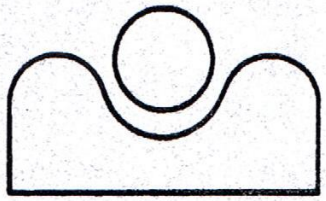

massachusetts midwives alliance

Practice Guidelines

Massachusetts Midwives Alliance
169 Forest Street
Sherborn, MA 01770
508-655-7885

The Midwives Model of Care™

The Midwives Model of Care is based on the fact that pregnancy and birth are normal life processes.

The Midwives Model of Care includes:

- *monitoring the physical, psychological and social well-being of the mother throughout the childbearing cycle;*
- *providing the mother with individualized education, counseling, and 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.*

The application of this woman-centered model of care has been proven to reduce the incidence of birth injury, trauma, and cesarean section.

Table of Contents

The Purpose and Use of MMA Practice Guidelines…… Page 4

Professional Guidelines…… Page 5

Practice Guidelines:

Normal Pregnancy…… Page 8

Normal Labor & Birth …… Page 9

Normal Postpartum…… Page 11

Variations of Pregnancy…… Page 12

Variations of Labor & Birth……..... Page 16

Postpartum Variations: Maternal……... Page 18

Postpartum Variations: Neonatal……..... Page 20

Perinatal Death…….. Page 22

Limitations of Practice……... Page 23

Appendix 1: Transfer Criteria..…..…….…….....**.** Page 24

Appendix 2: Equipment and Supplies…….…… Page 26

Appendix 3: Sample Postpartum Depression Screening Tool….. Page 27

Resources…….…….…… Page 29

MMA Peer Review Form……..…….. Page 30

The Purpose and Use of MMA Practice Guidelines

The Massachusetts Midwives Alliance (MMA) is a professional trade organization created by and for a dynamic and diverse group of midwives. The MMA was founded to build cooperation among midwives, and to promote midwifery as a means of improving health care for women and their families. MMA promotes the Midwives Model of Care™, based on the fact that pregnancy and birth are normal life processes. This means members not only practice the Art of Midwifery, but also put a strong emphasis on evidence-based practice, and facilitation of fully-informed decision-making by clients. MMA represents Certified Professional Midwives (CPMs), Traditional/Direct-Entry Midwives (DEMs), and Certified Nurse Midwives (CNMs) who practice in home, birth center, and hospital environments.

In keeping with its purpose of upholding high standards of care, while both unifying and increasing communication among midwives, MMA has created the Practice Guidelines as a living document, with ongoing revisions overseen by MMA's Practice Guidelines Committee. Upon joining MMA, members agree to follow these Practice Guidelines and to carefully document circumstances of deviation. However, these Practice Guidelines are not intended to replace the midwife's clinical judgment or expertise, or the principals of individualized care, informed choice, and shared responsibility that are the cornerstones of midwifery practice.

MMA also encourages members to share these Practice Guidelines with other health care providers who offer consultation, collaboration, acceptance of client referrals or transfers of care, with the goal of enhancing understanding, heightening client safety, and maintaining optimal perinatal outcomes.

Professional Guidelines

I. Education and Training

A. MMA recognizes the North American Registry of Midwives (NARM) route of certification or equivalent for entry-level midwives.

B. MMA recommends completing the *Practical Skills Guide for Midwifery* (Weaver & Evans, most recent edition) as a foundation for the practical aspects of apprenticeship.

C. MMA recommends that only experienced midwives (by NARM's definition) take on students/apprentices.

D. MMA recognizes apprenticeship as an individualized, yet structured educational relationship with definitive endpoint goals.

II. Certification & Continuing Education

A. Keep current all certifications and continuing education required for safe practice:

1. Cardiopulmonary Resuscitation (CPR);
2. Neonatal Resuscitation (NNR);
3. Peer Review (at least 5 hours every three years);
4. Continuing Education Units (at least 10 CEUs per year);
5. Other midwifery certifications as appropriate to midwife type.

III. Equipment & Supplies

A. Stock, carry and maintain all equipment and supplies the midwife deems necessary for safe practice. (See Appendix 2, Equipment and Supplies.)

IV. Informed Consent/Refusal

MMA members facilitate fully-informed choice for their clients. Informed consent and refusal consists of three parts:

A. Full disclosure of practice, including experience, education, philosophy, peer review process and grievance process, services provided and legal status.

B. Full disclosure of the risks and benefits of home birth, as well as those of hospital and birth-center birth.

C. Detailed description of procedures and treatments, including risks, benefits and alternatives.

V. Client Records and Documentation

A. The midwife will share, store and dispose of client records in accordance with HIPAA and other state and federal guidelines.

B. All aspects of care will be documented in the client record.

VI. Consultation and Transfer of Care

A. Consultation is defined as communication with a health care provider outside one's own practice regarding the management of the client's care. Consultation can include phone or email contact between the midwife and other provider and/or visit(s)/ exam(s) with the client. The client remains in the care of the midwife.

B. The midwife will evaluate each client's level of risk during pregnancy, labor, birth and postpartum on an on-going basis and will offer consultation with other health care providers as appropriate.

C. Transfer of care is defined as when care of the client is given over to another provider outside the midwife's practice, although the midwife may remain in contact or provide another role such as labor and/or birth support. The client may or may not be moved to another location.

D. Transfer of care to another provider, practice and/or hospital may occur as the midwife and/or client desire or as clinically indicated. (See Appendix 1, Transfer Criteria.)

E. If the midwife determines that it would be in the best interest of a mother and/or baby to have their care transferred, the client will participate in the decision-making process by being given an explanation of the immediate problem and reason for the recommendation, as time and circumstances allow.

F. If the client declines any care recommended by the midwife, the midwife should document client education and discussion of why the care is recommended and obtain signed evidence of informed choice.

VII. Continuity of Care

A. The midwife will provide information to all clients about the nature and scope of her back-up relationships, if any, with other midwives and other healthcare providers.

B. The midwife will offer consultation with or transfer of care to an appropriate care provider if a client exhibits signs or symptoms that deviate from of the wide range of normal.

Normal Pregnancy, Birth & Postpartum

I. Normal Pregnancy

A. Prenatal care includes:

1. Complete history (medical/surgical, childbearing, psychosocial);
2. Physical assessment of mother and fetus, which may include weight, vital signs, fetal heart rate (FHR), fetal growth;
3. Client education;
4. Nutritional assessment and counseling;
5. Complete pelvic exam and assessment when appropriate;
6. Breast exam and assessment when appropriate;
7. Ongoing assessment of client's general well-being, including review of nutritional, educational and psychosocial needs, and concerns of the client and her family;
8. Diagnostic testing offered: standard prenatal screen including complete blood count (CBC), blood type, Rh factor and antibody screen, rubella titer, syphilis screen, hepatitis B surface antigen (HepBSAg), urinalysis (UA), gonorrhea & chlamydia (GC) culture;
9. Other diagnostic tests offered: pap test, glucose testing, alpha-fetoprotein (AFP), sickle-cell trait, urine culture & sensitivity (UC&S), toxoplasmosis, group B strep (GBS) culture, platelet & differential, HIV, hepatitis C, ultrasound (US), biophysical profile (BPP), etc.;
10. If the client declines any recommended diagnostic testing, the midwife should document client education and discussion of why the test is recommended, and obtain signed evidence of informed choice.

B. Return Visits

1. Frequency according to current community standards, e.g.: every 4 weeks, up to 28 weeks; every 2-3 weeks from 28 to 36 weeks; and every 1-2 weeks from 36 weeks until the birth;
2. Visits should take place more frequently as needed;
3. Repeat diagnostic testing as appropriate.

C. Third-Trimester Home Visit

1. Assess birth preparations and readiness and review emergency care plan.

D. Informed Consent/Refusal

1. If the client declines any recommended prenatal care, the midwife should document client education and discussion of why the care is recommended, and obtain signed evidence of informed choice.

II. Normal Labor and Birth

A. Initial assessment of maternal and fetal well-being

1. Includes FHR, and may include maternal blood vital signs, fetal position by palpation, and status of membranes. When indicated, a vaginal exam to assess dilatation, effacement and station may be done.

B. Labor

1. Intermittent auscultation of FHR:
    a. Frequency:
        i. Every 15-30 minutes during active labor;
        ii. Every 5-15 minutes during second stage.
    b. In addition, it is beneficial to evaluate FHR:
        i. Immediately after contractions for 30 seconds;
        ii. Intermittently through contractions;
        iii. Upon rupture of membranes (ROM);
        iv. With increasing frequency if abnormal pattern develops.
2. Repeat vital signs every 4 hours or more often as indicated;
3. Monitor progress of labor through observation and/or examination;
4. Anticipate transport if risk factors develop (See Appendix 2);
5. Midwife or qualified assistant must make every effort to be present in the home from beginning of active phase onward;
6. Monitor maternal hydration/nutrition/elimination;
7. Maintain aseptic technique as procedure dictates.

C. Birth

1. Prepare for birth; check / set up supplies, set appropriate room temperature;
2. Assist client with birth according to her wishes and present circumstances;
3. Use midwifery techniques to preserve perineal integrity.

D. Third Stage: Newborn

1. Assess neonatal status, record Apgars at 1 and 5 minutes (and 10 minutes if applicable);
2. Suction or resuscitate as needed;
3. Maintain newborn temperature through immediate maternal contact and appropriate room temperature;
4. Use sterile instruments for cord-cutting.

E. Third Stage: Mother

1. Use expectant management unless otherwise indicated;
2. Assess uterine height, tone, and estimate blood loss;
3. Facilitate birth of the placenta;
4. Take cord blood, if necessary;
5. Examine placenta and cord;
6. Examine perineum for lacerations;

7. Suture 1st or 2nd degree vaginal or perineal lacerations as necessary (or 3rd degree, if appropriate), using sterile technique and local anesthetic as needed.

F. Fourth Stage

1. Monitor mother for a minimum of 2 hours postpartum:
    a. Facilitate breastfeeding;
    b. Ensure adequate nourishment and ability to void;
    c. Give postpartum instructions for first 24 hours;
    d. Encourage appropriate home environment.
2. Monitor newborn for a minimum of 2 hours postpartum:
    a. Perform newborn assessment;
    b. Offer eye prophylaxis;
    c. Offer Vitamin K.
3. Ensure stable condition of mother and baby.

G. Informed Consent/Refusal

1. If the client declines any recommended intrapartum care, the midwife should document client education and discussion of why the care is recommended, and obtain signed evidence of informed choice.

III. Normal Postpartum

A. Minimum 2 postpartum visits: Typically include assessments of mental health, breastfeeding, perineal and rectal care, eating, and sleeping:

1. First visit within 24-36 hours;
2. Second visit within 5 days;
3. Observe and monitor parameters of maternal and neonatal well-being including involution, lochia, breastfeeding, jaundice, and cord condition.

B. Health care of the newborn: The midwife will advise the client about making arrangements for health care of the newborn. The midwife will provide a copy of the newborn assessment and any appropriate birth records.

1. Perform or refer for newborn metabolic screening within 72 hours of birth;
2. Refer for newborn hearing screen at nearest facility within two weeks of birth.

C. Six-week visit may include:

1. Pelvic exam;
2. Pap test;
3. Breast exam and instruction on self exam as needed;
4. Abdominal exam;
5. Assessment of family adjustment and parenting;
6. Birth-control counseling and information;
7. Follow-up on pediatric care.

D. Birth Certificate

1. Assist parents with filing for a birth certificate within the required time frame.

E. Postpartum Depression Screening

1. The midwife will continually screen for signs and symptoms of postpartum depression in all postpartum assessments;
2. The midwife may consider using an assessment tool (See Appendix 3 for example of a standard screening tool, the Edinburgh Scale);
2. When signs and symptoms are present, the midwife will facilitate timely access to appropriate community resources and emergency services if needed.

F. Informed Consent/Refusal

1. If the client declines any recommended postpartum care, the midwife should document client education and discussion of why the care is recommended, and obtain signed evidence of informed choice.

Variations in Pregnancy, Labor, Birth & Postpartum

I. Variations of Pregnancy

A. Vaginal Bleeding

1. Perform full assessment to rule out spontaneous abortion, ectopic pregnancy, placenta previa or abruption:
    a. Take history noting time of onset, amount of bleeding, duration, activity at time of onset, presence of pain and any other symptoms;
    b. Assess maternal and fetal well-being.
    c. Note any health history that may be a contributing factor.
2. If bleeding is severe and/or painful, direct client to a medical facility immediately;
3. If bleeding appears as spotting or minimal to moderate, advise client regarding complete pelvic rest and review signs and symptoms to report;
4. Offer diagnostic blood work or US if appropriate;
5. Offer consultation to rule out other conditions if bleeding persists or transfer care to an obstetric care provider as appropriate

B. Suspected Miscarriage / Spontaneous Abortion

1. Defined as cramping and bleeding that lead to pregnancy loss;
2. Facilitate transfer of care if client desires to be in the hospital or symptoms necessitate transport;
3. Stay in close contact with client if she desires to be at home:
    a. Provide teaching and ensure client and family have a clear understanding of what is expected / normal and what is not;
    b. Encourage client and family to keep a record of the amount of bleeding and to save any clots or tissue passed;
    c. Suggest comfort measures and offer labor support to client as needed;
    d. Offer Rh immune globulin (Rhogam) if Rh negative.

C. History of Previous Cesarean Section

1. Review complete health and childbearing history;
2. Obtain and review all hospital labor and delivery records, including documentation of uterine incision;
3. Discuss benefits and risks of home and hospital vaginal-birth-after-cesarean (VBAC) early in pregnancy and obtain written informed consent;
4. Be aware of possible increased emotional needs and be prepared to consult with or transfer care to an obstetric provider as appropriate.

D. Genital Herpes

1. Culture all suspicious lesions in pregnancy and offer consultation if primary outbreak;
2. If diagnosed, discuss with client risks of herpes in pregnancy and preventative measures for eliminating and/or reducing genital herpes outbreaks in pregnancy;
3. Any area that is likely to come in contact with the baby during birth must be free of active herpes lesions or appropriately covered to prevent contact;
4. Offer consultation with or transfer of care to an obstetric care provider for birth if contact with active lesion cannot be prevented.

E. Urinary Tract Infection (UTI)

1. Defined objectively as bacteriuria on routine urinalysis or subjectively as one or more of the following: dysuria, urgency, frequency, dyspareunia, malaise, fever of unknown origin, suprapubic pressure and/or spastic cramps;
2. Obtain clean-catch urine specimen for culture;
3. Encourage increased fluids, review diet and provide counseling as needed;
4. Examine for costo-vertebral angle (CVA) tenderness;
5. If urine culture is positive or CVA tenderness elicited, offer treatment or consultation with an obstetric care provider for treatment;
6. Repeat culture after treatment.

F. Vaginitis

1. Defined as increased discharge, burning, itching, dysuria, dyspareunia, and/or odor;
2. Screen for UTI or vaginal infection;
3. Review diet, recommend complementary therapies and provide counseling as needed;
4. Offer consultation with obstetric care provider for evaluation/treatment as needed.

G. Elevated Blood Pressure

1. Advise client on signs and symptoms of increasing severity of preeclampsia (epigastric pain, visual disturbances, edema of the face, clonus);
2. Consider appropriate baseline lab work including 24-hour urine collection for protein, particularly if there is a history of gestational hypertension or preeclampsia;
3. Based on results of assessment:
    a. With no symptoms of preeclampsia, advise client to assume left lateral lying position 3–4 times daily for 30 minutes for 2 days;
    b. Review diet and lifestyle, advise increased fluids and dietary protein, recommend complementary therapies as appropriate;
    c. If elevation continues, offer consultation with or transfer of care to obstetric provider for further evaluation/treatment.

4. If accompanied by signs and symptoms of preeclampsia such as significant proteinuria, weight gain greater than 3 lbs. in one week and/or non-dependent edema:
    a. Faciliate transfer of care to an obstetric provider immediately,
    b. Advise client to anticipate possible hospitalization, IV therapy, bed rest and additional diagnostic testing.

H. Maternal Blood Type Rh Negative

1. Negative antibody screen with initial blood work:
    a. Discuss risks and benefits of prenatal Rhogam and offer at 28 weeks;
    b. If declined, repeat antibody screen at 36 weeks.
2. Positive antibody screen with initial blood work:
    a. Offer Rhogam;
    b. Offer consultation with or transfer of care to obstetric care provider as needed.
3. If maternal trauma or bleeding occurs during pregnancy, offer Rhogam.
4. When administering Rhogam, monitor client for signs of adverse reaction.

I. Suspected Large for Gestational Age Fetus

1. Based on subjective history and objective findings, including 3 cm or greater discrepancy between measured and expected fundal height between 18 and 36 weeks;
2. Reevaluate estimated due date (EDD) considering last menstrual period (LMP), dates of quickening & first auscultation of FHT, fetal size and position, amount of amniotic fluid, and/or US;
3. Evaluate diet and counsel as appropriate;
4. With two consecutive large measurements, offer US and consultation to rule out other conditions or transfer care to obstetric care provider as needed.

J. Suspected Small for Gestational Age Fetus or Intrauterine Growth Restriction

1. Based on subjective history and objective findings of the failure to gain weight and/or failure of fundal measurements to progress over 3 consecutive weeks in the second trimester;
2. Reevaluate EDD considering LMP, dates of quickening & first auscultation of FHT, fetal size and position, amount of amniotic fluid and/or US;
3. Evaluate diet and counsel as appropriate;
4. With two consecutive small measurements, offer US and consultation to rule out other conditions or transfer care to obstetric care provider as needed.

K. Postdates

1. Defined as pregnancy which continues for more than 40 weeks from conception. (If conception date unknown, then more than 42 weeks from LMP, when cycles are 28 days);
2. Re-evaluate EDD considering LMP, dates of quickening & first auscultation of FHT, fetal size and position, amount of amniotic fluid and/or US;
3. Offer auscultated Non-Stress Test (NST) and/or BPP during the 41st week; repeat at least weekly until birth;

4. If NST or BPP abnormal, or if pregnancy continues to 43 weeks, offer consultation for further evaluation or transfer care to an obstetric provider as needed.

L. Pre-labor Rupture of Membranes, Preterm

1. Diagnosed as spontaneous ROM before 36 weeks;
2. Offer consultation for further evaluation/treatment or facilitate transfer of care to obstetric provider as appropriate.

M. Pre-labor Rupture of Membranes at Term

1. Defined as spontaneous ROM with no contractions for greater than 24 hours;
2. Offer nitrazine paper test or sterile speculum exam to confirm if unsure;
3. If positive for ROM, discuss potential risks and options of management;
4. Expectant management:
    a. Assess fetal well-being, including auscultated NST and monitoring of amniotic fluid characteristics;
    b. Instruct client regarding:
        i. Fetal kick counts;
        ii. Monitoring of temperature and pulse every 4 hours;
        iii. Vaginal/perineal hygiene;
        iv. Signs and symptoms to report.
    c. Promote adequate nourishment/elimination and rest for client;
    d. Offer complementary therapies to encourage the onset of labor as indicated.
5. Repeat expectant management daily until labor begins.
6. Offer consultation with or transfer of care to an obstetric care provider for:
    a. Maternal tachycardia or fetal distress unresponsive to corrective measures;
    b. Maternal temperature exceeds 100° F;
    c. Development of other signs and symptoms of infection.

N. Group Beta Strep

1. Offer screening by culture per CDC guidelines. If positive, discuss benefits a and risks of intrapartum treatment options, prior to the onset of labor when possible.

O. Informed Consent/Refusal

1. If the client declines any recommended prenatal care in the presence of variation, the midwife should document client education and discussion of why the care is recommended, and obtain signed evidence of informed choice.

II. Variations of Labor & Birth

A. Group B Strep

1. If mother is considered positive (history or culture):
    a. Review benefits and risks of treatment;
    b. Offer 0.2% chlorhexidine wash therapy or other evidence-based therapy.

B. Meconium-Stained Amniotic Fluid

1. Assess for fetal distress;
2. Alert obstetric provider and prepare for transfer in the evidence of fetal distress; if birth is imminent, prepare for NNR and transfer if necessary;
3. For stable fetus/stable newborn:
    a. Assess lungs and respiratory status as appropriate;
    b. Offer precautionary instructions for parents on signs and symptoms of respiratory distress.

C. Undiagnosed Breech

1. Alert obstetric care provider and prepare for transfer if necessary;
2. If birth is imminent, facilitate birth and prepare for NNR and transfer if necessary.

D. Undiagnosed Twins

1. Alert obstetric care provider and prepare for transfer if necessary;
2. If birth is imminent:
    a. Clamp and cut cord immediately following birth of 1st baby;
    b. Apply identification bracelet or ensure other means of ID for 1st baby;
    c. Determine position and FHR of 2nd baby;
    d. If birth of 2nd baby is imminent, proceed with birth;
    e. Be prepared to transport for birth of 2nd baby if not imminent;
    f. Be prepared for neonatal resuscitation, maternal hemorrhage, and/or transport if necessary.

E. Shoulder Dystocia

1. Depending on position of the mother, perform appropriate maneuver(s);
2. Have assistant keep track of time passing announce time elapsed at 30 second intervals;
3. Facilitate the birth: assist mother to change position and try all maneuvers in most appropriate order until birth occurs;
4. Be prepared for NNR and/or transport if necessary;
5. Assess for birth injury related to shoulder dystocia (e.g. fractured clavicle, nerve damage) postpartum;
6. Offer consultation for further evaluation or treatment or transfer care to an obstetric provider as needed..

F. Prolonged ROM

1. Defined as ROM greater than 24 hours during labor;
2. Discuss potential risks and options of management with client;
3. Expectant management:
    a. Continue to monitor maternal well-being, including temperature and pulse every 2-4 hours;
    b. Continue to monitor fetal well-being, including FHR and amniotic fluid characteristics;
    c. Promote adequate nourishment, elimination and rest for client;
    d. Offer complementary therapies to enhance labor progress as indicated.
4. Offer consultation with or transfer of care to obstetric care provider for:
    a. Maternal tachycardia or fetal distress unresponsive to corrective measures;
    b. Maternal temperature exceeding 100° F;
    c. Development of other signs or symptoms of infection.

G. Informed Consent/Refusal

1. If the client declines any recommended intrapartum care in the presence of variation(s), the midwife should document client education and discussion of why the care is recommended, and obtain signed evidence of informed choice.

III. Postpartum Variations: Maternal

A. Maternal Hemorrhage after Placenta delivered

1. Defined as blood loss greater than 500 cc.
2. Place mother in appropriate position.
3. Check to rule out uterine atony and express clots.
4. If uterus contracted, assess for cervical, vaginal and perineal lacerations.
5. If uterus is atonic:
    a. Massage uterus to stimulate contraction;
    b. Administer antihemorrhagic agents;
    c. If hemorrhage is ongoing, perform bimanual compression;
    d. Examine the placenta to ascertain if any fragments or cotyledons have been retained. If so or if undeterminable, consider sterile uterine exploration if bleeding is severe, or prepare for transport if necessary.
6. Continue monitoring maternal blood pressure and pulse for signs of shock.
    a. If bleeding not under control or mother not stable, prepare for transport;
    b. Start IV bolus if time allows;
    c. If shock ensues, place mother in shock position, cover with warm blankets and administer oxygen until transport possible;
7. For follow-up postpartum care, advise client regarding complementary therapies for anemia.

B. Retained Placenta

1. Defined as placenta undelivered at 1– 2 hours postpartum with no excessive bleeding.
2. Encourage natural delivery of placenta with complementary therapies, including herbs, squatting, emptying bladder, etc.
3. If unsuccessful, perform manual removal.
4. If unsuccessful, consult backup and prepare for transport.
5. Watchfully wait if parents decline transport.

C. Maternal Fever

1. Defined as elevation of maternal temperature greater than 100.4°F postpartum.
2. Hydrate well, recommend bed rest and complementary therapies.
3. Assess for uterine infection:
    a. Odor, color, consistency of lochia, uterine tenderness, enlarged lymph nodes in groin area, malaise.
    b. If present, perform culture;
    c. Consult, collaborate or refer to obstetric care provider for evaluation/treatment as appropriate.
4. Assess for perineal integrity:
    a. Status of sutures (if any), purulent discharge, pain, edema, inflammation.

b. If signs of infection present, advise warm sitz baths and other complementary therapies; offer consultation for evaluation/treatment or transfer care to to an obstetric care provider as appropriate.

5. Assess for mastitis:
    a. Redness, tenderness, enlarged axillary lymph nodes, fever, chills, malaise.
    b. If present, advise frequent nursing, application of warm compresses, and massage to affected area.
    c. Offer consultation for evaluation/treatment or transfer care to an obstetric provider as appropriate.

D. Severe Vaginal or Perineal Laceration

1. Assess extent of damage and ensure bleeding is minimized;
2. Offer consultation for repair of 3rd or 4th degree laceration or transfer care to an obstetric care provider as needed.

E. Maternal Blood Type Rh Negative

1. Collect cord blood sample in the immediate postpartum period to determine Rh factor of baby's blood:
    a. If baby is Rh-, no further action is necessary;
    b. If baby is Rh+:
        i. Consider direct Coombs test; if positive, repeat maternal antibody screen.
        ii. Offer/administer Rhogam within 72 hours of birth.
        iii. When administerning Rhogam, monitor client (and advise client to monitor) for adverse effects.

F. Informed Consent/Refusal

1. If the client declines any recommended postpartum care in the presence of variation(s), the midwife should document client education and discussion of why the care is recommended, and obtain signed evidence of informed choice.

IV. Postpartum Variations: Neonatal

A. Newborn with Low Apgar Scores

1. Defined as Apgar of 1–3 at 1 minute, with no immediate improvement.
2. Simultaneously:
    a. Activate EMS;
    b. Perform neonatal resuscitation;
    c. Document all events, actions and decisions.

B. Respiratory Distress or Sustained Tachypnea

1. Initial postpartum: defined as sustained presence of grunting, nasal flaring, retractions, or respiratory rate <30 or >70 per minute;
2. Monitor and observe closely while administering blow-by oxygen and/or complementary therapies;
3. Ensure adequate thermoregulation of the newborn;
4. Continue to monitor until newborn has stabilized or the need to consult or transfer care is evident.

C. Neonatal Temperature Irregularities

1. Defined as a variance from the normal temperature of 97.7°F to 99.4°F.
2. Subnormal temperatures:
    a. Ensure adequate warming techniques;
    b. Monitor every 15-30 minutes;
    c. Prepare for transport if not responsive.
3. For elevated temperatures:
    a. Assess baby's clothing, blankets for over-warming;
    b. Assess baby's hydration;
    c. Evaluate for signs and symptoms of infection. Prepare for transport if signs of infection present;
    d. Offer consultation or transfer of care to pediatric care provider if temperature remains abnormal.

D. Newborn Jaundice

1. Before 24 hours: Offer consultation for evaluation/treatment or transfer care to pediatric care provider as needed
2. Mild jaundice (involving face, neck, and chest to umbilicus) occurring after 24 hours, advise client regarding:
    a. Frequent nursing;
    b. Sun baths with eyes protected in non-UV-protected window (or full-spectrum lights) up to 30 minutes, 2 times per day;
    c. Watchful waiting;
    d. Encourage passage of meconium.
3. Moderate jaundice (involving face, neck, chest and extremities) to severe jaundice (involving entire newborn, including sclera, soles of feet, palms of hands), advise client regarding all of the above and:
    a. Assess infant behavior and arousal state;

b. Alert, responsive baby nursing well is within normal limits;
c. If abnormal, offer consultation for evaluation/treatment or transfer care to to pediatric care provider as needed

E. Informed Consent/Refusal

1. If the client declines any recommended postpartum care for the newborn in the presence of variation(s), the midwife should document client education and discussion of why the care is recommended, and obtain signed evidence of informed choice.

V. Perinatal Death

A. Apparent Maternal Death

1. Activate EMS;
2. Perform CPR until responsibility of care is transferred to appropriate medical personnel;
3. Document all events, actions, and decisions.

B. Apparent Stillbirth

1. Activate EMS;
2. Perform NNR until responsibility of care is transferred to appropriate medical personnel;
3. Document all events, actions, and decisions.

C. Client Support for Suspected or Confirmed Perinatal Death of Baby

1. Consult with or facilitate transfer of care to an obstetrical provider for confirmation of death and assistance with care planning;
2. Discuss birth options with client:
    a. Place of birth (home or hospital);
    b. Medication;
    c. Ensure supportive network in place for immediate postpartum.
3. Care during the immediate postpartum:
    a. Encourage parents to hold the baby;
    b. Give second opportunity to see baby;
    c. Offer to bathe and dress infant;
    d. Take pictures;
    e. Encourage naming the baby;
    f. Offer tangible mementos, such as footprints, crib card, or lock of hair.
4. Maintain frequent supportive postpartum communication and contact with client/family;
5. Provide information regarding access to community resources (i.e. counseling and support through the grieving process) to ensure the client and family's physical, spiritual and emotional needs are met.

D. Professional Support for Perinatal Death

1. Schedule Peer Review for any perinatal death over 20 weeks' gestation;
2. Professional counseling or therapy is encouraged to ensure the midwife's physical, spiritual and emotional needs are met.

Limitations of Practice

1. The midwife recognizes certain conditions as high-risk and generally deemed inappropriate for home birth. The midwife shall make every effort to educate parents as to the risks and assist them in transfer to physician and/or hospital care when necessary.

2. The midwife will not perform any surgical procedure other than an episiotomy when indicated, cutting the umbilical cord, and/or perineal/vaginal repair.

3. Drugs:
    a. The midwife shall not administer any drug without prior instruction as to how it is administered and knowledge of side effects.
    b. The midwife shall not administer oxytocin (Pitocin) prior to delivery of the infant.

4. The midwife shall not use mechanical means to assist birth.

5. Each midwife shall consider using a signed consent form from the parents stating agreement to, and understanding of, any procedure and responsibility accepted for it.

6. Exceptions to the above limitations may be made only with the fully informed agreement of the woman and her health care providers, and may be subject to additional restrictions.

7. Exceptions to the above limitations may be subject to evaluation by a Practice Review Board, as established by the MMA Practice Committee.

8. Exceptions to the above may be appropriate in certain settings by protocol by trained and experienced midwives in emergency situations.

Appendix 1: Transfer Criteria

It is inevitable that a certain percentage of clients will require care beyond the scope of midwifery. Transfer to the OB practice and/or hospital may occur if any of the transfer criteria are met. When a primary care provider decides that a woman and/or baby must be transferred, the family will participate in the decision-making process and will be given a full explanation of the immediate problem and reason for the decision.

Transfer Criteria During Pregnancy:

Severe unresponsive anemia
Infection
High blood pressure
Pre-eclampsia
Acute proteinuria
Rh sensitization
Small for gestational age
Large for gestational age
Threatened preterm labor
Placenta previa or abruption

Transfer Criteria During Labor:

Prolapsed cord
Abnormal bleeding
Fever of 100º F or greater taken orally on two occasions, two hours apart, or any other evidence of active infectious process
Development of pre-eclampsia
Meconium-stained amniotic fluid with evidence of fetal distress
Evidence of fetal distress unresponsive to a variety of therapies
Uterine dysfunction unresponsive to noninvasive/alternative therapies
Failure to progress in labor
Dehydration and exhaustion
Intrapartum blood loss greater than 500 cc
Development of other severe medical/surgical/obstetrical problem
Client desires to transfer to the hospital
Any medical/surgical/obstetrical development requiring more complex treatment or equipment than is available at home

Appendix 1 *(continued)*

Transfer Criteria During the Postpartum Period:

Retained placenta after unsuccessful attempted manual removal
Lacerations requiring repair in a hospital
Uncontrollable third or fourth stage hemorrhage
Development of pre-eclampsia
Severe hematoma
Evidence of active infectious process
Development of other severe medical/surgical/obstetrical problem
Any condition requiring more than 12 hours of postpartum observation

Transfer Criteria for the Newborn:

Chest compressions required during resuscitation at birth
Very little or no muscle tone
Weight less than 2200 grams / 5 pounds
Respiratory distress syndrome
Prolonged resuscitative efforts
Cardiac irregularities
Central cyanosis
Any cyanosis persisting after 24 hours of birth
Jaundice within first 24 hours
Exaggerated tremors/seizures
Any sign of infection
Significant temperature deviation (taken rectally)
Persistent hypothermia (less than 36º C / 96.8º F) more than 2 hours after birth
Medically significant anomaly
Any condition requiring more than 6 hours of continuous care post-birth
Any condition requiring more than 12 hours of observation post-birth
Hypoglycemia unresponsive to treatment such as (but not limited to) feeding difficulty, apnea, irregular respiratory effort, cyanosis, weak or high pitched cry, twitching, lethargy, dysmaturity
Failure to urinate or pass meconium within 48 hours
Edema
Lethargy that inhibits breastfeeding
Suspected or diagnosed birth injuries

Appendix 2: Equipment and Supplies

MMA recommends that all midwives maintain the equipment necessary to assess maternal, fetal and newborn well-being, maintain aseptic technique, respond to emergencies requiring immediate attention, and resuscitate mother and newborn when attending an out-of-hospital birth. The following list serves as a basic guideline:

(a) Anti-hemorrhagic agents;
(b) Antiseptic scrub;
(c) Birth-certificate paperwork;
(d) Blood pressure cuff;
(e) Bulb syringe;
(f) Equipment for amniotomy;
(g) Equipment for administering injections;
(h) Equipment for administering intravenous fluids;
(i) Flashlight or lantern and batteries;
(j) Heat source for newborn resuscitation;
(k) Sterile hemostats (three);
(l) Infant and adult resuscitation equipment;
(m) Infant suction catheter with mucus trap;
(n) Labor, delivery, postpartum and statistical records forms;
(o) Nitrazine paper;
(p) Scales and measuring tape;
(q) Sealable plastic containers for blood and bodily fluids;
(r) Sharps and rigid sealable containers;
(s) Sterile and non-sterile exam gloves;
(t) Stethoscope and fetoscope;
(u) Thermometer;
(v) Umbilical-cord occlusion devices;
(w) Urine dipsticks;
(x) Venipuncture equipment;
(y) Sterile suturing equipment.

Appendix 3: Sample Screening Tool for Postpartum Depression

Edinburgh Postnatal Depression Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt *during the previous week*. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Appendix 3 *(continued)*

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- ☐ Yes, all the time
- ☒ Yes, most of the time — This would mean: "I have felt happy most of the time" during the past week.
- ☐ No, not very often — Please complete the other questions in the same way.
- ☐ No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Resources

American College of Obstetricians and Gynecologists. "Intrapartum Fetal Heart Rate Monitoring." *Practice Bulletin*, no. 62, 2005.

American Heart Association. "Neonatal Resuscitation: 2010 AHA Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care." *Circulation*, no. 122, 2010.

Amnesty International. *Deadly Delivery: The Maternal Health Care Crisis in the USA.* London: Amnesty International Secretariat, 2010.

Centers for Disease Control and Prevention. "Prevention of Perinatal Group B Streptooccal Disease: Revised Guidelines from CDC, 2010." *Morbidity and Mortality Weekly Report*, vol. 59, no. RR-10.

Coalition for Improving Maternity Services. "Evidence Basis for the Ten Steps of Mother-Friendly Care," *The Journal of Perinatal Education, vol.16, no. 1.* Lamaze International, 2007.

Cox, J., Holden, J., Sagovsky, R. "Detection of Postnatal Depression: Development of the 10-Item Edinburgh Postnatal Depression Scale," *British Journal of Psychiatry* 150:782-786, 1987.

Davis, E. *Heart & Hands: A Midwife's Guide to Pregnancy and Birth*, 4th ed. Berkeley, California: Celestial Arts, 2004.

Enkin, M., Keirse, M., Neilson, J., Crowther, C., Duley, L., Hodnett, E., and Hofmeyr, J. *A Guide to Effective Care in Pregnancy and Childbirth*, 3rd ed. Oxford: Oxford University Press, 2000.

Frye, A. *Holistic Midwifery: A Comprehensive Textbook for Midwives in Homebirth Practice, Vol. I, Care During Pregnancy*. Portland, Oregon: Labrys Press, 1998.

Frye, A. *Holistic Midwifery: A Comprehensive Textbook for Midwives in Homebirth Practice, Vol. II, Care of the Mother and Baby From the Onset of Labor Through the First Hours After Birth.* Portland, Oregon: Labrys Press, 2004.

Gruenberg, B. *Birth Emergency Skills Training: Manual for Out-of-Hospital Midwives.* Duncannon, Pennsylvania: Birth Muse Press, 2008.

Klein, S., Miller, S., Thompson, F. *A Book for Midwives: Care for Pregnancy, Birth, and Women's Health.* Berkeley, California: The Hesperian Foundation, 2004.

Midwives Alliance of North America, "Core Competencies for Basic Midwifery Practice." Midwifery Alliance Board, 1994.

North American Registry of Midwives. *Certified Professional Midwife Candidate Information Bulletin.* January 2008.

Sakala, C., Corry, M. *Evidence-Based Maternity Care: What It Is and What It Can Achieve.* New York: The Milbank Memorial Fund, 2008.

Varney, H. *Varney's Midwifery,* 4th ed. Sudbury, Massachusetts: Jones and Bartlett, 2004.

Weaver, P., Evans, S. *Practical Skills Guide for Midwifery,* 4th ed. Bend, Oregon: Morningstar, 2007.

World Health Organization. *Care in Normal Birth: A Practical Guide.* Geneva: WHO Safe Motherhood Technical Working Group, 1996.

Massachusetts Midwives Alliance Peer Review Form

Name _____ Date _____

Organization _____ Membership Number _____

Peer Review Encounters:

Date	Topic/Incident and others present	Time Spent	Initials
_____	_____	_____	_____
	_____		
	_____		
	_____		
_____	_____	_____	_____
	_____		
	_____		
	_____		
_____	_____	_____	_____
	_____		
	_____		
	_____		
_____	_____	_____	_____
	_____		
	_____		