Intrapartum Policies and Procedures

The following policies and directives are adjunct to good clinical judgment and are not an inclusive list.

ACCESS TO CARE:

The midwife or backup is accessible on a 24 hr basis by phone for labor or emergencies. All non-emergency calls are to be placed during business hours. In the event the client cannot contact the midwife, the client is to leave a complete message and then call the midwife's assistant. If this fails to contact someone and it is an emergency, the client should call 911 or go to the hospital.

LIMITATIONS OF SERVICE:

For specific screening criteria see "Risk Assessment" and "Indications for Physician Consultation and Referral".

ROUTINE INTRAPARTUM HOME BIRTH CARE--STAGES I-IV:

Admissions Evaluation:

1. When the client presents in labor, the midwife will perform an evaluation, to include:
   a. Initial onset evaluation, may be by phone
   b. Record stated history of onset of labor
   c. State of the membranes and amniotic fluid
   d. Evaluation and fetal activity and heart rate
   e. Maternal vital signs, intake / output
   f. Optional pelvic exam for effacement, dilation & consistency of the cervix; position, station and presenting part of the baby; condition of the membranes
   g. Lab tests as indicated
   h. Contraction pattern, strength, frequency, and duration
   i. Coping abilities of woman and family
   j. Risk criteria will be continuously applied, and the physician notified in the event of significant deviations from the normal
2. Answer questions / counseling / anticipatory guidance
3. Client will have supplies in birth room, per list supplied by midwife
4. Midwife may choose to leave in early labor until labor is more active
5. Once it is determined that active labor is established, the midwife or birth assistant will remain in continuous attendance and perform regular periodic monitoring

Labor Management:

1. FHR auscultated with Doppler or fetoscope as follows:
   a. Latent phase every hour if in the home with awake client
   b. Active phase every 30-60 mins, or after significant position changes or ROM
   c. Second stage every 5-15 mins and/or through contractions
   d. More frequent auscultations if any decelerations or bradycardia

   e. Check for fetal reactivity to movement or scalp stimulation if decelerations or bradycardia occur, change maternal position and monitor response
2. Maintain maternal hydration and monitor intake of food & fluids and voiding & elimination
3. Aid in coping with labor through coaching and support of mother/partner, which may include: ambulation/rest, showers/baths, music, position changes, heat/ice, massage, herbal/homeopathic remedies, acupressure, breathing or hypnobirthing techniques
4. Evaluate labor progress as indicated by maternal signs and symptoms and vaginal exams
5. Monitor vital signs (BP every 2-4 hours, Temp & Pulse every 4 hrs after ROM)
6. Amniotomy -- may be done if clearly indicated and if the following criteria are met:
   a. Vertex is well applied to the cervix at 0 station or lower, not asynclitic
   b. Client is in active labor, (4+ cm)
   c. There is a medical or risk-related indication to speed labor, and client agrees
7. Use of heparin lock, IV fluids, oxygen, antibiotics for GBS, prn
8. Attend to the emotional needs of the family
9. Monitor temperature of water if birth tub is used

Management of Birth:

The following procedures may be performed as indicated:

1. Perineal massage and support during spontaneous vaginal delivery
2. Check for nuchal cord, management with emphasis on avoiding any need to cut cord
3. If mother's own efforts are not effecting progress then directed pushing instituted
4. Episiotomy only if clearly indicated to ensure health of the baby
5. Keep family informed of maternal/fetal well-being and progress
6. Management of emergency situations such as cord prolapse, shoulder dystocia, etc.

Management of Third and Fourth Stage:

The following procedures may be performed as indicated:

1. Deliver the placenta
2. Inspect placenta for completeness, condition, abnormalities, and number of vessels
3. Estimate blood loss
4. Monitor newborn and maternal vital signs and administer oxygen, PPV, IV fluids prn
5. Administer comfort measures prn: ice pack, clean up, shower, nutrition, fluids, after pains care, etc.
6. Facilitate family bonding
7. Facilitate breast feeding
8. Facilitate bladder voiding (catheterization, prn)
9. Review postpartum instructions, early home care and normal newborn demeanor, actions and expectations
10. Manually remove the placenta &/or exploration of the uterus only in the presence of hemorrhage
11. Monitor/manage bleeding by: fundal massage, bimanual compression, oxytocics, herbs, etc.
12. Repair of episiotomy or lacerations using local anesthetic, prn
13. Perform newborn exam
14. Pre-prepare placenta for disposal, encapsulation, or lotus birth as desired by client
15. The midwife may discharge client from supervised midwifery care after not less than 2 hours postpartum if all criteria are met and mother and baby are healthy and stable.