



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(s) is accessible on a 24 hr basis by phone and pager for labor or emergencies. All other, non-emergency calls are to be placed during business hours. In the event the client cannot contact the midwife, the woman is to leave a complete message and then call or page the midwife's assistant. If this fails at contacting someone and it is an emergency, the woman is to 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. FHR evaluation and fetal activity
 - e. Maternal vital signs, intake/output
 - f. Pelvic exam for effacement, dilation & consistency of the cervix; position, station and presenting part of the baby; condition of the membranes
 - g. Lab tests, prn (i.e., nitrazine, urinalysis, Hct/Hgb)
 - 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 q 1 hr if in the home with awake client
 - b. Active phase (Cx >4) q 30-60 mins, or after sig. position changes or ROM

- c. Second stage q 5-15 mins and/or through qo UC
- d. More frequent auscultations if decelerations or bradycardia
- e. Check for fetal reactivity to movement or scalp stimulation if decelerations or bradycardia occur
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 by, but not limited to: ambulation/rest, showers/baths, music, position changes, heat/ice, massage, herbal/homeopathic remedies
4. Evaluate labor progress as indicated by maternal signs and symptoms and vaginal exams
5. Monitor vital signs (i.e., BP q 2-4 hrs, Temp & Pulse q 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, fetal head at -2 station or lower
 - b. Client is in active labor, (4+ cm)
 - c. Client agrees
7. Use of heparin lock, IV fluids, oxygen, antibiotics for GBS, prn
8. Attend to the emotional needs of the family

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 and management
3. If mother's own efforts are not effecting progress then directed pushing instituted
4. Episiotomy, prn 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 the placenta for completeness, condition, abnormalities, and number of vessels
3. Estimate blood loss
4. Monitor maternal vital signs (BP, temp, pulse), administer IV fluids prn
5. Administer comfort measures prn: ice pack, clean up, shower, nutrition, fluids, after pains care, and 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. The midwife may discharge client from supervised midwifery care after 2 hours postpartum if all criteria are met and mother and baby are healthy and stable.