.

(d) The ratio of licensed midwives to supervising physicians shall not be greater than four individual licensed midwives to one individual supervising physician.

(e) A midwife is not authorized to practice medicine and surgery by this article.

Note regarding physician supervision as referenced above ~ Currently the malpractice carriers who provide professional liability insurance to California obstetricians will not permit physicians to have a supervisory relationship with licensed midwives who provide community-based birth services.

Specific Arrangements for Medical Care are as follows:

Licensed Midwife _____ License #_____

Client Name _____ Date _____

(1) Medical/Obstetrical Consultation and Transfer of Care during your pregnancy:
_____

(2) Hospital-based physician care during your labor, birth and the immediate postpartum:
_____

(3) Emergency Care for you or your newborn baby during or after the birth:
_____

As a consumer of healthcare services you have the right to check on the licensure status of any health care practitioner licensed in California. Physicians, Licensed Midwives and 18 allied health professions are licensed and regulated by the Medical Board of California (MBC). For information on Medical Board licentiates call **1- 916 / 263-2382** or visit their web site at www.caldocinfo.ca.gov/. You also have the right to report any complaints about care received to the MBC by calling **1- 800 / 633-2322**. Instructions and a complaint form are available on-line by visiting the MBC Internet site @ www.caldocinfo.ca.gov/.

If the above named licensed midwife <u>does not carry</u> professional liability (i.e. malpractice) insurance, I have been so informed of that fact. Initials _____

Client Signature _____ **Date** _____

Partner's Signature _____ **Date** _____

Witness Signature _____ **Date**_____

Section I-E

To establish minimum standards in regard to **RECORD KEEPING**

The licensed midwife shall keep appropriate records on all clients.

All records shall, at a minimum:

1. Be accurate, current and comprehensive, giving information concerning the condition and care of the client and associated observations
2. Provide a record of any problems that arise and actions taken in response to them
3. Provide evidence of care required, interventions provided by professional practitioners and patient responses
4. Include a record of any factors--physical, psychological, or social-- that appear to affect the patient
5. Record the chronology of events and the reasons behind decisions made
6. Provide baseline data against which improvement or deterioration may be judged
7. Date each entry or page and include a signature or initials for each entry or page
8. Make records available to the receiving health care provider in the event of transfer of care or the transport of mother or newborn

The licensed midwife:

1. Facilitates clients' access to their own records
2. Complies with HIPPA regulations regarding confidentiality and notification of client prior to release of records to third parties
3. Retains records for a minimum of seven years
4. Completes/files all state required reports/certificates in a timely manner

Client records shall include, at a minimum:

1. All pertinent forms for disclosure of information and informed consent, including any decline of care waivers, etc.
2. History, physical exam, lab and other test results, risk assessment and emergency plan
3. Routine prenatal assessments, physical findings, interventions and recommendations
4. Records of referrals and consultations with physicians or other health care providers and reports such as ultrasound, biophysical profiles, AFP, etc
5. Progress of labor and maternal assessments during labor
6. Fetal assessments during labor
7. Apgar scores and newborn examination
8. Administration of eye prophylaxis, vitamin K
9. Postpartum care/visits, and follow-up neonatal evaluations
10. Newborn genetic screening
11. Registering the birth

Section I – F –

TERMINATION of the Midwife-Client Relationship and Withdrawal of Service

A licensed midwife shall terminate care of a client only in accordance with this section, unless a transfer of care results from an emergency situation.

A. Once a licensed midwife has accepted a client, the relationship is ongoing and the licensed midwife cannot refuse to continue to provide midwifery care to the client unless:

1. Client has no need of further care
2. Client terminates the relationship
3. Licensed midwife formally terminates the relationship

B. The licensed midwife may terminate care by:

1. Providing a minimum of 14 days written notice, during which the licensed midwife shall continue to provide midwifery care to enable the client to select another health care provider
2. Delivering written notice to the client by certified mail, including referrals to other appropriate caregivers or institutions
3. Documenting the termination of care in midwifery records

C. After the onset of progressive labor, the licensed midwife shall withdraw only if she/he believes she/he is unable to care responsibly for the client and/or newborn and the client refuses to transfer.

The licensed midwife shall:

1. Document the relevant events
2. Makes every attempt to ensure that the client is not left unattended, such as contacting a responsible family member, a physician, the paramedics, or other appropriate emergency personnel

Section I – G-

PROHIBITIONS relative to the Domiciliary-based Practice of Midwifery

Restrictions and prohibitions on the out-of-hospital administration of medications, surgical procedures and instrumental deliveries

A. The licensed midwife shall not administer or inject any prescription drugs except as indicated in the LMPA and its amendments or as authorized by a licensed physician or mid-level practitioner such as a certified nurse midwife, registered nurse practitioner or physician assistant practicing in association with the licensed physician. -.

B. Administration of labor-stimulating prescription drugs prohibited

1. The use of synthetic prostaglandin compounds for cervical ripening such as, but not limited to, Cervidil, Prepidil, or Cytotec, is prohibited for out-of-hospital use, even when prescribed by a physician or physician associate.

2. The use of artificial oxytocics, such as Pitocin, to induce or augment labor, is prohibited through all routes of administration for out-of-hospital use, even when prescribed by a physician or physician associate.

C. Prohibited and permitted surgical procedures ~ A licensed midwife shall not perform any routine operative procedures or surgical repairs other than:

1. Artificial rupture of membranes (AROM)
2. Clamping and cutting of the newborn's umbilical cord
3. Episiotomy
4. Perineal/vaginal repair after delivery

D. Instrumental delivery ~ A licensed midwife shall not use forceps and/or vacuum extraction to assist the birth of the baby.

Section I – H -

PROFESSIONAL RELATIONSHIPS & RESPONSIBILITIES

Note: The following categories are general definitions of professional relationships and responsibilities between licensed midwives and other healthcare practitioners. They are independent from the topic of physician supervision as mandated by the LMPA.

A. Consultation is the process by which a licensed midwife, who maintains primary management responsibility for the woman's care, seeks the advice of another health care professional or member of the health care team. These discussions may occur in person, by electronic communication or by telephone and may include other professional midwives as well as physicians and specialists in other healthcare disciplines.

B. Informal peer review with another licensed midwife: When significant concern about the well-being of mother and/or baby arises from an identified risk, variation or deviation from norm or a potential complication, the licensed midwife shall, if possible, initiate a discussion with another experienced midwife or a physician familiar with home-based birth services in order to discuss the relevant options and plan care appropriately.

C. Formal peer review: Some consultative situations are encountered frequently by midwives and lend themselves to peer group policies made beforehand by the professional midwives who regularly attend a formal peer review, by or other experienced midwives and/or physicians who regularly confer with one another, either by phone or in person.

1. These specific recommendations should be memorialized in writing in the peer review attendance log, a journal, or other form of documentation specific to the peer review process.

2. Whenever a peer group or experienced midwife's recommendations apply to a client's specific circumstance, the primary care licensed midwife need not consult with another professional again unless there are new or additional factors. Peer review recommendations resulting in specific decisions or actions should be documented in the client's chart.

D. Collaboration is the process in which a licensed midwife and a health care practitioner of a different profession jointly manage the care of a woman or newborn who has become medically complicated. The scope of collaboration may encompass the physical care of the client, including delivery by the midwife, according to a mutually agreed-upon plan of care. If a physician must assume a dominant role in the care of the client due to increased risk status, the licensed midwife may continue to participate in physical care, counseling, guidance, teaching, and support. Effective communication between the midwife and the health care professional is essential to ongoing collaborative management.

E. Referral is the process by which a licensed midwife recommends that the client obtain evaluation or health care from another professional. When medical care is required, the client

must be referred to a physician or a mid-level practitioner working in association with a licensed physician. The client and the physician or physician associate shall determine whether subsequent care shall be provided by the physician or associate, referred back to the licensed midwife, or provided through collaboration between the licensed midwife and the physician or mid-level practitioner.

1. The client may decline a referral to a physician or physician associate or, after medical evaluation, may decline the advice of a physician or associate. Such a decline of medical care shall be documented in writing; the licensed midwife may then continue to care for the client according to her own policies and guidelines and the standards and guidelines for California licensed midwives.

F. Transfer to medical care: Due to a serious medical condition of the client, the fetus, or the client's newborn, the licensed midwife relinquishes primary care under non-urgent circumstances to a physician, or mid-level practitioner working in association with a licensed physician, who has current obstetric or pediatric knowledge.

1. If the licensed midwife is unable to transfer the client's care to a health care professional, the client will be transferred to the nearest appropriate health care facility. The licensed midwife shall attempt to contact the facility and continue to provide care as indicated by the situation.

2. If a client elects not to accept a medically necessary transfer of care, the licensed midwife shall terminate the midwife-client relationship

G. Transport for immediate, urgent, or emergent medical care: In the event that immediate medical evaluation or medical intervention is necessary, the licensed midwife and/or the client family shall initiate an appropriate transportation process for mother and/or neonate.

1. If emergency transport is required during labor, delivery, or the immediate postpartum/neonatal period and the client refuses, the licensed midwife shall call 911 and provide further care as indicated by the situation.

Section I –I-

PRACTICE POLICIES & GUIDELINES

Policies and practice guidelines for routine care and unusual circumstances shall be evidence-based. When appropriate, citations of their scientific source should be made available for client review.

A. The licensed midwife shall establish, review, update, and adhere to individualized policies and guidelines in the practice of midwifery. The on-going process of developing, reviewing, updating and implementing evidence-based policies and guidelines protects the consumer and elevates the profession of midwifery via the acquisition of additional knowledge and skills and the appropriate use of new technologies. This promotes the active integration of evidence-based parameters and practical needs into a formalized plan.

B. These policies and guidelines shall be consistent with standard midwifery management as described in a standard midwifery textbook or a combination of standard textbooks and references, including research published in peer-reviewed journals. Any textbook or reference which is also an approved textbook or reference for a midwifery educational program or school shall be considered an acceptable textbook or reference for use in developing a licensed midwife's individual policies and practice guidelines.

C. The licensed midwife shall establish policies and/or guidelines for each practice area, which include but are not limited to antepartum, intrapartum, postpartum, and neonatal period. The customary method for establishing and implementing clinical guidelines for routine care is through the adoption of, or development of, appropriate chart forms, informed consent documents and other appropriate documents used routinely during each of these periods of care. Standard chart forms function as an aid to the caregiver to ensure conformity to the care plan as well as completeness of clinical assessments.

1. **Antepartum**

a) Parameters and methods for initial assessment of the current pregnancy, including history, physical exam/assessment, and laboratory tests
b) Parameters and methods for assessing the progress of pregnancy, including history, physical exam/assessment, and laboratory tests
c) Parameters and methods for assessing fetal well-being, including history, physical exam/assessment, and laboratory tests
d) Indicators of risk in pregnancy and appropriate intervention
e) Risk prevention or risk-reduction through nutrition, lifestyle changes, and natural remedies safe for use during pregnancy

2. Intrapartum

a) Parameters and methods for assessment of labor and birth, including history, physical exam/assessment, and laboratory tests
b) Appropriate interventions for normal but significant deviations
c) Risk prevention or risk-reduction through nutrition and natural remedies safe for use during labor and birth
d) Methods to facilitate the newborn's transition and adaptation to extrauterine life

3. **Postpartum and Newborn**

a) Parameters and methods for assessing the postpartum status of the mother, including history, physical exam/assessment, and laboratory tests
b) Parameters and methods for assessing the well-being of the newborn, including history, physical exam/assessment, and laboratory tests
c) Appropriate interventions for normal but significant deviations
d) Risk prevention or risk reduction through nutrition, lifestyle changes, and natural remedies safe for use in the postpartum and newborn period

4. Moderate Risk ~ Refers to unusual circumstances or unusual needs**,** including but not limited to variations of normal, minor or temporary deviations, and moderate risk situations that fall within the definition of normal birth, i.e., no mechanical or other reason that spontaneous vaginal delivery of a healthy neonate cannot be expected:

a) Parameters and methods for assessing risk and preventing or reducing complications through the development of specific plans or evidence-based protocols that address identified variation or deviations
b) Plans describing specific actions such as patient education, additional levels of informed consent/decline, an increase in the quality or quantity of monitoring, consultation with other health care professionals, and other preventative measures

D. The licensed midwife shall develop and implement an individual plan of care for each client based on the licensed midwife's practice policies and guidelines

E. The licensed midwife shall evaluate and modify the plan of care as necessary

F. The licensed midwife shall provide health education and counseling based on her policies and guidelines

G. The midwife shall review policies and guidelines annually or as indicated, modify as needed, and document any changes

Section I – J

MODERATE-RISK LABOR & BIRTH ~ Guidelines & Criteria for Licensed Midwives providing domiciliary birth services in "Special Circumstances"

Special circumstances of pregnancy or parturition require special training, special skills and special preparation on the part of the licensed midwife, as well as a willingness by the licensed midwife to take on potentially complicated legal consequences. It also requires special arrangements and a special informed consent or decline of standard care waiver from the client and her family and a similar willingness on the part of the client to expose herself to potential complications of unknown severity and the legal consequences of an unpopular choice.

In a perfect world, neither the client nor the midwife would have to make these difficult choices. In the mother-friendly Dutch system, it would be resolved by what they call a "relocated home birth," that is routine physiological management by midwives in a low-tech hospital environment with immediate access to obstetrical care and surgery. In this integrated system, mothers and babies get the best of both worlds.

Unfortunately our obstetrical system does not offer this opportunity due to fear of lawsuits. In the US, doctors and hospital do not offer or even permit the childbearing women to choose physiological management in certain moderate risk situations. At present pregnant women with moderate risk factors are frequently forced to decide between multiple unwanted medical interventions and/or physiologically unnecessary cesarean surgery *or* to labor at home unattended. However, childbearing women and their unborn or newborn babies are always safer with an experienced professional present than they would be giving birth unattended.

Risk vs. Complication: The *Licensed Midwifery Practice Act of 1993* prohibits providing care to childbearing women with any significant medical *complication*. However, the LMPA is silent about the topic of *risk*. The scope of practice for California licensed midwives legally defines midwives as being authorized to attend "normal childbirth."

Normal Birth Defined: The term *normal*, as used in the LMPA and both previous California statutes relative to midwifery, equates with a natural or spontaneous birth process, that is, one *not* requiring the use of any "artificial, forcible or mechanical means." Thus *normal* would encompass all spontaneous physiological processes characteristic of healthy reproductive biology in healthy childbearing women that can reasonably be expected to lead to normal, healthy conclusions.

Criteria for Moderate Risk Circumstances: When client and midwife both agree that the risk-benefit ratio is acceptable, the following criteria must *also* be satisfied in order for the licensed midwife to provide domiciliary birth services to women with moderate risk circumstances:

Criteria for the Licensed Midwife: **(per OAL decision by Judge Roman)**

1. Must have attended at least 75 births as the primary midwife following licensure

2. Must have advanced training that clearly identifies her experience, skills and comfort to represent an elevated level of professional ability well beyond entry -level midwifery
3. Must be current in neonatal resuscitation and have training and skills in emergency or first-responder abilities for mother and baby, such as the ALSO (Advanced Life Support in Obstetrics) or equivalent
4. Must have advanced experience via attendance of moderate risk labors at home, hospital or birth center, with supervised hands-on experience in the specific circumstance that applies to the specific client
5. "Special Circumstances // Moderate-Risk Informed Consent Waiver of Standard Midwifery Advice" must be read, agreed to, signed by the client, and retained in the client's chart (see samples of Informed Consent/Special Circumstances Decline of Standard Care waivers)

Criteria for the Client:

A. Normal pregnancy with reasonable expectation of the normal birth of a healthy baby:

1. *Normal* is functionally defined as a healthy pregnancy that naturally advances to term with a live, growth-appropriate fetus/fetuses in a vertical lie and which can reasonably to expected to culminate with a spontaneous onset of labor that will progress normally to the spontaneous live birth of a viable neonate, with **conservation of the health of the mother and well-being of the baby being the desired outcome and goal**.

2. *Normal* requires a baby in a longitudinal lie that engages in the pelvis before or during early labor and which establishes its ability to fit by advancing sequentially through the stations of the pelvis in a timely manner while displaying no evidence of significant or persistent fetal distress.

B. Circumstances of fetal demise or fetus with documented lethal untreatable congenital anomalies (incompatible with life such as anencephaly, etc) for which medical care is unable to influence outcome and for whom the parents have declined hospitalization with appropriate informed consent/decline of medical advice waiver.

ADVANCED MIDWIFERY SKILLS ~ For Specific Circumstances in Moderate Risk Parturition in Domiciliary Setting (list is not exhaustive)

A. All moderate risk labor situations call for the highest level of fetal monitoring with intermittent auscultation at a minimum of q 20 minutes in active labor, q 10 minutes in second stage and q 5 minutes while actively pushing. Alternative method - episodic or continuous electronic fetal monitoring

B. A moderate risk labor calls for exceptionally well-defined emergency transport plans, including less than 30 minutes to a tertiary care hospital which offers 24/7 in-house obstetrical and anesthesia coverage, with access to a fully staffed operating room and other services such as lab and blood banking.

C. **Criteria and guidelines for physiological management of vaginal breech birth** (per OAL decision by Judge Roman)

1. Gestational age >36 ½ weeks, <41 ½ weeks
2. Frank breech position with head flexed
3. Pelvis adequate for fetal size
4. Sonogram to rule out anomalies associated with breech presentation
5. Distance to hospital less than 30 minutes
6. Psycho-social aspects conducive to cooperation during labor and delivery
7. Signed informed consent for topic-specific, moderate-risk decline of medicalization
8. Once *active* labor begins, progress must be straightforward
9. Highest level of fetal monitoring with intermittent auscultation or episodic or continuous electronic fetal monitoring

D. **Criteria and guidelines for physiological management of vaginal twin birth** (based on the model identified by the OAL decision)

1. Gestational age – within 36 hours of 37 weeks completed weeks of pregnancy
2. First baby's head in the pelvis
3. Distance to hospital less than 30 minutes
4. Signed informed consent for topic-specific moderate-risk decline of medicalization
5. Once *active* labor begins, progress must be straightforward
6. Highest level of fetal monitoring with intermittent auscultation, or episodic or continuous electronic fetal monitoring.
7. After birth of the first twin, the second baby should deliver promptly -- ideally within 30 minutes, outside limit 2 hours; highest level of fetal monitoring during this period, should be at least every 5 minutes or continuous electronic fetal monitoring.

E. Criteria and guidelines for physiological management of vaginal post-term labor and birth (based on the model identified by the OAL decision)

1. Adequate amniotic fluid by ultrasound or palpation q 3-4 days starting at 41 ½ weeks
2. NST by EFM or FHTs for 10-20 minutes, reactive outcome with good variability
3. Normal fetal movement and responsiveness
4. Begin at 41 weeks to explain risks associated with >42 weeks, such as increase in problems for babies due to placental insufficiency, sutures becoming hard, macrosomia, etc.
5. Discuss castor oil/ herbal induction at 42 weeks and/or obstetrical referral
6. Biophysical profile at 42 weeks
7. Distance to hospital less than 30 minutes
8. Signed informed consent / topic-specific moderate-risk decline of medicalization
9. Once *active* labor begins, progress must be straightforward
10. After rupture of membranes, no evidence of meconium beyond very light tea-staining
11. Highest level of fetal monitoring with intermittent auscultation, or episodic or **c**ontinuous electronic fetal monitoring

F. Criteria and guidelines for physiological management of post-cesarean vaginal birth (based on the model identified by the OAL decision)

1. Documentation of low transverse incision without serious post-op morbidity/infection
2. Strong recommendation for greater than 18 months between births
3. Adequate pelvis for size of baby
4. Distance to hospital less than 30 minutes
5. Discuss ultrasound exam in 3rd trimester to determine thickness of lower uterine segment (note: Cochrane date base has not established the efficacy of this diagnostic procedure)
6. Signed informed consent / topic-specific special circumstances decline of medicalization (see special circumstances VBAC informed consent for other VBAC-specific criteria)
7. Once *active* labor begins, progress must be straightforward
8. Highest level of fetal monitoring with intermittent auscultation, or episodic or continuous electronic fetal monitoring

========== **Expectant Management of PROM** ==========

G. **Criteria and guidelines for pre-labor rupture of membranes** (**PROM**) **in mother who is GBS negative** – Expectant management of spontaneous rupture of amniotic membranes (SROM) without spontaneous onset of labor (SOOL) from the 18th to the 48th hour:

1. Most pregnant women experience spontaneous onset of labor within 12 hours of SROM. Published studies on PROM at term document SOOL within 24 hours in 70% of pregnant women and by 48 hours in 90% of such cases. Based on scientific opinion, expectant management is an acceptable alternative to induction when the mother is afebrile (no fever), fluid is clear and the fetal heart rate evaluation is normal. The following criteria and guidelines apply:

   a) 37 completed weeks of pregnancy w/o other clinically significant factors
   b) mother afebrile with normal pulse rate
   c) normal FHT baseline with normal variability and no clinically significant decels
   d) amniotic fluid without odor, blood, or meconium beyond light tea-staining
   e) informed consent discussion and topic-specific decline of medicalization waiver
   f) mother agrees to monitor her temperature and pulse every 4 hours while awake
   g) education of parents regarding personal hygiene, prevention of sepsis, stimulation of labor, and emergency signs and symptoms
   h) instructions to parents to contact the licensed midwife if any change in parameters
   i) on-going assessment of situation by the licensed midwife as indicated
   j) discuss castor oil/ herbal/acupuncture induction at 24 hours and/or obstetrical referral

2. Transfer of care for:
   a) clinically-significant elevation of maternal or fetal pulse rate
   b) maternal fever of 100.6 or >
   c) foul-smelling amniotic fluid
   d) frank blood or meconium beyond light or tea-stained, non-particulate fluid
   e) failure to establish progressive labor by 48 hours

f) client's desire for medical management or licensed midwife's unwillingness/inability to continue managing expectantly at home

H. Criteria and guidelines for risk-based management of PROM in mother whose GBS status is unknown or is positive:

1. The licensed midwife shall initiate a general informed consent discussion regarding GBS in pregnancy and the specific difference between screening-based protocols and risk-based protocols, including the provision of printed educational resource such as the synopsis of current CDD guidelines, ACOG's client brochure on GBS, or evidence-based information from other sources.

2. If mother is known to be GBS+, discuss possible plan for hospitalization @ 18 hours to receive prophylactic IV antibiotics

3. If mother is known to be GBS+, discuss physician referral for outpatient regimen of prophylactic PO antibiotics (Kaiser, UCSF)

4. Risk-based criteria & guidelines for PROM with unknown or positive GBS status:
   a) no history of previous baby born with early-onset GBS infection
   b) no history of urinary tract infection with GBS bacteria in previous or current pregnancy
   c) 37 completed weeks of pregnancy w/o other clinically significant factors
   d) mother afebrile with normal pulse rate as compared to pulse prenatally
   e) normal FHT baseline with normal variability and no clinically significant decels
   f) amniotic fluid without odor, blood, or meconium beyond light tea-staining
   g) mother agrees to monitor her temperature and pulse every 4 hours during waking
   h) client reads, agrees to, and signs a topic-specific decline of medicalization waiver
   i) education to parents regarding personal hygiene, prevention of sepsis, stimulation of labor, and emergency signs and symptoms
   j) instructions to parents to contact the licensed midwife if any change in parameters
   k) on-going assessment of situation by the licensed midwife as indicated
   l) discuss castor oil/ herbal/acupuncture induction at 12 -18 hours

5. Transfer of care for:
   a) clinically-significant elevation of maternal or fetal pulse rate
   b) maternal fever of 100.6
   c) foul-smelling amniotic fluid
   d) frank blood or meconium beyond light or tea-stained, non-particulate fluid
   e) failure to establish progressive labor by 48 hours
   f) client's desire for medical management or licensed midwife's unwillingness/inability to continue managing expectantly at home

========== **Works-in-progress ~** emergency protocol ==========

I. Umbilical Cord Prolapse ~ After contacting paramedics and while awaiting emergency transport, insert a Foley catheter into the mother's bladder and fill retention balloon with 30 cc sterile water. Then instill 500 cc sterile solution, clamp catheter and tape to mother's leg. Once the bladder is filled and the catheter secured, check the fetal heart rate. If it returns to normal and remains WNR, mother may remain in a left lateral position (instead of knee-chest position) on the stretcher while being transported by EMTs to the hospital.

Rationale: Since the bladder and uterus share a membranous attachment, a full bladder mechanically elevates the baby up out of the pelvis and off the umbilical card so that fetal blood circulation can resume. This emergency procedure relieves the pressure on the cord that was the result of it becoming trapped between the baby's head and the mother's pubic bone, thus buying additional time and aiding in the emergency transport process. *This protocol is recommended in Varney's Packet Midwife, p. 277*

Minimum Practice Requirements

associated with science-based maternity care

Index ~ Section II:

Consultation, Referral, Transfer of Care & Minimum Practice Requirements

Section II – A

To define and clarify **CRITERIA FOR CLIENT SELECTION** for community-based midwifery care

Criteria for initial selection of clients for domiciliary birth services assume a:

- Healthy mother without serious pre-existing medical or mental conditions affecting major body organs or biological systems
- History, physical assessment, and laboratory results should be within limits commonly accepted as *normal with no clinically significant evidence of the following*:

1. Cardiac disease
2. Pulmonary disease, tuberculosis, or severe asthma uncontrolled by medication
3. Renal disease
4. Hepatic disease
5. Endocrine disease
6. Significant hematological disorders /coagulopathies
7. Neurological disease
8. Essential hypertension (BP >140/90 on two or more occasions six hours apart)
9. Active cancer
10. Insulin-dependent diabetes mellitus
11. History of a cesarean section with classical
12. incision, 3 or more previous cesareans, cesarean less than 18 months from current EDC
13. Serious congenital abnormalities affecting childbirth
14. Significant pelvic/uterine abnormalities (tumors, malformations, etc.)
15. Alcoholism or abuse
16. Drug addiction or abuse
17. Isoimmunization
18. HIV positive status or AIDS
19. Current serious psychiatric illness
20. Social or familial conditions unsatisfactory for OOH birth
21. Other significant abnormality or social/mental functioning affecting pregnancy, parturition, and/or the ability to safely care for a newborn
22. Other as defined by the licensed midwife

Obstetrical Consultation or Referral ~ Medical or mental conditions that need to be evaluated by a physician before a client is accepted for domiciliary services

1. Morbid obesity
2. Medical condition of significance for which ongoing treatment is required or Rx medication is routinely being taken
3. Family history of genetic disorders, hereditary disease, or significant congenital or genetic anomalies
4. History of repeated spontaneous abortions and/or two or more late miscarriages
5. History of preterm birth of VLBW infant, unexplained stillbirth, or neonatal mortality associated with maternal disease, GBS infected newborn, congenital or genetic anomaly
6. History of fibroids or uterine surgery
7. Previous unexplained antepartum / postpartum hemorrhage requiring transfusion
8. Grand multipara (more than 5 previous births)
9. Less than 12 months from last delivery to present due date
10. Previous uncomplicated low-transverse cesarean surgery with non-repeating etiology and approximately 18 months or more before EDC for subsequent birth
11. Other medical or mental conditions that need to be medically evaluated before a client is accepted for domiciliary services

Section II – B

To establish minimum practice requirements in regard to a SAFE ENVIRONMENT FOR PLANNED HOME BIRTH

The licensed midwife providing community-based maternity care does so in a safe and clean environment. The licensed midwife shall make a preliminary home visit three to five weeks before the EDC to ensure adequate sanitation, light, heat, water, availability of telephone, transportation, and plans for emergency evacuation to a hospital. The licensed midwife also uses the occasion of the house call to help prepare the parents and their home for domiciliary care and to correct, if possible, any environmental hazards or other circumstance that would negatively impact on the birth setting or call for a change of plans.

The licensed midwife shall:

1. Carry and use, when needed, resuscitation equipment
2. Use clean, aseptic and/or sterile techniques and supplies and universal precautions in regard to equipment, examinations, and procedures
3. Respond promptly to the laboring client's needs, deciding in conversation with the client or her designate whether the appropriate level of care required at the time is for immediate attendance by the licensed midwife in the client's home, continued telephone contact, or arrangements for consultation, referral, transfer of care, or emergency transport as indicated
4. Perform an initial assessment upon arrival at the client's home to determine the health status of the mother and fetus and whether the mother is in labor. If the client is in labor, the licensed midwife identifies the phase or stage and determines whether continued domiciliary care is appropriate. If domiciliary care is not appropriate, the licensed midwife arranges for referral, transfer of care, or emergency transport
5. Continue to assess for normalcy and, if necessary, initiate appropriate interventions including transfer of care, first responder emergency care, and/or emergency transport.

OFFICIAL DECLARATION OF 'HOME' AS PLANNED PLACE OF BIRTH

The licensed midwife shall identify the phase of <u>active</u> labor (typically at 4-5 cms dilatation) or other point in time that it is appropriate to make a decision about planned place of birth. The question to be addressed is whether the mother and fetus are healthy and can reasonably be expected to progress and give birth normally at home *OR,* due to the *absence* of effective labor or the presence of *complications*, a timely elective transfer to medical services is called for. Official determination of planned place of labor and birth should be made in conjunction with the mother/parents. Unless this results in referral or transfer of care at that time, the licensed midwife shall enter a note in the chart confirming the intention of a "**planned home birth in an essentially healthy mother with a normal fetus**."

Section II – C --

To establish minimum practice requirements regarding APPROPRIATE EQUIPMENT:

The licensed midwife is equipped to assess and support maternal, fetal, and newborn well-being; to maintain a clean, aseptic or sterile technique as indicated; to conduct deliveries; to treat maternal hemorrhage; to resuscitate mother and/or infant; to repair 1st and 2nd degree perineal laceration or episiotomy.

To establish minimum practice requirements regarding ADMINISTRATION OF MEDICATIONS:

Upon the administration of any medication(s), the licensed midwife shall document in the client's chart the type and/or name of medication(s), the reason for administration, dosage, the method of administration, site, date, time, and the medication's effect.

Administration of medications by a licensed midwife:

1. **Oxygen** intrapartum or postpartum for maternal, fetal or neonatal distress
2. **Lactated Ringers** or other appropriate IV fluids administered intravenously for hydration or as an accompaniment to treatment for excessive postpartum bleeding
3. **Pitocin** administered by intramuscular injection or intravenous drip, in an emergency situation for the control of postpartum hemorrhage
4. **Methergine**, orally or intramuscularly for excessive postpartum bleeding
5. **Local anesthetic such as Xylocaine hydrochloride**, one or two percent, administered by infiltration, for the postpartum repair of tears, lacerations, and episiotomy
6. **Cetacaine**, applied topically to minor perineal lacerations or painful hemorrhoids
7. **Prophylactic ophthalmic antibiotic** medication for newborn
8. **Vitamin K,** orally or intramuscularly, for newborn for the prevention of acute and late onset hemorrhagic disease of the infant
9. **Rh Immune Globulin (RhoGam)**, administered by intramuscular injection, for an unsensitized client with Rh negative type blood to prevent Rh disease
10. **Epinephrine** for life-threatening allergic reaction or anaphylactic shock

11. **Additional medications as prescribed by a physician**

Section II – D

To establish the minimum practice requirements in regard to EMERGENCY CARE & EMERGENCY TRANSPORTATION

EMERGENCY DEFINED ~ *emergency* refers to a situation that presents an immediate hazard to the health and safety of the client or her unborn or newborn baby or would cause extreme and unnecessary suffering.

The following procedures may be performed by the licensed midwife **in an emergency situation, for which the health and safety of the mother or newborn are determined to be at risk.**

1. Cardiopulmonary resuscitation of the mother or newborn with a bag and mask
2. Administration of oxygen
3. Episiotomy
4. Administration of oxytocin (Pitocin or Methergine) to control postpartum bleeding
5. Manual exploration of the uterus for placenta to control severe bleeding
6. Lactated Ringer or other appropriate IV fluids
7. Epinephrine for life-threatening allergic reaction or anaphylactic shock

Transfer of Care & Transportation in an Emergency Situation

In an emergency situation, the licensed midwife is the *first responder* whose immediate responsibility is to initiate emergency care as indicated by the situation. Concurrently with the first responder role, the licensed midwife shall initiate immediate transfer of care in accordance with practice guidelines and the specific arrangements identified in the client's emergency transfer plan. The licensed midwife shall make a reasonable effort to contact the health care professional and/or institution to which the client will be transferred and to follow the health care professional's instructions. She shall continue emergency care as needed while:

1. Transporting the client by private vehicle or
2. Calling 911 and reporting the need for immediate transfer

Emergency Exemptions Clause (Sec 2063) The California licensed midwife may deliver a woman with complications or other bona fide emergency conditions, if the delivery is a verifiable emergency and no physician or other equivalent medical services are available.

Section II – E- ANTEPARTUM CARE

To define and clarify minimum practice requirements for the safe care of women and infants during the period of ANTEPARTUM CARE

During prenatal care, the client shall be seen by the licensed midwife or other appropriate health care provider at least once every four weeks until 30 weeks gestation, once every two weeks from 30 until 36 weeks gestation, and weekly after 36 weeks gestation, or as appropriate, or unless the client declines specific visits due to personal or family reasons.

A. Initial prenatal visit

1. Medical history / assessment of general health
2. Obstetrical history / assessment of obstetric status
3. History / assessment of psychosocial status
4. A baseline physical exam to include, but not be limited to:
    a) height
    b) weight
    c) blood pressure
    d) pulse
    e) breasts, to include teaching self exam (may be deferred)
    f) abdomen, to include fundal height, fetal heart tones, fetal lie, and presentation
    g) estimation of gestational age by physical findings
    h) assessment of varicosities, edema and reflexes

5. Laboratory tests. The client will be offered the following laboratory tests to include but not be limited to: CBC with differential
    a) urinalysis with microscopic
    b) syphilis serology
    c) blood group, Rh type, and antibody screen
    d) hepatitis B surface antigen
    e) rubella screen
    f) genetic screening tests
    g) gonorrhea test, if at risk
    h) chlamydia test, if at risk
    i) HIV test, if at risk
    j) tuberculosis, if at risk

B. On-going prenatal care

1. Assessment of the mother's general physical health
2. Assessment of psychosocial health
3. Nutritional assessment and counseling if indicated
4. Physical exam to include, but not be limited to:
    a) blood pressure and pulse
    b) weight

c) abdomen, to include fundal height, fetal heart tones, fetal lie, and presentation
d) estimation of fetal size and gestational age by physical findings
e) assessment of varicosities, edema, and deep tendon reflexes

5. Additional lab tests and genetic screening -- the following laboratory tests will be explained and recommended as indicated, including but not limited to:

a) gross urinalysis for protein and glucose at each visit
b) ultrasound during the first trimester to determine viability, number of fetuses, and/or date the pregnancy; during second or third trimester to diagnosis congenital anomalies, confirm fetal position, or evaluate amniotic fluid levels, fetal breathing movements, and other parameters of well-being
c) maternal serum alpha-feto protein (AFP) screening at 15 to 20 weeks of gestation
d) glucose tolerance test (GTT) at 16-28 wks, if indicated
e) hemoglobin and hematocrit after 28 weeks and/or CBC for platelet count
f) antibody titer for Rh negative mothers
g) prophylactic Rhogam information for Rh negative clients at 28 wks, as indicated
h) group beta strep (GBS) culture at 35-37 wks, according to CDC Guidelines
i) herpes (HSV 1 and/or HSV 2) cultures, according to current ACOG protocols as indicated

Section II – F – ANTEPARTUM REFERRAL

To define and clarify minimum practice requirements for the safe care of childbearing women in regard to PHYSICIAN CONSULTATION, REFERRAL & TRANSFER OF CARE during the ANTEPARTUM PERIOD

The licensed midwife shall consult with a physician and/or another professional midwife whenever there are significant deviations, including abnormal laboratory results, during a client's pregnancy. If a referral to a physician is needed the licensed midwife will, if possible, remain in consultation with the physician until resolution of the concern. It is appropriate for the licensed midwife to maintain care of her client to the greatest degree possible, in accordance with the client's wishes, remaining available throughout the remainder of the pregnancy and birth, if possible.

The following conditions require physician consultation or client referral and may require transfer of care. A referral for immediate medical care does not preclude the possibility of a domiciliary labor and birth if the physician who performs the medical evaluation determines that the client does not have, or no longer has, any of the conditions set out in this section.

A. **Antepartal maternal conditions** include, but not limited to:

1. Positive HIV antibody test
2. Threatened or spontaneous abortion after 14 weeks
3. Significant vaginal bleeding
4. Persistent vomiting with dehydration
5. Symptoms of malnutrition or anorexia
6. Protracted weight loss or failure to gain weight
7. Gestational diabetes, uncontrolled by diet
8. Severe anemia, not responsive to treatment
9. Severe or persistent headache
10. Evidence of PIH or pre-eclampsia (2 BP readings > than 140/90, 6 hours apart)
11. Deep vein thrombosis (DVT)
12. Symptoms of urinary tract infection (UTI)
13. Signs/symptoms of infection, fever of 100.6 F. or> for longer than 24 hours
14. Genital herpes outbreak
15. Isoimmunization diagnosed by positive antibody titer for Rh negative mother
16. Documented placental anomaly or placenta previa
17. Documented low lying placenta in woman with history of previous cesarean
18. Preterm labor, before the completion of the 37th week of gestation
19. Premature rupture of membranes, before 37 completed weeks of pregnancy
20. Prolonged rupture of membranes -- 48 hours without onset of active labor (see criteria and protocols for ROM greater than 18 hours in mother whose GBS status is unknown or positive)
21. Post-mature pregnancy with non-reactive NST or abnormal biophysical profile

B. Antepartal fetal conditions including but not limited to:

1. Lie other than vertex at term
2. Multiple gestation
3. Fetal anomalies compatible with life *and* affected by site of birth
4. Marked decrease in fetal movement, abnormal FHTs, non-reassuring NST
5. Marked or severe poly- or oligohydramnios (too much or too little amniotic fluid)
6. Consistent size/dates discrepancy or intrauterine growth restriction (IUGR)
7. Abnormal ultrasound finding

Section II – G -- INTRAPARTUM CARE

To define and clarify minimum practice requirements for the safe care of women and infants during the INTRAPARTUM period

Aseptic technique and universal precautions will be used while rendering care.
During active labor, the licensed midwife of record, or an appropriate designate shall remain present to monitor and support the spontaneous process of labor and birth, employing evidence-based principles of physiological management. The licensed midwife shall also provide appropriate psychological and social support to assist the laboring woman and her family members to cope with the natural stress of active labor.

With the permission of the client, the licensed midwife shall assess mother and baby throughout the stages and phases of labor.

A. Assesses, monitors, and charts fetal well-being. While in attendance, the licensed midwife assesses fetal heart tones (FHTs), in conjunction with characteristics of the amniotic fluid, to determine fetal status during active labor. Fetal well-being is defined by evidenced-based parameters. Currently (circa 2004) a reassuring fetal heart tone pattern consists of:

1. Normal baseline -- 110 to 156
2. Normal variability – baseline variations ranging from 6 to 25 beats per minute (bpm)
3. Periodic *presence* of accelerations – an increase above baseline equaling 15 or more bpm for 15 or more consecutive seconds
4. Absence of decelerations -- a decrease below baseline equaling 15 or more bpm for 15 or more consecutive seconds

Baseline rate, long-term beat-to-beat variability, normal accelerations and, if present, decelerations can be detected via intermittent auscultation (IA) or electronic fetal monitoring (EFM). The method commonly recommended for IA is to listen with a fetoscope or electronic doptone for a minimum of 60 seconds (during labor listen immediately following a contraction), and counting FHTs in five-second sets (i.e., a series of 12 or more samplings). For example, a normal baseline of 144 bpm will produce a pattern that is predominantly sets of 12s, with an occasional set of 10, 11 or 13. Normal accelerations, if present, will produce a series of three or more consecutive sets of 13s, 14s or 15s. Decels, if present, will manifest as three or more consecutive sets of 9 or fewer beats per unit. Based on the numerical pattern of these sampling sets, it is possible to confirm all four parameters of a reassuring FHT pattern *or* to detect non-reassuring patterns by using intermittent auscultation.
An alternative method to confirm a reassuring fetal heart tone pattern is the episodic use of EFM.

The following schedule for monitoring FHTs via IA or episodic EFM is recommended:

1. Latent labor: at least once every 2 hours, or as indicated
2. Early 1st stage of labor: at least once every hour, or as indicated
3. Active 1st stage of labor: every 30 minutes, or as indicated
4. Early 2nd stage of labor: every 20 minutes, or as indicated
5. Active pushing and perineal phase: every 10 minutes or after every 3rd UC, or more frequently as indicated

Note: Occasional variable decels that are infrequent, brief in length and mild in depth or head compression decels occurring during rapid fetal descent and the pushing phase and which display good recovery, are generally benign. Medicalization is usually not indicated unless these decelerations progress to a more serious status as evidenced by a deeper nadir, longer duration, more frequent occurrence and/or longer period of recovery, or are associated with other evidence of fetal distress such as baseline abnormality, fresh or more concentrated meconium, or abnormal vaginal bleeding.

B. While in attendance, the licensed midwife shall assist, assess, monitor, and chart maternal wellbeing as follows:

1. Monitor vital signs every four hours (with maternal permission) or as otherwise indicated
2. Monitor the progress of labor, noting length, force and frequency of uterine contractions and maternal response to the stress of labor
3. Monitor amniotic membrane status for rupture, relative fluid volume, odor, and color of amniotic fluid
4. Monitor hydration status, encourage adequate fluid intake, check for signs of maternal fatigue
5. Monitor voiding and, if indicated, check for bladder distention
6. Whenever vaginal examinations are performed to assess the progress of labor, they will be kept to a minimum to reduce the risk of infection and will be performed only with permission of the mother. Attention shall be directed toward aseptic technique, with the following information noted and documented in client's chart:
   a) cervical placement and consistency
   b) presence of bloody show
   c) presence and characteristics of amniotic fluid
   d) dilatation and effacement of cervix
   e) fetal station, presentation, and position
7. Assist the mother to give birth spontaneously and receive her newborn baby
8. Immediately observe the neonate to establish its transitional status, keep baby warm, provide stimulation or neonatal resuscitation if indicated
9. Immediately observe maternal status, estimate maternal blood loss, and monitor vaginal bleeding
10. Assist in the delivery of the placenta using gentle cord traction
11. Check the perineum for lacerations and, if indicated, check the vaginal vault and/or the cervix, and either repair or make appropriate referral for suturing when necessary

12. Inspect the placenta and membranes, noting condition of placenta and condition of the umbilical cord including its length, number of vessels, and other notable features
13. Obtain a cord blood specimen, if feasible, which shall accompany the infant in case of transport or, in the case of Rh negative mother, shall be sent to the lab for blood typing and Coombs
14. Manage any variations, deviations, or problems in accordance with individual practice protocols and manage any complications in accordance with guidelines cited elsewhere in this document

Section II – H– INTRAPARTUM REFFERAL

To define and clarify minimum practice requirements for the safe care of women and infants in regard to PHYSICIAN CONSULTATION, REFERRAL, TRANSFER of CARE & EMERGENCY TRANSPORT during the INTRAPARTUM period

The licensed midwife shall consult with a physician and/or another professional whenever there are significant deviations, including abnormal laboratory results, during a client's labor and birth, and/or with her newborn. If a referral to a physician is needed, the licensed midwife will, if possible, remain in consultation with the physician until resolution of the concern. It is appropriate for the licensed midwife to maintain care of her client to the greatest degree possible, in accordance with the client's wishes, remaining present through the birth and resuming postpartum care if appropriate.

The following conditions require physician consultation and may require transfer of care. Consultation does not preclude the possibility of a domiciliary labor and birth if, following the referral, the client does not have any of the conditions set out in this section.

A. Maternal intrapartum conditions ~ Serious medical/obstetrical or perinatal conditions including, but not limited to:

1. Prolonged lack of progress in labor after use of normal midwifery support
2. Abnormal bleeding, with or without abdominal pain; signs of placental abruption including continuous lower abdominal pain and tenderness
3. Significant rise in blood pressure above woman's baseline with or without proteinuria
4. Maternal temperature greater than 101.6 degrees Fahrenheit, unresponsive to treatment
5. Maternal pulse over 110 and/or significant hypotension
6. Genital herpes outbreak
7. Client's desire for pain medication
8. Client's request for transfer to obstetrical care

B. Fetal intrapartum conditions ~ Serious medical conditions including, but not limited to:

1. Abnormal FHT baseline -- tachycardia (>170 b.p.m. for 30+ minutes) or bradycardia (<100 longer than 3 minutes) w/o good recovery to normal baseline
2. Persistent non-reassuring FHT pattern with diminished variability that is unresponsive to corrective measures
3. Ominous FHT patterns – variable or late decels of increasing frequency, and/or length and/or depth, or other signs of immediate fetal distress
4. Thick meconium-stained fluid or frank bleeding with birth not imminent
5. Abnormal or unstable lie
6. Prolapsed cord

C. Emergency transport: If, on initial or subsequent assessment during the 1st, 2nd,or 3rd stage of labor, one of the following conditions exists, the licensed midwife shall immediately consult and/or initiate immediate emergency transfer according to the emergency plan, and shall document that action in the midwifery record in the hours following the birth.

It should be noted that because of time urgency during certain situations, it may be necessary to institute emergency interventions while waiting for physician response or emergency transport.

1. Prolapsed cord
2. Uncontrolled hemorrhage
3. Preeclampsia or eclampsia
4. Severe abdominal pain inconsistent with normal labor
5. Chorioamnionitis
6. Ominous fetal heart rate pattern or other manifestation of fetal distress
7. Seizures or unconsciousness
8. Thick meconium, unless the birth imminent
9. Frank blood in amniotic fluid, unless the birth is imminent
10. Evidence of maternal shock
11. Presentation not compatible with spontaneous vaginal delivery licensed midwife
12. Laceration requiring repair outside the protocols or scope of practice of the licensed midwife
13. Retained placenta or placental fragments
14. Neonate with persistent pulse rate greater than 160
15. Neonate with persistent respirations greater than 80
16 Any other condition or symptom which could threaten the life of the mother or fetus, as assessed by a licensed midwife exercising ordinary skill and knowledge.

D. Emergency Exemptions Clause (Sec 2063) The California licensed midwife may deliver a woman with any of the above complications or conditions, or other bona fide emergency, if the delivery is a verifiable emergency and no physician or other equivalent medical services are available. **EMERGENCY DEFINED ~** emergency means a situation that presents an immediate hazard to the health and safety of the client or entails extraordinary and unnecessary suffering.

Section II – I - POSTPARTUM CARE

To define and clarify minimum practice requirements for the safe care of women and their infants during the POSTPARTUM period

After the birth of the baby, the licensed midwife shall assess, monitor, and support the mother during the immediate postpartum period and shall remain with the mother and infant for a minimum of two hours after the birth or until the mother and infant are in stable condition, whichever is longer.

1. Maternal stability is evidenced by normal blood pressure, pulse, and respiration, firmness of fundus, normal lochia, and the ability to empty the bladder

2. Neonatal stability is evidenced by normal color, established respirations, normal temperature, normal heart rate, and appropriate sucking reflex in the infant

A. Immediate postpartum care and assessment of the mother will include**:**

1. Overall maternal wellbeing
2. Bleeding
3. Vital signs
4. Fundal height and firmness
5. Bowel/bladder function
6. Perineal exam and assessment
7. Repair of 1st or 2nd degree laceration(s)/episiotomy, as indicated
8. Facilitation of maternal-infant bonding and family adjustment
9. Concerns of the mother

B. The licensed midwife shall instruct the mother and family in normal newborn behavior, breastfeeding or formula feeding as applicable, postpartum self care, and emergency measures, and shall schedule or make arrangements for the follow up visit before leaving the family's home.

C. The licensed midwife shall provide RhoGam, or shall refer for RhoGam, to all Rh negative mothers within 72 hours of the birth.

D. On-going / follow-up postpartum care
The licensed midwife shall make a follow up visit within 72 hours to assess the progress of the mother and infant. Such visit shall include an assessment of, at a minimum:

1. Overall maternal well-being including vital signs as indicated
2. Lochia
3. Fundal height and firmness
4. Perineal exam and assessment of healing
5. Breasts, nipples, presence of colostrum or milk
6. Nutrition and hydration

7. Ability or willingness of family to assist new mother
8. Elimination including ability to void and status of hemorrhoids
9. Emotional adjustment, maternal- infant bonding and family adjustment
10. Concerns of the mother

Section II – J – POSTPARTUM REFERRAL

To define and clarify minimum practice requirement for the safe care of women and infants in regard to PHYSICIAN CONSULTATION, REFERRAL, ELECTIVE TRANSFER OF CARE & EMERGENCY TRANSPORT during the POSTPARTUM period

The licensed midwife shall consult with a physician and/or another professional whenever there are significant deviations, including abnormal laboratory results, during the postpartum period. If a referral to a physician is needed, the licensed midwife will remain in consultation with the physician until resolution of the concern. It is appropriate for the licensed midwife to maintain care of her client to the greatest degree possible, in accordance with the client's wishes.

A. Immediate postpartum conditions requiring physician consultation, referral, and/or transfer of care. *It should be noted that because of time urgency during certain situations, it may be necessary to institute emergency interventions while awaiting physician consultation or emergency transport.* The licensed midwife shall arrange for immediate consultation and transport according to the emergency plan if the following maternal conditions exist. They include but are not limited to:

1. Seizure or unconsciousness, beyond transient fainting when getting up after birth
2. Significant hemorrhage, not responsive to treatment
3. Total maternal blood loss of more than 1,000 cc
4. Sustained maternal vital sign instability
5. Adherent or retained placenta
6. Uterine prolapse
7. Uterine inversion
8. Need for repair of laceration(s)/episiotomy beyond licensed midwife's level of expertise
9. Anaphylaxis
10. Infection
11. Normally hydrated mother unable to void spontaneously within 6 hours after birth if cannot be catheterized, or within12 hours postpartum if catheterized and still unable to void
12. Other serious medical or mental conditions
13. Mother's request

B. Extended postpartum condition ~ The licensed midwife shall arrange for consultation and/or transport when/if:

1. Maternal fever of greater than 101oF on any of the second through tenth days postpartum
2. Lochia that is excessive, foul smelling, or otherwise abnormal
3. Evidence of clinically significant depression, beyond the "baby blues"
4. Evidence of infection in perineal laceration or episiotomy repair
5. Social, emotional or other physical conditions as determined by the licensed midwife

Section II – K - NEWBORN CARE

To define and clarify minimum practice requirements for the safe care of infants during the NEONATAL transitional period

After the birth of the baby, the licensed midwife shall assess, monitor, and support the baby during the immediate postpartum period until the baby is in stable condition, and during the on-going postpartum period. Physiologic stability is defined as the ability to maintain stable cardio-respiratory function and the ability to suckle, feed, and maintain normal body temperature in an open environment. **(AAP)**

A. Immediate newborn care includes:

1. Monitoring overall newborn well-being
2. Performing APGAR scores at 1 and 5 minutes, and at 10 minutes when indicated
3. Clamping/cutting of umbilical cord
4. Assessing vital signs including color, tone/reflexes, temperature*, pulse, and respirations
5. Performing newborn physical exam, including weight, length, measurement of head, chest, abdominal circumference, normal reflex response, and gestational age assessment
6. Administering antibiotic eye prophylaxis
7. Administration of vitamin K, orally or intramuscularly
8. Assisting with initiation of breastfeeding/other feeding
9. Taking note of voiding and meconium stools
10. Arranging to obtain, or obtaining, laboratory testing on the infant of an Rh negative mother to include blood group/type and Coombs test
11. Addressing the concerns of the family

Note: * Neonates at delivery do not have the capacity to produce a fever. The purpose of assessing the newborn's temperature immediately after the birth relates to whether or not the baby is able to maintain normal warmth. This does not require or even benefit from oral, rectal or axial temperatures taken with a thermometer. Therefore assessing temperature after delivery can be achieved by feeling the baby's skin and observing its skin color, which will be pale or slightly cyanotic if too cold. Uniform warmth with pink skin, except for hands and feet, which may be slightly blue and slightly cool, is a normal characteristic of a well-adapted newborn.

B. Ongoing newborn care ~ The physiologic competencies that are generally recognized as defining the normal healthy neonate are the continued ability to maintain stable cardio-respiratory function, the ability to maintain a normal body temperature fully clothed in an open bed with normal ambient temperature, the ability to coordinate suckle feeding, swallowing, and breathing while ingesting an adequate volume of feeding, the normal elimination of urine and stool, and evidence of growth.

Follow-up visits shall include assessment of the infant and procedures, as indicated:

1. Status of the umbilical cord and clamp
2. Vital signs
3. Weight gain
4. Skin color
5. Feeding, hydration status, and elimination
6. Sleep/wake patterns
7. Bonding and family response to the baby's needs
8. Arranging for or drawing the required newborn screenings
9. Addressing the concerns of family

Section II – L - NEWBORN REFERRAL

To define and clarify minimum practice requirements for the safe care of infants in regard to **PHYSICIAN CONSULTATION, REFERRAL, TRANSFER OF CARE & EMERGENCY TRANSPORT** during the **NEONATAL** period

The licensed midwife shall consult with a physician and/or another professional midwife whenever there are significant deviations relative to the newborn. If a referral to a physician is needed, the licensed midwife will, if possible, remain in consultation with the physician until resolution of the concern. It is appropriate for the licensed midwife to continue caring for her client to the greatest degree possible, in accordance with the client's wishes, during the postpartum/postnatal period.

A. The following conditions require physician consultation or client referral and may require transfer of care.

1. Perinatal conditions of the neonate: The licensed midwife shall arrange for immediate consultation and transport according to the emergency plan if the following conditions exist. *Due to time urgency during certain situations, it may be necessary to institute emergency interventions while waiting for physical consultation or emergency transport.*

These conditions include but are not limited to:

a) Apgar score less than 7 at five minutes of age, without significant improvement at 10 minutes
b) persistent respiratory distress exhibited by respirations greater than 70 per minute, grunting, retractions, or nasal flaring at one hour of age that is not showing consistent improvement, and/or pulse oximetry readings below normal at one hour
c) persistent cardiac irregularities
d) central cyanosis, pallor, or gray skin color
e) lethargy or poor muscle tone
f) prolonged temperature instability
g) fever >100.6 degrees Fahrenheit, unresponsive to treatment
h) significant clinical evidence of glycemic instability
i) evidence of seizures
j) bulging or depressed fontanel
k) birth weight <2300 grams
l) significant clinical evidence of prematurity
m) clinically significant jaundice at birth
n) major or medically significant congenital anomalies
o) significant or suspected birth injury
p) other serious medical conditions
q) parental request

2. Postnatal care of the neonate: The physiologic competencies that are generally recognized as defining the normal healthy neonate are the ability to maintain a normal body

temperature fully clothed in an open bed with normal ambient temperature, the ability to coordinate suckle feeding, swallowing, and breathing while ingesting an adequate volume of feeding, the ability to grow at an acceptable rate, and normal elimination of urine and stool. Inability or dysfunction in any of the above named areas is cause for concern and on-going evaluation. Unless the problem can be corrected in a timely fashion, consultation, referral or transfer of care will become necessary.

The licensed midwife will arrange for consultation, referral or transport for an infant who exhibits the following:

a) abnormal cry
b) diminished consciousness
c) inability to suck
d) failure to pass urine in 30 hours or meconium in 48 hours
e) fever >100.6 degrees Fahrenheit, unresponsive to treatment
f) baseline pulse rate greater than 156 or less than 90
g) baseline respiratory rate greater than 70 or less than 30
h) clinically significant color abnormality - cyanotic, pale, grey
i) abdominal distension
j) projectile vomiting
k) jaundice within 30 hours of birth
l) signs of a significant infection or skin of umbilical stump
m) strongly positive direct Coombs test
n) loss of >10% of birth weight/failure to thrive
o) other concerns of family or midwife

Section II – M - **GUIDELINES FOR ASSESSING THE NEONATE**

To describe the profile of a healthy neonate, provide criteria for evaluating deviations from normal newborn physiology and identifying transient conditions via extended observation and other management strategies

The following criteria and guidelines are provided to help distinguish between those serious neonatal conditions requiring immediate medicalization and less serious problems that are mild, transient and/or spontaneously resolving. Observation for at least 2 hours by the licensed midwife or a trained assistant is appropriate for all newborns; observation period should be longer if there is any concern about the baby's transition to a stable status.

A. Profile of a healthy neonate

Physiologic stability is established by the newborn's ability to maintain stable cardio-respiratory function and the ability to suckle, feed, and maintain normal body temperature in an open environment. **(AAP)** Newborn stability is evidenced by established respirations, normal temperature, normal heart rate, and appropriate sucking reflex in the infant. A physically healthy newborn has no evidence of prematurity or congenital anomalies.

1. Newborn exam within a few hours of birth should demonstrate:

- Heart rate between 110 – 150 *without* heart murmurs or signs of circulatory insufficiency
- Lungs clear with a regular respiratory rate between 40 and 70 – *without* central or circumoral cyanosis, flaring of nares, persistent grunting, retractions of sternum, or sea-saw breathing
- Abdomen soft w/o masses, 3 vessels in umbilical cord
- No signs of seizure activity
- No signs of lethargy (inability to wake baby or trigger crying)
- Reasonable muscle tone (normal arm recoil as used in Dubowitz or Ballard Gestational Age Assessment)
- Ability to suckle or nurse

B. Serious neonatal problems:

Evaluation by a physician and/or hospital transfer is indicated in the event of an extremely difficult labor or birth with sequelae such as a significantly depressed baby or one who is ill or injured, a baby suffering from a significant congenital anomaly, or any baby for whom the parents are concerned and request hospital care. It's a good idea to honor the parents' intuition if they are very worried or have feelings of foreboding.

C. Cluster phenomenon – a large number of small discrepancies:

Be particularly watchful of babies with a cluster of *several* small or subtle abnormalities that would be of little concern if they were a *single isolated finding*. For example, TTN (transient tachypnea of the newborn) in a baby with *no* labor/birth-related risk factors, who is nursing well and for whom all others parameters are within the normal range is far less worrisome than a baby with a known risk factor (e.g. longer 2nd stage, shoulder dystocia, lower Apgars, or slow adaptation to extra-uterine life, etc) *and* who also presents a cluster of mild abnormalities such as *slightly raised* respiratory rate, *slight* pallor, just *a bit* floppy, *mild* grunting, *and/or* won't nurse.

Pulse oximetery would be useful equipment in these situations, to determine whether or not this cluster indicates falling or inadequate oxygenation. If unable to establish the wellbeing of the baby, pediatric evaluation will be necessary.

D. Transient problems:

Licensed midwives providing community-based maternity care sometimes find themselves caring for babies with transient problems of mild to moderate severity which have stabilized and are resolving and thus do not appear to warrant immediate medicalization. Other factors to consider are remote or rural locations with long travel distances to appropriate medical services, those living in locations where the services of an experienced perinatologist are not available, families with no healthcare insurance or MediCal coverage, or those who decline prophylactic medical care for religious or philosophical reasons.

Examples of transient problems include mild to moderate episodes of bradycardia or tachycardia during labor followed by good recovery with continued normal FHT variability, the unexpected appearance of thick meconium at delivery, shoulder dystocia that required significant manipulations but resolved without sequelae, any baby requiring resuscitative procedures at birth beyond a few puffs of positive pressure ventilation. Prophylactic positive pressure ventilation (PPV) for a "slow starter" -- 6 or fewer assisted respirations during the first 30-40 seconds, or blow-by O2 which can be discontinued in less than 30 minutes, are generally associated with benign situations and are not cause for medicalization.

However many babies, even those *without* identifiable stressors, can be mildly depressed at birth and may take up to an hour to stabilize at an optimal level. Benign conditions that are stable or improving are accompanied by improving Apgars. During the first hour after the birth, the licensed midwife is continually present and actively observing the baby, noting color, vigor, respiratory rate, heart rate, and ability to nurse. For this reason, more latitude can be taken during this period of intense observation. By the end of the first hour most healthy babies will have an Apgar of 9 or 10 and a normal newborn exam.

E. Extended observation and/or pediatric evaluation:

Transient neonatal problems often require a longer observation period, additional neonatal monitoring, and parental instructions. Recommendation of a pediatric evaluation may be appropriate. If parents choose not to have the baby examined by a physician, their informed consent/decline must be documented in the intrapartum chart.

If there is continuing concern over the well-being of the baby, the midwife or another qualified observer should watch the baby for the first 4 to 8 hours and transport the baby if it does not maintain an essentially normal profile with normal vital signs. Extended observation is particularly important at night when parents may be sleeping. Such observation can be provided by a parent or another adult familiar with infant behavior (grandmother, etc) who:

- Agrees to remain awake and observe the baby
- Can demonstrate the ability to count the baby's respiration and heart rate
- Has been given very specific guidelines on what to watch for and when to call the licensed midwife or medical care providers

If the baby is being observed by a family member, the licensed midwife must remain available and should make a house call or check in by phone at stated times or regular, agreed-upon intervals.

Section II – N - INSTRUCTIONS TO NEW PARENTS

To define and clarify minimum practice requirements for providing INSTRUCTIONS TO NEW PARENTS ON THE SAFE CARE OF THEIR NEWBORN BABY

Before leaving the parents' home, the licensed midwife shall provide appropriate information on normal newborn behavior, infant care and feeding, directions for dealing with a pediatric emergency, and arrangements for subsequent postpartum/neonatal return visits.

The goal is to assist the mother and father to provide safe and competent care to their new baby as well as to become comfortable and confident in their new role as parents. Verbal instructions are best provided to new parents in small, specific increments relative to the particular circumstance. This increases understanding and retention of the information and guards against the mother or father feeling overwhelmed by the responsibility. These topics can also be addressed during prenatal education and/or through printed handouts that can be provided to the parents before or after the birth.

A. Instructions to parents

Information provided at the time of the birth and during the immediate postpartum home visits should cover the following topics as appropriate:

- Visible characteristics of a healthy baby, including slightly cooler temperature of extremities and normal mild cyanosis of hands and feet for the first 24 hours
- How to help baby to maintain a stable body temperature through adequate but not excessive clothing and covers, skin-to-skin contact, and regulating room temperature
- If breastfeeding – colostrum, protection of nipples, role of frequent nursing in helping the milk to come in, how to deal with engorgement, how to tell if baby is getting enough
- If not breastfeeding – how to prepare formula, sterilize equipment, refrigeration of reconstituted formula, frequency of feeding, how to recognize formula intolerance
- Diapering, tracking passage of meconium and urine, and characteristics of stools
- Possibility that boy baby might display "red brick" stain in diaper, and that girl baby might display "witch's period"
- Sleeping arrangements and positions including SIDs precautions
- Bathing and routine care for umbilical cord
- Encouragement of liberal doses of parental affection and lots of cuddling – yes, *spoil* the baby!
- Arrangements for initial medical evaluation and ongoing pediatric care

B. Emergency precautions:

No one spends more time with a baby or cares more for the baby's wellbeing than its parents. For this reason, *parents play the most central role in safeguarding the newborn.* They should receive appropriate information on the most common newborn problems, signs and symptoms

of serious medical conditions affecting infants during the first weeks of life, how to recognize a pediatric emergency, and directions for how to respond to problems or a medical emergency. In particular it is useful to emphasize to parents that when the licensed midwife leaves a few hours after the birth, they, the parents, will need to take over the responsibility of determining if or when medical services are indicated. While they may call the licensed midwife to solicit advice, she cannot see the baby or examine it over the phone. Parents should be encouraged to act on any intuition or premonition by seeking out physician care, even if it is inconvenient or the parents do not have health insurance. It *is* better to be safe than sorry.

1. Parents should be instructed to contact the licensed midwife immediately or arrange for immediate physician evaluation of their newborn if they observe any potential problem such as poor color, weak cry, lethargy, respiratory difficulty, diminished consciousness, seizures, failure to pass urine, persistent vomiting, diarrhea, inability to take oral nourishment, etc.

2. Parents should be advised to take their baby to the emergency room if unable to contact their licensed midwife or doctor for more than one hour.

3. **Parents should be advised to call paramedics immediately** if they believe their baby's condition seems extremely serious or if the baby manifest signs of a life-threatening emergency such as central cyanosis or erratic respirations, abnormal bleeding or loss of consciousness.

C. Professional interface between midwifery care and pediatric care providers

To assist the professional interface between the licensed midwife and the pediatric care provider chosen by the parent, some form of neonatal record should be provided to the parents. Exactly how this is accomplished is at the discretion of each licensed midwife.

While copying the neonatal chart would be ideal, most homes do not have access to photocopying equipment. A convenient alternative is a one page synoptic record of newborn care that can be left with the parents at the time of the birth. This permits them to carry a brief neonatal record with them to the baby's first pediatric appointment or to provide a record to paramedics should emergency medical care be required. An example of this type of document is the "Nativity Card" distributed by the American College of Community Midwives (ACCM). Other examples are booklet-type medical records commonly carried by European and Japanese citizens.

Ideally this type of newborn record should provide the name and phone number of the licensed midwife, parents' name(s) and address, relevant information on the mother's health history, results of diagnostic tests performed during pregnancy, GBS status, time of ROM, the length of the labor, circumstances of the birth including any interventions required, Apgars, immediate neonatal care as rendered by the licensed midwife, findings of the newborn exam including weight and other measurements, whether vitamin K and antibiotic eye prophylaxis were administered, and relevant information from any of the subsequent house calls during the immediate postpartum/postnatal period.

End of Section II