Oregon Midwifery Council
Community Practice Standards & Best Practice Guidelines

COMMUNITY PRACTICE STANDARDS

Midwives in Oregon are as different as the clients we serve but we all strive to provide safe care grounded in informed choice. Direct-Entry Midwives in Oregon are Certified Professional Midwives, Licensed Direct-Entry Midwives, and Traditional Midwives and while we each practice according to the practice standards and OARs applicable to us, including the MANA Standards and Qualifications for the Art and Practice of Midwifery, we also practice within the standards of our local communities.

We recognize that women are the central decision makers in pregnancy, birth, and postpartum and see our job as walking alongside them through the experiences of pregnancy, birth and postpartum and providing them with the information needed to make care decisions. We expect midwives to offer tests and procedures that are standard of care in Oregon, practice within the limits of their experience, and consult and/or transfer care as needed. We are united in the goal of providing safe and satisfying care to the women we serve.

When transfer of care to another provider type or to a hospital is indicated we rely on the Homebirth Summit Transfer from Planned Home Birth to Hospital Best Practice Guidelines. The homebirth community has been working together with supportive medical providers to improve the transport experience for families, midwives and receiving healthcare providers. We expect all midwives to participate in helping create a system that provides optimal outcomes while remaining respectful to all.

We value peer review as one of our main tools for learning from challenging or unusual cases and ensuring excellent care for the families we work with. We expect midwives to attend regular peer review as outlined in the Oregon Midwifery Council Peer Review Standards.

BEST PRACTICE GUIDELINES

The Oregon Midwifery Council Best Practice Guidelines are meant to be used as one of many tools to guide and improve home and birth center midwifery care. These Guidelines should not be construed as rules or requirements in the practice of midwifery in Oregon. Each client and each pregnancy, birth, and postpartum must be considered individually and no guideline will ever be appropriate to all situations. These guidelines are offered to support midwives and student midwives in the practice of midwifery centered in informed choice and respect for the autonomy of birthing people.

These Guidelines progress chronologically through clinical training of students, pregnancy, birth, and postpartum and then address some more complex situations individually.

Clinical Training Experience & Student-Preceptor Relationship

We recognize the clinical training or apprenticeship*experience as a core element of midwifery training, and we value high standards for students and preceptors. These best practice guidelines are intended to support quality care for clients, effective teaching practices for preceptors, and excellent training for student midwives.

* We use the terms clinical training and apprenticeship interchangeably within this document.

Anti-Racism Statement

OMC acknowledges that racism and white supremacy are deeply rooted in the histories of birth and midwifery in the United States. We know that systemic inequality due to racism results in poorer birth outcomes for Black, Indigenous, and People of Color, than for white people. We recognize that racism has been part of midwifery education, including clinical training, at the systemic and individual levels. OMC is committed to anti-racist action, reducing disparities, eliminating barriers, and improving educational experiences for BIPOC students. We hope that the practice guidelines outlined in this document contribute to fulfilling this commitment.

OMC strives to support students and preceptors in creating a learning environment that is inclusive and where Black, Indigenous, and all People of Color students and midwives feel welcomed and safe. To that end, OMC stands by the following:

- All preceptors and students who are white or benefit from white privilege are encouraged to participate in equity, anti-racism, and cultural humility training.
- OMC does not tolerate racist or white supremacist behavior and will take seriously any account of racism reported or witnessed by a student or midwife.
- In an effort to offer support and address racism within our community we invite students and preceptors to communicate with their regional representative or another member of the advocacy council about behavior or language which is experienced as racist. The advocacy council member can provide support or assist in seeking additional help in addressing the behavior or language.

OMC intends these actions to be educational and not punitive. We are all learning and we will all make mistakes. We want to encourage increased awareness and understanding of what it means to be anti-racist and support those who wish to make changes in this regard.

1. Power Dynamics in student-preceptor relationship

The student-preceptor relationship is based on mutual respect and cooperation.

1A. The power dynamic inherent in the student/preceptor relationship comes with the potential for healthy exchange or misuse. In most cases the preceptor holds more power than the student. As a community, we commit to holding each other accountable to prevent mishandling or abuse of power. The preceptor is responsible for establishing and maintaining a respectful and accountable training relationship.

1B. We also recognize that students are active participants in their apprenticeship/training relationships and are responsible for professional, respectful, and responsible behavior towards the practice, the preceptor, and the clients.

2. Preceptor Responsibilities

The preceptor is responsible for following the requirements and guidelines in the NARM Preceptor Handbook (http://narm.org/preceptors/preceptor-handbook-and-registration/) including:

- Being physically present during student experiences and whenever the student is performing clinical skills.
- The specific requirements for primary under supervision. This includes allowing and encouraging the apprentice to manage the labor, birth, and immediate postpartum under the preceptor's supervision, and only becoming involved as necessary for safety or educational purposes. (http://narm.org/pdffiles/PreceptorRegHandbook.pdf **Page 7)**
- Only signing off on experiences performed competently by the student.
- Committing to sign for an experience or skill rightly attended or earned without retraction.
- Completing the paperwork the student needs for credentialing in a timely manner.

3. COMMUNICATION & AGREEMENTS

3A. Before the apprenticeship begins, the preceptor will provide a written agreement with clear expectations for both the student and the midwife. This agreement will be reviewed and discussed and signed before clinical training begins. Students will communicate any concerns about meeting the set expectations as they arise. This agreement can be revisited as needed

throughout the apprenticeship. Both student and preceptor(s) are responsible for upholding the agreement. The contract should clearly communicate expectations for each party, and should have a mechanism for regular review. A trial period is highly recommended.

- At a minimum, the agreement will include:
  - Information about the trial period if applicable
  - Workload, call schedule, on-call expectations, appointment etiquette, off-call agreements, and schedule change communication (see Community Standard #4, below)
  - Expectations about attending peer review
  - Expectations about NRP and BLS training and renewal
  - Expectations of PEP students re: participation in structured learning for the academic/theory part of training
  - Expectations related to dress
  - Plan for debriefing births for student learning
  - Schedule of student/preceptor periodic review of the student's progress
  - Quantity of administrative, cleaning, and other non-clinical work expected of the student.
  - Conflict resolution options
  - Clear expectations of a student's skills/abilities before beginning their primaries
  - Reasons for termination and plan for early termination
  - Confidentiality including HIPAA requirements
  - Practice policy regarding student involvement in multiple apprenticeships; including any flexibility or exceptions
  - Financial expectations
  - Expectations regarding contact with clients outside of clinical experience
- Sample contract
  - The Oregon Midwifery Council can provide a sample apprenticeship agreement to midwives or student midwives upon request.

3B. Students are responsible for communicating availability conflicts with as much advance notice as possible.

3C. Students and preceptors will seek assistance from a third party such as another midwife or member of the Oregon Midwifery Council, if they are unable to resolve a conflict directly. Conflict-resolution should involve a plan for how to move forward and when to reassess the situation.

3D. Preceptors are responsible for modeling effective communication.

- Communication between student and preceptor should be clear, kind, and professional.
- Preceptors should give both positive and constructive feedback to students during reviews
- Preceptors should not reprimand students in front of a client. Necessary and urgent corrections in front of clients can be done as respectfully as possible under the circumstances.
- Students should not disagree with a preceptor in front of a client, unless there is an urgent safety concern. They should save detailed questions/feedback for outside of appointments.

4. WORKLOAD & OFF CALL TIME

4 **A.** The student-preceptor relationship and clinical training experience is designed to be a fair exchange. As part of this exchange, students should expect to be available for some mutually agreed upon amount of administrative, cleaning, or other non-clinical work related to the practice.

- Time spent doing non-urgent administrative tasks (e.g. MANA stats) should not displace the debriefing of a birth, client care, or any kind of educational opportunity, such as allotted time to review specific skills.

4B. Negotiation of number of births a student is expected to attend monthly should be part of initial agreement and contract and renegotiated as needed with full agreement with informed consent and free from coercion.

4C. Preceptors need to be sensitive to the student's need to support themselves and the need to work outside of midwifery.

4D. Students should have access to a minimum of 14 days off-call time per year in an apprenticeship, without threat of repercussions by the preceptor. Students are expected to communicate ahead of time with their preceptors in order to arrange off-call time, and a preceptor can grant or deny a particular request.

5. STUDENT EVALUATION & STUDENT/PRECEPTOR ASSESSMENT

5A. At least once every 3 months, student and preceptor will meet for evaluation/review. This review will cover positive feedback, areas of concern, and goal-setting.

- See: http://narm.org/pdffiles/PreceptorRegHandbook.pdf appendix, for an evaluation form example.

5B. Students are responsible for staying current with their clinical training documentation and should request frequent sign offs from their preceptor(s). Clinical experiences should be signed off at least every 60 days or as decided upon between student and midwife in their contract

5C. Preceptor and student will regularly debrief birth experiences for student learning. The student and preceptor should each take an active role in making time/space to debrief every birth, ideally within 7 days of the event. The preceptor will also make time to debrief non-birth clinical experiences as needed.

5D. Student will be included in ongoing risk assessment and chart review, and will attend peer review regularly with preceptor.

5E. Preceptors and students will hold regular "drills" for emergency skills review.

5F. The preceptor will communicate clear expectations of a student's skills/abilities before beginning their primaries and at each phase of transitional growth.

6. CLIENT EXPERIENCE, CLIENT RIGHTS,

6A. Client consent must always be obtained at every step of the way in midwifery care, by all members of a midwifery team. This includes consent for, and understanding of, student participation in hands on care.

- Students and preceptors hold the client's autonomy and right to give or take away consent as an essential guiding principle for care. As students are learning and practicing skills, they must hold the client's autonomy and right to decline care from a student above the student's acquisition of skills practice.
- Preceptor and student should have a mutually agreed upon plan in the event that a client communicates discomfort with a team member, including a student.

6B. Information about the student's role in the practice should be included in the practice's informed disclosure, as well as mentioned during the initial interview.

- Preceptors must disclose to clients that the midwifery practice has a student(s), whose skills are currently being refined under the supervision of the preceptor(s) in the practice. The disclosure should include that particular students' role, which includes performing skills on the client in the assist role, or in the case of primary under supervision, the students role will be of a primary midwife on the team, under the supervision of a preceptor.
- Students should be present at interviews when possible to give clients an accurate sense of the practice and give students experience of interviews.

- Preceptors will communicate to both clients and students if and when it is appropriate for the client to contact students directly with clinical questions or other needs between visits.

6C. Preceptors will evaluate student involvement in emergency situations on a case by case basis, balancing the safety and experience of the client with the need for experience of the student.

7. TRAINING FOR PRECEPTORS

7A. Before taking on a student midwife, preceptors will:

- Be clear that they *want* to work with student midwives
- Have sufficient midwifery experience and clinical competence per NARM guidelines: https://narm.org/preceptors/
- Complete midwifery preceptor training. Here is a list of suggested resources: http://narm.org/preceptors/narm-preceptor-resources/

7B. Recommended topics for preceptor training:

- NARM guidelines
- Key components of preceptorship
  - Direct Supervision
  - Debriefing
  - Mutual learning
  - Changing roles over time and experience
  - Clear expectations on both sides
  - What are the preceptorship community standards
- The progression of skills acquisition (theory, observe, step by step guidance, practice, perform skill)
- How to assess student readiness for a skill and how to relinquish hands-on control
- Appropriate preceptor-student boundaries
- Communication skills for giving and receiving feedback
- Student/preceptor power dynamics
- Bullying, abuse, and lateral/horizontal violence
- Cultural humility/anti-racism
- Confidentiality
- Initiation, cultivation, termination or completion of student/preceptor relationship
- Principles of adult education

7C. Ongoing preceptor training should be a regular part of continuing education for preceptors.

Primary Risk Assessment

Things to assess and consider before you accept a client into your care and during the first appointments. This list is meant to help you evaluate potential clients and decide what risks you are or are not willing to take on. With each potential client, we are responsible to assess the risks and determine whether we are a good care option for this person and, if so, can we intervene to mitigate some of the risk. If you have any concerns about taking a potential client, discuss with a peer (either at peer review or in private consultation).

1. Historical Perspectives and Experiences, evaluate for:
    - Hostility toward previous healthcare provider by mother or partner
    - Someone who has sued another healthcare provider in the past
    - Extreme aversion to transfer
    - Social relationship: family members opposed to homebirth who are involved with client, obvious violence, partner always speaking for her, etc.
2. Psychosocial
    - Affect/communication/ability to understand what's being communicated.
    - Level of responsibility they are willing to take: financially, nutritionally, personal health, communication (answers questions, returns phone calls, shows up to appointments)
    - Language barrier
    - Literacy
    - Ability to access resources
    - Prior involvement of protective services, child removed from the home.
3. Health History
    - Health/Medical/Surgical history
    - Ob/Gyn history including STIs
    - Family health history
    - Prior drug abuse
    - OARs Risk Assessment Criteria: Absolutes and Non-absolutes
    - Late to care
    - Access to current or previous records
4. Midwife's Self-Assessment
    - Appropriate boundaries
    - Impression
    - Intuition
    - Appropriate skill level and/or experience

Consult with another midwife if you are noticing a significant layering of risk factors.
The more risks factors present, the more consideration should be given to planning your care or not initiating care.

Ongoing Prenatal Risk Assessment

Midwives engage in an ongoing process of risk assessment that begins during the initial consultation and continues through the completion of care which will include the following:

- At every prenatal or on-going:
  - Evaluate maternal nutrition
  - Maternal: BP, pulse, offer a weight check, to establish baselines and assess maternal well-being
  - Fetal: evaluate fundal height, abdominal palpation, FHT; to assess for fetal growth, position, and well-being
  - Psychosocial issues assessment, including but not limited to physical safety, socioeconomic status, obstacles to accessing care, mental health and emotional status
  - Provide education when appropriate on the following topics: pregnancy, labor and birth, breastfeeding, postpartum and newborn care
  - Offer labs/external services with informed choice/shared decision making including but not limited to: OB Panel, genetic screening, STI screen, GD screen, GBS screen
  - Assess and address maternal discomforts
- Offer breast exam evaluation for breastfeeding
- Evaluate client responsibility and follow-through (ex: keeping appointments, upholding financial agreement, upholding care agreements)
- Offer vaginal exam in late pregnancy
- Offer ultrasound to evaluate dating, fetal development, and position as needed
- At 4+3 weeks begin following postdates guideline

The assessment and plans for on-going risks will be charted at each visit and the midwife will consult or transfer care when appropriate, including for possible cumulative risks that are neither non-absolute or absolute (per OARs).

35 Week Risk Assessment

As the client approaches term the midwife will review and assess risk factors including:

- Labs and ultrasounds
- Health History
- Ob/Gyn History
- Baseline and/or changes in Maternal Vitals
- Baseline and/or changes in Fetal Heart Tones
- Fetal growth and position
- Any ongoing issues resolved or appropriate follow-up (for example anemia or recurrent UTIs)
- Bleeding in pregnancy
- Presence of any absolute or non-absolute risks (OARs)
- Social-emotional health
- Moms preparedness/expectations for birth, postpartum and breastfeeding

- Appropriateness for midwifery care and OOH birth

Midwife will chart risk assessment and plan at 35-36 weeks and review at term.
Consult with another midwife if you are noticing a significant layering of risk factors.
The more risks factors present, the more consideration should be given to planning your care or transferring care.
Ask yourself, at what point is the client risked out?

Labor Guidelines

Initial Contact Assessment
When a client calls to report signs of labor, midwife will:

- Assess if there is an immediate need for the birth team's presence,
- If the midwife's immediate presence is not required, additional assessment may include:
    - Review prenatal course and relevant risk factors
    - Emotional well-being, labor coping
    - Rest and hydration
    - Contraction pattern: strength, duration and frequency as reported
    - Evaluation of amniotic fluid, if ROM has occurred
    - Fetal movement
    - Evaluation of birth environment and support system
    - ROM (see below)
- The assessment and plan should be charted including the midwives' interpretation of the assessed data, actions necessary to address the assessments, and define the time frame for next steps.
- Give the client any information appropriate for labor coping, nutrition, hydration, rest
- In addition, provide information regarding reducing the risk of infection with ROM

Initial Labor Assessment will include:

- Ideally, a midwife will be present for the initial labor assessment. If another birth team member arrives first she will consult directly with a midwife about the initial assessment unless needs of direct care prevent this (i.e. precipitous birth)
- Review prenatal course and identified risks
- Maternal vital signs
- Emotional well-being, labor coping
- Hydration and voiding
- Contraction pattern: strength, duration and frequency
- Fetal heart tones before, during and after contraction, minimum two minutes to establish baseline
- Evaluation of amniotic fluid, if ROM has occurred
- Position of baby
- Fetal movement
- Evaluation of birth environment and support system
- The assessment and plan should be charted including the midwives' interpretation of the assessed data, actions necessary to address the assessments, and define the time frame for next steps.

Equipment Setup

- Check and prepare equipment for resuscitation
- Lay out supplies for birth and hemorrhage

Ongoing 1st Stage Assessment:

- Throughout labor, midwife will regularly evaluate the following:
  - Maternal vital signs (minimum every four hours)
  - Change in emotional well-being, labor coping
  - Hydration and voiding
  - Contraction pattern: strength, duration and frequency
  - Fetal heart tones (see below)
  - Evaluation of amniotic fluid, if ROM has occurred
  - Position of baby, if applicable
  - Fetal movement
  - Change in birth environment and support system
  - Progress during labor and causes of slow progress
- Reevaluate assessment and plan every four hours and as risk factors arise, paying attention to the cumulative risks
- Consider vaginal exam to assess progress, fetal position, presenting part
- All of the assessment and plan should be regularly charted including the midwives' interpretation of the assessed data, actions necessary to address the assessments, and define the time frame for next steps.

Ongoing 2nd Stage Assessment

- Throughout second stage, midwife will regularly evaluate the following:
  - FHTs (every 10 minutes and listening during and after contraction regularly, more frequently if any concerns present)
  - Vitals every 4 hours, more often if indicated
  - Progress during pushing and causes of slow progress
  - Evaluate hydration, bladder, energy level, exhaustion
- Reevaluate assessment and plan every hour and as risk factors arise, paying attention to the cumulative risks
- Consider vaginal exam to assess progress, fetal position, presenting part
- Consult and/or transport should be considered if progress not seen with active pushing or if there is concern about exhaustion
- All of the assessment and plan should be regularly charted including the midwives' interpretation of the assessed data, actions necessary to address the assessments, and define the time frame for next steps.

Ongoing 3rd Stage Assessment

- Placenta
  - If placenta not delivered by 1 hour, assess cause, address at home if possible, consult if needed, and transport if indicated
  - Transport if placenta not delivered by 2 hours
- With no abnormal bleeding or vitals,

- assess vitals
- assess placental detachment
- at 30 min try non-allopathic methods, herbs, voiding, position changes, talk with mother
- evaluated for the need for catheterization
- consider pitocin injection (if within scope of practice)
- consider initiating transport prior to 2 hours

- With bleeding or non-reassuring vitals (low bp or elevated pulse)
  - Consider pitocin, misoprostol, or methergine as appropriate (if within scope of practice)
  - assess vital signs frequently
  - consider starting an IV or using an enema
  - oxygen
  - shock treatment
  - consider catheterization
  - consider manual removal if applicable, evaluate whether manual removal is possible/advisable
  - consider transport
- Reevaluate assessment and plan every 1/2 hour and as risk factors arise, paying attention to the cumulative risks
- Assessment and plan should be regularly charted including the midwives' interpretation of the assessed data, actions necessary to address the assessments, and define the time frame for next steps.

Fetal Heart Tone Monitoring:

Once the midwife has arrived at the birth, she will regularly evaluate and chart fetal heart tones.

- Every hour in early labor
- Every 20-30 minutes in active labor
- At least every 10 minutes or after every other push, as indicated, during second stage
- More frequently if concerns or abnormalities arise
- Midwife will use her discretion to alter the frequency of FHT assessment according to the clinical picture and maternal needs/requests

Rupture of Membranes

- Upon report of ROM, midwife should rule out what can falsely appear to be ROM
- When ROM occurs the midwife will assess in person, or by phone if the midwife has not arrived at the birth, the following: fetal movement, fluid color, contraction pattern, concerns of the mother, any prior concerns specific to particular mother and baby, FHT (if midwife is present)
- If the color of the fluid changes there will be further assessment of the plan

Community Standards: Immediate Postpartum Care

Midwife should stay and assess for minimum of 2 hours postpartum

<u>Maternal</u>

- Immediately after placenta check fundus, bleeding, pulse
- Vitals (pulse, BP) checked within 30 minutes of placenta then once an hour until leaving
- Assess temperature once before discharge and more if indicated
- Assess bleeding and fundus regularly.
- Encourage urination. If unable to urinate, assess bladder.
- Assess perineum, vagina, and anal sphincter within first two hours
- Ensure mother's questions about breastfeeding are addressed and encourage skin to skin contact
- Evaluate need for repair
- If repair needed, is repair within practitioner's scope of practice and skill level
- Provide informed choice regarding repair

Newborn

- Assess APGAR at 1 and 5 minutes, and 10 minutes if less than 7
- Assess color, tone and respiration regularly.
- Assess newborn temperature
- Perform a thorough and complete newborn exam including all vitals (heart rate, temp, resp rate)
- Administer, or provide access to (if not in scope), vitamin K and eye prophylaxis if parents have consented to these.
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If Rh negative mom, give informed choice re: collect cord blood and send/bring to lab

Before Departing

Perform full set of vitals on mother and baby within one hour of leaving
Provide oral and written maternal and newborn postpartum instructions

Community Standards: Postpartum Care in the First Week

At least two home visits, in absence of risk factors
First visit within 36 hours
Second visit at 2-4 days
Third visit at 7-10 days
Postnatal care given by midwife (not by an unsupervised student/apprentice)

BABY

- vital signs, including but not limited to temperature, heart rate and sounds, respiratory rate and sounds, color
- file birth certificate
- newborn screens (with informed consent)
- breastfeeding evaluation
- cord
- input/output, stool evaluation
- monitor weight gain/loss, monitor for 7-10% loss
- behavior and sleep patterns, neuro-muscular evaluation, behavioral milestones
- recommend hearing screening, provide referral information
- consider follow-up, including labs as indicated, for jaundice, birth injury

MOTHER

- vital signs, including but not limited to BP, heart rate, color, temperature
- evaluate fundus, perineum, lochia, breasts
- input/output
- support system evaluation
- sleep
- emotional state, mood disorder evaluation
- evaluation for infection
- appropriate intervention,, consult, labs or referral as needed
- provide opportunity for emotional evaluation of birth
- consider follow-up, including labs as appropriate, for hemorrhage, pre-eclampsia or concerning s/sx prenatally, incision/suturing
- Rho-gam if indicated
- Between visit phone contact as necessary, on-call status continues
- Follow-up with postpartum instructions, clarification of concerning signs to monitor

Community Standards: Postpartum Care Weeks 2-8

Visits Schedule

- Minimum of 2 from 2-8 weeks or more as indicated by individual client needs.

Baby

- adequate weight gain
- if breastfeeding issues are unresolved by 2 weeks, consider new strategies or referrals
- 2nd NB screen at or before 2 weeks
- if oral mephyton was chosen, recommend follow-up doses weekly for 12 weeks and provide at least 3 doses in your care
- auscultation of heart and lungs for rate and clarity of lungs
- assessment of skin including umbilical healing
- assessment of jaundice
- assessment of output
- assessment of normal physical development and developmental milestones
- assessment of normal maternal-child attachment
- assessment of birth trauma resolving (hematoma, bruising, birth injury)
- follow-up on any abnormal findings from newborn exams, or issues that arose in the first two weeks
- give information on family doctors/pediatricians, or specific referral if needed for specific reason
- follow-up on recommendation for hearing screen
- monitor healing if circumcised
- discuss care of the normal newborn penis if left intact
- provide vaccination information resources and referral as needed
- assessing healing of frenectomy as needed

Mom

- if breastfeeding issues are unresolved, consider new strategies or referrals (i.e. IBCLC)
- assess BP, pulse, bleeding, and appropriate involution of the uterus

- follow-up on perineal recovery plan, including offering to visually assess healing as appropriate
- assess for adequate nutrition and hydration
- assess for pelvic floor health and any lingering incontinence, constipation, or hemorrhoids
- discuss plan for family planning
- educate regarding resumption of sexual activity, ask about pain with sex
- Follow-up on any past issues and run appropriate labs (anemia, thyroid, glucose testing, etc.)
- Assess for PAP being due per ACOG guidelines, or revisit assessment done during pregnancy. Do or refer for PAP if indicated, or notify when next due.
- Assess postpartum mental health, including both disorders and normal processing of birth/motherhood, refer if appropriate.
- Assess for diastasis.
- Discuss plan for return to normal activity level.

Community Standards: Postpartum Care after Transport

First 48 hours

- Check in - either phone or in-person
- In person visit in hospital
- Stay with client until on PP unit (or otherwise settled for their postpartum stay)
- Provide support around breastfeeding initiation
- Communicate with other providers about client choice re: oral vitamin K administration and ensure that we provide it within proper time frames
- Communication with hospital about midwife's availability and plan for PP care
- Provide education around rebuilding flora for mom and baby if antibiotics were used
- Find out about what information they received regarding breastfeeding and then assess what additional and constructive info could support them
- Assess plans for placenta and help facilitate client choice
- Revisit plans for newborn procedures and reassess recommendations
- Work to facilitate bonding and attachment
- Ensure clarity around your availability by phone (we're still on-call for you)

When clients come home from hospital

- Home visit within 48 hours of hospital discharge
- Emotionally support the transition from hospital to home

Within first two weeks

- Normal PP care
- Follow up on newborn procedures (who is doing the second newborn screen, etc.)
- Screen for attachment disorder and bonding issues
- Screen for PPD
- Assess weight gain/loss and possible need for lactation support

Within first 6 weeks

- Provide opportunities for review of sequence of events leading up to transfer with the client
- Review recommendations for subsequent pregnancies (if impacted)
- Provide opportunity for client to share her experience of the story
- Provide opportunities to debrief with others at the birth (co-parent, grandparent, siblings)
- Request records from hospital
- Discussion about body healing (might be different depending on complications) and give resources
- Discussion about emotional healing (might be different depending on complications)
- Assess for newborn neurological development (possibly impacted by birth trauma)

On-Going

- General screen for PPD
- Appropriate outreach to clients and respect for client choice around PP care
- General screen for attachment disorder and bonding issues
- Provide resources as needed (i.e. Lactation, Baby Blues Connection, cranial-sacral therapy)

We agree there would be extra care if there is a situation that merits it, such as a baby in the NICU. With a baby in the NICU support maternal access to baby, help her get a breast pump

If a client discontinues care

- Formal contact to check in sometime in the first 6 weeks
    - (i.e. We're calling to check in. Your 2 week appointment would be on Friday, we're just checking in to find out what your hopes are for care.)
- Offer multiple opportunities for listening to client and family about their experience.

Post cesarean care

- Visually evaluate incision at PP visits
- Provide resources (ICAN, Homebirth Cesarean International)

Prolonged Rupture of Membranes

When a client calls with possible ROM the midwife will assess in person or by phone if the midwife has not arrived at the birth, the following:

- fetal movement
- amount of fluid and pattern of leaking
- fluid color
- contraction pattern
- concerns of the mother
- any prior concerns specific to particular mother and baby
- FHT (if midwife is present)

Once rupture of membranes has been confirmed by the midwife, she will see the mother within the first 24 hours and provide her with information about

- the risk of infection
- ways to reduce the risk of infection
- the option of hospital transport for induction of labor

If labor has not begun within 12-24 hours, consider:

- Drawing a baseline CBC.
- Encouraging labor with acupuncture, herbs, nipple stimulation or other methods appropriate to the situation and OOH midwifery care.

Prolonged Labor

Midwives perform and chart a general labor assessment every four to six hours. In a longer labor, especially after 24 hours of attendance in active labor, consider consulting with another midwife or physician. During pushing, consider consulting if mom has ROM and has been actively pushing without notable progress for three hours. Special attention should be paid to normal labor progress with VBAC, breech or postdates births (42+ weeks).

Postdates

Careful evaluation of dates, ultrasound, and menstrual cycle length will be done at the start of care to optimize the accuracy of pregnancy dating. Between 41and 42 weeks the midwife will re-assess the risk factors of this mother and pregnancy and then discuss risks and care options for postdates pregnancy. Fetal surveillance tests are offered every 3-4 days starting at 41+3. Reassessment of risk factors becomes more frequent after 41+3 and midwife will discuss risks and care options including transfer to hospital care for induction by 42 weeks. If pregnancy continues past 42 weeks, evaluation of mother and baby and discussion of risks and care options happens at least every 3 days. Out-of-hospital birth past 43 weeks is outside of our community standard of care.

Vaginal Birth After Cesarean

Midwives will offer thorough informed choice including the clear information about the risk of uterine rupture to clients considering OOH birth after a previous cesarean section. Care will be taken to evaluate whether each particular VBAC mom is a good candidate for OOH birth. Surgical report records will be acquired as part of accepting a client into care. Client education on optimal fetal positioning can be a useful tool. Midwife will offer ultrasound to evaluate position of placenta before labor. More frequent auscultation and vital sign assessment is appropriate. FHT are checked every 15-20 minutes in active labor and vitals will be re-evaluated

between regular assessments if any concerns arise. Consider transport for prolonged labor or irregular progress in active labor.