Little Orchids Childbirth Services
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STANDARDS, DUTIES, AND GUIDELINES FOR PRACTICE STANDARDS OF PRACTICE:

1. Strive to provide continuity of care for women & newborns during the perinatal period.
2. Foster the delivery of safe and satisfying care.
3. Recognize that childbearing is a family experience.
4. Uphold the right of the woman/family to informed consent and self-determination, within the boundaries of safe care.
5. Focus on health and personal growth of a woman during the reproductive years.
6. Work as an independent midwife, and work towards an interdependent relationship within a health care system capable of providing consultation & referral.
7. Involve myself with opportunities for continuing education that will enhance professional growth & development and complete the CEUs required by my license/certification.
8. Perform duties with professional competence.
9. Participate in ongoing peer evaluation.
10. Keep all aspects of license/certification current.

DUTIES AND RESPONSIBILITIES:

1. Job Description: The midwife assumes responsibility for the management and care of the essentially healthy woman and newborn throughout the childbearing period.
2. Client Records: Confidential client records are maintained documenting all care provided to the client including referrals to other healthcare providers.
3. Disclosure Statement: My disclosure statement shall be given to each client and family at the interview appointment. This includes my educational background, experience level, my certifications or licenses, professional affiliations, my services, expectations of my clients, and financial charges.
4. Informed Consent: If a client chooses to decline any offered service an informed consent will be signed by the client. If a client chooses to continue plans for a home birth after full discussion of any risks involved, this too will be documented. Any time this occurs it will be discussed in peer review.
5. Lab Tests: All women in my care shall receive required tests during their care, including at minimum initial labs, glucose testing of the client's choosing, and a CBC in the third trimester. Additional labs may be needed depending on the client's clinical needs.
6. Team Practice: I make every attempt to attend each birth with another trained assistant or midwife, and I have 24-hour on-call service always.
7. Asepsis: All equipment used in my practice will be maintained in an aseptic manner and kept in good working order.
8. Advance preparation: Prior to the onset of labor, arrangements are discussed regarding the transport of the mother and/or infant to a hospital, and all clients must be in agreement to transport if I believe it has become necessary.
9. Newborn Screening: The baby's physician will be responsible for newborn screening within two weeks of the birth. In South Carolina I will perform the Newborn Screening will be performed by me at the three day postpartum.
10. Birth Registration: I will file the birth certificate for the parents. A certified copy is available for a fee at the Vital Records department.
11. Risk Status: An initial risk assessment is done and ongoing risk status is revised as necessary. Referrals and/or consultation will occur as appropriate or required by law.

GUIDELINES OF PRACTICE:

Part 1- Normal prenatal care

A. The midwife's duties include a maternal, family, previous pregnancy/obstetric history; reviewing previous health and surgical history; determination of dates; referral for PAP and other cultures as indicated; basic physical and breast exam; ordering of blood work (type & factor, antibody screen, rubella, CBC with differential, RPR and HbsAg). Other tests such as various titers, blood sugars, GBS cultures, HIV & MSAFP are available upon request. A diet history will be taken and nutritional recommendations made.

B. Following the initial visit, the client is rescheduled at 4-week intervals until 30 weeks, then every 2 weeks until 36-37 weeks, then weekly until she delivers. One visit to the client's home will be made to assess facilities and appropriateness/readiness for homebirth at 36-37 weeks.

C. In South Carolina, the parents will schedule two visits with a physician, nurse practitioner, or nurse midwife for risk assessment. One of these visits will occur in the last six weeks of pregnancy.

D. Routine prenatals include weight, BP, urine dip for protein, glucose, nitrites, leukocytes, blood and ketones; measuring fundal height and baby's growth; fetal heart tones; evaluating baby's presentation, position, and activity; and maternal nutritional, exercise, and psychosocial well-being. Any additional labs are to be ordered, including hgb, Rh antibody screening, glucose tests if indicated, etc.

E. A chart is maintained for each woman and includes observations, lab results, records of consultations and referrals, records of L&D and postpartum care, and all other pertinent medical and psychosocial data. This chart is to be made available upon request and with the client's written or verbal consent to any physician or other health care provider, who is called upon for consultation, referral, or in the event of a hospital transport.

F. A home visit is made at 36-37 weeks gestation, and the following are assessed:

1. Facilities, including cleanliness and appropriate preparation
2. Supplies
3. Adequate temperature control
4. Availability of a phone & ER numbers posted
5. Transportation readiness
6. Issues relevant to a home birth are discussed during prenatals and at the home visit, including signs of labor, when and how to contact me, father's participation, sibling preparation and plans for them, meeting others who are invited to be present at the birth, nursing preparation, and emergency transport.
7. Also noted is discussion of the parent's choice of newborn health care provider.

<u>Part 2- Contraindications for Home Birth</u>
I do not assume primary care of clients with the following conditions:

A. Diabetes, essential hypertension, active TB, heart, lung, liver or kidney disease, cancer, bleeding disorders, or any other major medical problem or congenital abnormality that affects childbearing

B. History of Deep Vein Thrombosis or pulmonary embolism

C. Use of psychotropic medication (not including antidepressants) or evidence of significant mental illness

D. Substance Abuse

E. Smoking cigarettes with no likelihood of quitting or changing

F. Preeclampsia

Part 3- Prenatal Conditions Requiring Consultation and or referral:

A. Active syphilis, gonorrhea, or chlamydia.
B. Unresolved signs of PIH.
C. Vaginitis, which doesn't respond to alternative or OTC meds
D. UTI, which doesn't respond to alternative or OTC meds.
E. Anemia, which doesn't respond to alternative or OTC meds.
F. Persistent glucosuria or other signs & symptoms of diabetes.
G. Third trimester vaginal bleeding.
H. ROM prior to 37 weeks.
I. History of genetic abnormalities.
J. Prior obstetrical problems, e.g. uterine abnormalities, placent accreta or abruption, incompetent cervix.
K. Polyhydramnios or oligohydramnios.
L. Abnormal PAP (Class III or greater).
M. Size/dates discrepancy.
N. Suspected malpresentation.
O. Suspected twins/multiples or breech.
P. Indications that the baby has died in utero or unexplained decrease in fetal movement.
Q. Rh-negative mother with positive titers.
R. Signs of preterm labor (before 37 weeks).
S. Gestation past 42 weeks.
T. Fever of 100.4 degrees for longer than 24 hours.
U. Herpes: Initial primary outbreak any time during pregnancy.
V. Abnormal fetal heart tones.
W. Intrauterine Growth Restriction.
X. Signs of placental previa or abruption.
Y. Active herpes when beginning labor.
Z. Fetus with congenital anomalies that may require immediate medical attention.
AA. Conditions requiring consultation or referral by law.

Midwives recognize the medical factors of risk involved with some situations including breech birth and twin pregnancies. It is my policy to counsel any client with these situations regarding these risk factors for both herself and her baby. I encourage the parents to make a responsible decision in conjunction with their physician, while upholding the right of the consumer to informed consent and self-determination.

The intrinsic right of the parents to choose their place of birth is recognized, and within the bounds of my training and my comfort level I shall not be prohibited from aiding the clients with their choice. If unusual conditions exist an informed consent will be signed. I reserve the right to withdraw care if situations arise that are irreconcilable or are outside my training and/or comfort level.

"REFER" is defined by Webster as: To send or direct for aid, information, etc." Women have the right to decline referral. Again, if referral is declined, informed consent will be documented.

Part 4: Normal Intrapartum Care

A. During labor & delivery, the following is done:
    1. Monitoring of the well being of the mother & baby. Initial vitals are taken upon

arrival, as soon as the client is ready. They are repeated every four hours if normal, more often as indicated if not normal; Periodic auscultation of FHTs- every half-hour once labor has been established, more often as labor intensifies, after every two to three contractions once pushing has begun; Vaginal exams when I arrive and as often as necessary after that, unless ROM has occurred with no active labor.

2. Coaching the mom.
3. Assisting the birth.
4. Examining and assessing the newborn.
5. Managing any third stage bleeding.
6. Inspecting the placenta, membranes and cord vessels.
7. Inspecting the perineum, vagina, and if necessary the cervix.
8. Assuring that lacerations are repaired as necessary.
9. Provide care for the mother and infant for at least 2 hours postpartum or until the mother's and infant's conditions are stable, whichever is longer.

Part 5: Intrapartum Conditions Requiring Consultation and/or Transport, and Responsibilities During Transport

A. During labor or postpartum the following conditions will require hospital transport.
   1. Signs of preeclampsia
   2. Fever over 100.4 degrees
   3. PROM accompanied by diminished maternal or fetal well being
   4. Evidence of fetal distress as indicated by fetal heart rate unless birth is imminent
   5. Abnormal amount of bleeding before delivery.
   6. Significant meconium-stained fluid with birth not imminent.
   7. Prolonged labor accompanied by potential or actual diminished maternal or fetal well-being.
   8. Signs of maternal shock.
   9. Severe maternal hemorrhage.
   10. Retained placenta or parts.
   11. Unexplained pain.
   12. > Two hours 2nd stage with no progress.
   13. Maternal desire.

B. In the event that the client is transferred to a hospital, I make every effort to remain with her. I make a telephone report advising the hospital that I am transporting, then I make a report to the RN on duty, and then I make a report to the doctor. Records will be provided with client's permission.

Part 6: Normal Postpartum Care

A. I, or an assistant/apprentice midwife, will see or call my clients at 24-36 hours postpartum and will see them in their home between three and four days postpartum.

Responsibilities include ascertaining that the mother's lochia is normal, fundus is firm, no signs & symptoms of infection, is successfully breastfeeding, and that she is getting adequate rest and support, both mom and baby are voiding without difficulty, and that the baby is stable, alert, breathing normally, that the heart sounds normal and that the heart rate is normal, that the cord is healing properly and that the weight loss/gain is normal, and that there are no signs of infection.

B. I recommend that the mom have a pediatrician, family practice doctor, or another provider chosen for newborn care.

C. For the Rh- woman, I obtain cord blood at birth and get a type and Rh factor. If indicated, I administer or refer for administration the Rhogam within 72 hours.

D. I am always available by telephone or cellphone for my clients through 6-weeks postpartum. If I am out of town, I make arrangements for another midwife to take call.

E. It is available for my clients to see me at 2-3 weeks postpartum for a "casual visit" to weigh the baby and discuss questions.

F. I provide a 6-week postpartum visit which includes:

1. Weight of mom and baby.
2. Discussion of birth control and referral when indicated.
3. Inspection of tears and/or repairs and assess healing if necessary.
4. Answer questions, which have arisen.
5. Provide referrals as indicated.

<u>Part 7: Postpartum conditions requiring consultation, referral or transport as indicated.</u>

A. Newborn problems:

1. Apgar score of less than 7 at 10 minutes.
2. Baby with obvious anomaly.
3. Respirations with grunting, retractions, nasal flaring and tachypnea.
4. Cardiac irregularities.
5. Persistent pale, cyanotic or gray color.
6. Jaundice within 24 hours of birth.
7. Abnormal cry
8. Signs of prematurity or postmaturity.
9. Absence of passage of meconium or urination during first 24 hours.
10. Lethargy or poor feeding.
11. Any other conditions which the parents or I have questions about.
12. Any other condition requiring consultation or referral by law.

B. Maternal Problems:

1. A laceration beyond the ability of the midwife to repair.
2. Persistent uterine atony.
3. Excessive bleeding.
4. Inability to void within 6 hours of birth.
5. Fever greater than 100.4.
6. Foul smelling lochia.
7. Failure of episiotomy or tear to heal properly.
8. Pelvic, leg or chest pain.
9. Signs of postpartum shock.
10. Insufficient involution.
11. Any other condition requiring consultation or referral by law