The Minnesota Midwives' Guild

Standards of Care

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The Minnesota Midwives' Guild Standards of Care
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Introduction and History

In 1975, Genesis was formed as a midwifery group in the Twin Cities area. The founding mothers of Genesis were and are women who spontaneously evolved from being mothers to being midwives to fill the void left by the retirement of Minnesota's last licensed midwife, Ebba Kirschbaum.

In time, other women in the Twin Cities and throughout the state began to attend to the needs of pregnant women desiring to birth at home. The Minnesota Midwives' Association (MMA) was formed in 1985 to provide a cohesive network for midwives in the state.

The Minnesota Midwives' Guild was formed in the fall of 1988 in response to a need for an all-inclusive statewide network for traditional midwives.

We see traditional midwifery as an art, and a craft uniquely passed from one woman to another; from one generation of women to the next. In our work, we honor the knowledge and the wisdom of our mothers, our grandmothers, and the mothers that came before them. We draw from the commonality and the diversity of our cultural and ethnic heritages to provide care that is unique to our area and its people.

We seek egalitarian relationships between our members, and the families we serve. In educating, supporting, and counseling women and their families before, during, and after childbirth, we impart our expertise, and remove ourselves from the role of expert. Our care emphasizes the time tested principles, methods, and values of traditional midwifery, and embraces modern, innovative concepts that are compatible with long standing midwifery traditions.

1996: This guide defines and delineates the practice of professional midwifery in the state of Minnesota for the purposes of self-regulation and NARM certification. Our intent is to gain recognition by the State of Minnesota, and to legitimize the status of Certified Professional Midwife under Minnesota law. Until a mutually satisfying agreement can be made for both parties, the MMG will continue to advocate for independent midwifery in Minnesota while defining safe practice standards and basic competency requirements for midwife members.

2001: The Minnesota statute recognizing licensure for Minnesota midwives was successfully re-activated and put into law. Traditional midwives in Minnesota may now apply to the Minnesota Board of Medical Practice for a license to practice traditional midwifery. The CPM credential is a licensure requirement but the licensing law is voluntary which does not require a midwife possess a license in order to practice. An advisory council has been set up through the Board of Medical Practice to oversee and advise the BMP on licensure applications and complaints/grievances.

MidwiferyNow! (MNow!) is a legal/political action group, and umbrella for legislative work, peer review, and support for midwives in Minnesota.

The MMG's most recent role in these historical changes is concerned with the maintenance and integrity of the Standards of Care. Licensed traditional midwives in Minnesota are required to adhere to and abide by these Practice Standards. The Standard of Care committee within the MMG is comprised of licensed midwives and CPMs.

Prenatal Care Standards

"Parents who choose to give birth at home are, in essence, saying that they are accepting full responsibility for their bodies, their pregnancies, and their babies."

Cheryl Bates

Acknowledging the need for common language, we define the prenatal period as the time from the first day of the last menstrual period (LMP) prior to conception to the onset of labor.

Pregnancy is a healthy life event. It is a unique and highly individual experience that brings commonality to the lives of most women. The obvious and subtle changes brought about by pregnancy prepare the woman for giving birth and mothering.

To optimize the health and well-being of the mother, the baby, and thus the family, every pregnant woman needs thorough prenatal care that entails observation, evaluation, education, and guidance toward making pregnancy a safe and satisfying time. The best possible outcome for both mother and baby is more likely to be achieved when prenatal care is comprehensive and begins within the first trimester of pregnancy. In recognition of this fact, the following guidelines were set:

The midwife must focus on the health of mother and baby. The place of birth is secondary. An expecting mother, and her family, should understand, and accept the advice of her midwife, but realize that she retains ultimate control over, and responsibility for her individual situation.

The midwife should emphasize the importance of good nutrition, exercise, sleep, rest, and relaxation, as well as spiritual/religious resources that may be needed to cope with the stresses of pregnancy, labor, and birth.

The midwife must be alert to potential complications that may arise from unresolved anxieties surrounding a woman's previous experiences, or preconceptions, regarding pregnancy, childbirth, motherhood, or childbirth in general.

The midwife reserves the right to terminate an agreement to assist a pregnant woman and her family, subject to the midwife's discretion, at any time she deems necessary, for reasons of emotional or physical safety. The date and reason for termination of care should be documented. A formal written notice of care transfer should be provided, along with a final assessment, and advice indicating alternate sources of care.

Regardless of the possibility that care will need to be transferred, the midwife should never compromise safety, or fail to provide appropriate care during any stage of pregnancy, including labor, birth, and postpartum.

All licensed traditional midwives are currently required by law to provide, discuss, and mutually sign an Informed Consent Agreement & Medical Consultation Plan for each client. It is recommended that all practicing midwives utilize the informed consent process as a way to facilitate, and clarify communication.

Initial Visit

The midwife meets with the pregnant woman and her family to decide on the feasibility of establishing a midwife-to-family relationship. It is of utmost importance to keep in mind the intimate and long-lasting nature of this relationship and make decisions accordingly. The midwife needs to feel comfortable with the pregnant woman's reasons for wanting to have a home birth, her family's lifestyle and belief system, and her commitment to breastfeeding. The family seeking midwife care must be in agreement as to their responsibility for home birth plans. Indecision or conflict in this area may manifest itself as a physical complication, placing the mother, baby, and midwife at risk.

The midwife should not assume the home to be the only safe place for birth. The midwife needs to ascertain on the initial visit, both verbally and in writing, a detailed health history that will help in evaluating the presence of situations or conditions that would contraindicate planning a home birth. The health history needs to be inclusive of the pregnant woman's social, medical, surgical, gynecological, contraceptive, obstetrical, family, nutritional, and drug/chemical use histories. The midwife will develop a form to help her gather all of this information in a thorough, systematic fashion.

In determining an accurate Estimated Due date (EDD) the following must be taken into account: date of the last menstrual period and whether there is any question as to normality of the quality or quantity of flow; the previous menstrual period to ascertain probable cycle length; the range of cycle in recent months; the possible or probable date of conception; the date of the positive pregnancy test, if available; the date of the first signs and symptoms suggestive of pregnancy; the date of quickening; and the week the fundus reached the umbilicus.

If the pregnant woman contacts the midwife after the first trimester of her pregnancy, the midwife shall assess the quality of any previous care and/or self-care, including nutrition, and shall assume responsibility for care only if satisfied that the prior care has been adequate. It is up to the pregnant woman to obtain copies of the records for the care she has received elsewhere.

The Traditional Midwife needs to educate parents of the current recommended obstetric lab tests, how to obtain them, and to provide a waiver to sign if they decline any or all of them.

LABORATORY TESTS

Lab tests which may be offered and ordered include, but are not limited to:

1. Initial pregnancy screening labs (blood group and type, antibody screen, rubella titer, CBC with differential, and syphilis serology).
2. Gonorrhea and Chlamydia cultures.
3. UA for protein and glucose
4. Hepatitis B
5. Genetic screening
6. HIV
7. Other vaginal cultures

The midwife should request any other information she deems pertinent to making a decision to work with a family.

First Prenatal Visit

The midwife shall maintain an individual chart for each woman in her care. The completed chart shall include the completed health history form, the laboratory results, labor and birth records, prenatal and postpartum flow sheets that include the information set forth in these guidelines.

The chart maintained by the midwife and the communications between the midwife and the women under her care shall be privileged and confidential information. The chart shall be made available upon request, and with the woman's consent, to any health care provider who is called upon for consultation or referral. Consultations, referrals, and visits with any other health care practitioners throughout the pregnancy, labor, birth, and the postpartum period need to be noted in the chart.

Included in the first prenatal visit is a thorough examination and discussion of the pregnant woman's diet history. The midwife needs to help the pregnant woman assess her nutritional status. The midwife may choose to refer the woman to another health care provider for nutritional consultation. The mother's nutritional status should be monitored throughout the pregnancy.

Also to be included in the first prenatal visit is a detailed discussion of the information gathered through the health history and lab results. Suggestions and recommendations need to be made immediately to optimize fetal and maternal well-being.

The midwife needs to address the family's postpartum plans throughout the pregnancy: postpartum expectations, needs, and plans require definition and redefinition.

Prenatal Education

Education for the pregnant woman and her family is an essential part of midwifery care. In pregnancy, there is much to be experienced and understood. By nurturing the pregnant woman and her family with information, support, counseling and referral, the midwife contributes to the well-being of the whole family.

A pregnant woman or family member who is helped to understand what is happening during pregnancy, childbirth, and the postpartum period will be better able to cooperate with the natural processes. This is realistically a preventive health measure to ensure healthy childbearing.

Education during pregnancy may include explanation of changes and needs related to pregnancy and childbirth, newborn and infant care, anticipatory guidance, short term counseling, crisis, intervention, and referral to health care providers and community groups and services. Education needs to continuously change as new information becomes available to the midwife. Time needs to be allotted during each prenatal visit for the purposes of education and counseling. The midwife needs to make herself available to answer pressing questions that may arise in between prenatal visits.

Components that may be addressed prenatally include, but are not limited to:

1. Nutrition during pregnancy and the postpartum period
2. Fetal development
3. Exercise and activity
4. Relaxation
5. Spiritual/religious resources
6. Sleep and rest requirements
7. Danger signs and symptoms during pregnancy
8. Breastfeeding
9. Family relationships
10. Fears and emotional aspects of pregnancy, birth, postpartum
11. Sexuality during pregnancy and postpartum
12. Pelvic floor preparation for birth
13. Signs of end of pregnancy
14. Normal labor and birth
15. Preparing children for the birth experience
16. Complications of labor, birth, and immediate postpartum, including neonatal death
17. Emergency plans
18. Essentials of newborn care
19. Contraception
20. Common Labs and Screenings

Prenatal Visits

Throughout the pregnancy, dialogue and discussion as to mutual expectations, rights, responsibilities, and limits needs to be encouraged and sustained. The relationship between the midwife and the families under her care is an egalitarian one in which the midwife imparts her expertise to empower the family and thus removes herself from the role of expert.

The midwife shall see the pregnant woman (and her family if possible) every three to four weeks until the 28th week; every two weeks between the 28th and the 36th week; and weekly from the 36th week to the time of birth. At least one of these visits needs to take place in the pregnant woman's home (around 36-38 weeks). If there is an indication of potential or existing problems/ difficulties/complication, the above schedule needs to be amended to include more frequent visits.

At each prenatal visit, the midwife should assess the pregnant woman's:

1. Weight
2. Blood pressure
3. Pulse
4. Edema
5. Nutrition
6. Exercise/rest/relaxation/sleep/stress/fatigue
7. Emotional well being
8. Discomforts associated with pregnancy, such as: nausea, vomiting, backaches, leg cramps, sciatica, digestive difficulties, constipation, diarrhea, hemorrhoids, and varicosities
9. Signs and symptoms requiring evaluation, such as: vaginal or rectal bldg., vaginal discharge, recent or current bacterial or viral infection, vertigo, visual changes, shortness of breath, structural problems, muscular problems, circulatory problems, contractions, swelling, ligament pain and/or tenderness, pelvic pressure, pubic tenderness, pain and any other complaint voiced by mother
10. Need for education as to cause, treatment, and prognosis of any symptoms, problems or concerns including the expected physical, emotional, spiritual, and mental changes brought about by pregnancy
11. Need for ongoing discussions about the benefits of good nutrition, exercise, sexuality, emotional changes, family relationships and other concerns that may arise
12. Need for information regarding community resources

At each prenatal visit, the midwife should assess the developing baby in terms of:

1. Fundal height
2. Gestational age assessment by dates and clinical examination
3. Presentation and position
4. Whether size appears consistent with gestational age
5. Fetal activity (note quickening and monitor each visit thereafter)
6. Rate and location of fetal heart tones (note date of first FHT's heard by fetoscope and auscultate FHT's thereafter)
7. HGB/HCT should be done as part of initial screening labs, at approximately 28 weeks, and repeated as necessary.

In cases of Rh negative mother, it is advisable to secure the father's blood group and type; and antibodies screening of the mother should be done at the time of acceptance of care, and again at 28 weeks to rule out sensitization.

Pelvimetry may be done with client's consent if the midwife deems appropriate. Shape is of greater importance than size. Clinical pelvimetry includes: the diagonal conjugate, the bi-ischial diameter, the ischial spines, the pubic arch, the AP diameter, the shape of the sacrum, and mobility of the coccyx, as well as visual inspection of the vulva and perineum.

Last Trimester

The midwife shall discuss with the family the selection of a health care provider who will be consulted for newborn care. The midwife needs to formulate a written medical consultation plan in case of a medical emergency.

The midwife and the family should discuss issues relating to the birth plan including:

1. Facilities in the home
2. Necessary supplies
3. Adequate heat
4. Availability of telephone and list of emergency numbers
5. Names and phone numbers of designated health care providers
6. The partner/father's preparation and participation
7. Preparation and care of older children
8. Those invited to be present at the birth
9. Signs of labor
10. When and how to contact the midwife

As the pregnancy comes to an end, it is imperative that the midwife guide the expectant family through an overview of the initial postpartum period. The expectant mother and her family should receive from the midwife an after-care sheet: as a minimum it needs to outline the basics of maternal and newborn care in the immediate postpartum and list signs that signal the parents should contact the midwife or a health care provider immediately.

The midwife needs to determine if a realistic postpartum plan has been developed by the family prior to the time of birth: ideally, the new mother will be free of all responsibilities beyond care for herself and her baby for a minimum of 1-2 weeks, although the time might be greater in case of a difficult birth or if there are small children in the family.

During the 36-38 week home visit, the midwife shall evaluate:

1. If all birth supplies are present
2. Alternate plans for the care of other children
3. Review plans for postpartum
4. Review parental and midwife expectations
5. Need for further plans

During this visit (or sooner), the midwife needs to initiate a discussion with the expectant family in which the original birth plans are re-evaluated in terms of the course of the pregnancy. It is important to address at this time the changes that have taken place physiologically, emotionally, and socially that bear significance on the original home birth plans.

The midwife is not to assume that the home is the only place for the birth to take place. Thoughts and feelings that have evolved or remain consistent need a closer look. Late pregnancy referral is almost always a better option than transporting to the hospital in labor.

Each midwife shall be responsible for having written protocols or resources regarding her care guidelines for the following prenatal conditions/situations:

1. Parameters of nutritional needs including the use of food supplements
2. Exercise/rest/relaxation/sleep guidelines
3. Anemia
4. Viral or bacterial infection
5. Urinary tract infection
6. Vaginal infection
7. Genital herpes
8. Pre-eclampsia
9. Excessive or insufficient weight gain
10. Elevated blood pressure
11. Proteinuria
12. Pitting edema
13. Suspected gestational diabetes
14. Signs of pre-term labor
15. Premature labor onset
16. Premature rupture of membranes
17. Suspected placenta previa
18. Suspected placental abruption
19. Malpresentation at or beyond 36 weeks

Labor and Birth Care Standards

"I never brought a baby without a prayer."

Ebba Kirschbaum, 1897-1984

Minnesota Licensed Granny Midwife

During labor and birth the midwife helps the laboring woman and her family in the following:

1. Ascertaining that labor is in progress
2. Assessing the well-being of mother and baby
3. Noting the progress of labor
4. Assisting with labor support, guidance, and comfort measures
5. Preparing the equipment and supplies for the birth
6. Monitoring the emotional atmosphere
7. Maintaining the integrity of the birth environment
8. Assisting in the birth of the baby and placenta
9. Assessing the newborn
10. Inspecting the placenta, membranes, and cord vessels
11. Inspecting the perineum, vagina, and if necessary, the cervix
12. Assuring that lacerations are repaired as necessary
13. Establishing breastfeeding
14. Dealing with any difficulties, problems and/or complications according to the guidelines cited elsewhere in this document and in accordance with traditional midwifery practice.
15. The midwife shall have the ability to recognize lacerations of the perineum requiring suturing, repair or arrange for repair.
16. The midwife shall have the ability to recognize and control postpartum hemorrhage and perform emergency resuscitation of the mother and/or newborn. The midwife shall have a current CPR card.

Pre -Labor

Pre labor activity can last for days and is unique to each birthing woman. The midwife needs to keep in close contact with the mother.

In case of ruptured membranes:

The pregnant woman and her family should be instructed prenatally to notify the midwife immediately of the spontaneous rupture of membranes.

First Stage

The first stage of labor is characterized by a history and timing of contractions, the existence or non-existence of bloody show, possible rupture of membranes and subjective feelings on the part of the laboring woman. On the part of the midwife, assessment of the labor depends on contraction strength, duration and frequency; observation of the laboring woman's behavior; and may include a vaginal exam to determine dilation, effacement, and station.

Whereas we recognize that the father/partner/labor support person(s) are valuable, they cannot be used in lieu of the midwife's assessment.

The midwife shall be available to the laboring woman to assess labor as it changes from early to active.

Professional midwife care of the laboring woman is directed toward total emotional, physical, and spiritual support of the woman. Assessing labor changes through subjective signs is one of the most important skills of traditional midwives. Objective assessments need to be made as per guidelines in a labor and birth flow sheet. Occasionally, a labor will slow down or stop altogether during the first stage. The woman needs to be fed, hydrated, and well rested if this occurs. The woman and her midwife can wait for resumption for as long as is needed and tolerated.

With prolonged labor, dipstick for ketones may be used to evaluate the laboring woman's need for metabolic energy: fluid and carbohydrates. The midwife is to encourage the woman to maintain activity as long as possible throughout the labor. Periods of activity need to alternate with periods of rest in longer labors. The laboring woman needs to be reminded of the importance of eating and drinking. Elimination is also important, and the laboring woman is reminded of the need to void frequently.

Signs and symptoms of transition: nausea, shaking, chills, increased perspiration, catch in the throat, increase in rectal pressure, subjection feeling of inability to cope, malor flush. Most women are very inner directed at this time. This is also the most common time for the spontaneous rupture of membranes.

Second Stage

The laboring woman is encouraged to hold off voluntary pushing as long as possible to avoid pushing against the cervical rim and to allow the baby to find the best possible angle of entry into the birth canal. The woman should empty her bladder prior to voluntary pushing efforts.

The laboring woman needs to be supported during this phase of the birth process in any position that she chooses. If a particular position does not bring steady progress, the woman should be encouraged to try other positions until an effective one for that woman and her baby is discovered. With posterior babies, it is recommended that the mother change position after every couple contractions. Whenever possible, the supine position should be avoided. Large babies, because of the possibility of large shoulders, need to be birthed in any position but supine or semi-sitting.

The midwife should make every attempt to help the woman keep her perineum intact. Hot compresses, perineal massage with oil, controlled pushing and attempting to birth the baby's head as gently as possible are all useful for avoiding perineal lacerations.

In rare occasions where it may be necessary to protect the health of the baby, an emergency episiotomy may be done. This may most likely occur with:

1. FHT decelerations (less than 80 bpm lasting more than 20 seconds after pushing)
2. Thick, tight, resistant perineal muscle that is arresting crowning causing change in scalp color or change in FHT's

The exact time of birth needs to be noted and recorded. In conjunction with any efforts necessary to encourage breathing, maintenance of warmth of the baby is of utmost importance. The most efficient method of warming is skin to skin contact. The baby needs to be dried and covered with warm blankets.

Ideally, clamping and cutting the cord is done after it has stopped pulsating and the woman has birthed the placenta. Sometimes due to a short cord or a history of ABO or Rh negative blood (cord blood sampling), the cord needs to be cut as soon as the baby is breathing well by its own efforts.

Once the baby is born, every attempt should be made to minimize the presence and impact of the midwife and other birth attendants on the environment as the new family bonds.

Third Stage

It is important for the midwife as well as the new family to remember that the birth is not complete until after the birth of the placenta.

Once the baby is born, the contractions become progressively weaker and occur at increasingly longer intervals. Because of this, it is necessary to attend to the birth of the placenta as soon as possible after the birth of the baby. Phone calls to family and friends should be delayed until the placenta has been passed.

If there are signs of extensive bleeding or concealed bleeding, the placenta must be passed at once. Otherwise the midwife can observe for signs of placental separation including lengthening of the cord, gush of fresh blood from the vagina, and the uterus rising up to the umbilicus and becoming globular and mobile. It is important not to massage the uterus until placental separation is certain as this may cause undue bleeding.

Gravity and maternal efforts are the safest methods to accomplish the birth of the placenta. Controlled cord traction could prove dangerous in cases of partial placental separation. The midwife shall examine the placenta for completeness and note gross anatomic characteristics: unusual coloration, calcifications, adipose accumulations, and integrity of cord insertion. The midwife shall examine the umbilical cord for the appropriate number of vessels. The midwife should also note if there is any unusual odor to the placenta. The midwife must do her best to keep the mother and her baby together throughout the third stage.

Fourth Stage

This is the beginning of the postpartum period, starting with the birth of the placenta and continuing for one hour.

During this time, the fundus and bleeding should be monitored. In cases of excessive bleeding during third stages, the uterus needs to be guarded by the midwife throughout the entire hour.

Professional midwife care at this time includes:

1. Maintaining the baby's airway
2. Keeping the baby warm and dry
3. Checking maternal and infant vital signs
4. Encouraging the nursing relationship
5. Cleaning the mother and infant
6. Seeing to it that the mother is fed
7. Offering a minimum of one quart of nutritious fluids with additional fluids available
8. Inspecting the perineum and the vagina
9. Making an ongoing assessment of mother and newborn well being

This is the transitional point between birth and postpartum. See postpartum section for more detailed guidelines.

Immediate Postpartum

The midwife will perform an Apgar score evaluation at one and five minutes.

In the immediate postpartum the midwife is responsible for the following guidance, observations, and assessments:

THE NEWBORN
1. Has a clear airway
2. Is stable and alert
3. Has proper cord care
4. Is establishing a healthy pattern of waking, feeding, and sleeping

The newborn needs to be kept warm, dry, and as physically close to the mother as possible. It has been established that the baby's desire to nurse is greatest during the first hour after the birth. Every effort should be made to allow the baby to nurse as long and frequently as possible. Keeping the mother and baby together at this point will reinforce bonding and help prevent later nursing difficulties.

THE MOTHER
1. Has a normal lochia
2. Has a firm fundus
3. Has no fever or other signs of infection
4. Is voiding properly
5. Is getting adequate rest, nourishment, and support

The midwife shall examine the mother's vagina, perineum, and cervix (if indicated) for lacerations. For an Rh negative mother, the midwife shall obtain a specimen of cord blood to determine baby's blood type.
When indicated, RhoGam should be given to the mother within 72 hours.

The midwife shall remain with the mother and newborn for at least two hours postpartum or until she is certain that both mother and baby are in stabilized condition: the mother has eaten, voided, has had a generous amount of fluids, has a firm fundus, normal lochia flow; the newborn is nursing and has a normal body temperature and respirations.

The midwife shall leave detailed written instructions with the parents regarding care for both mother and newborn including:

NEWBORN
Temperature regulation
Observation for passage of meconium and urine by 24 hours
Observation for any nursing problems
Observation of newborn's color, respirations, and general appearance
Cord care

MOTHER
Amount of bleeding and condition of fundus
Perineal hygiene
Breastfeeding and breast care
Adequate rest and nutrition
Adequate elimination. Particularly urination
General condition

The items above should be carefully discussed so that everyone involved understands their importance.

Newborn Assessment

The newborn assessment must be completed during the immediate postpartum period.

The assessment shall include:

Weight
Length
Heart rate
Respirations
Temperature
Head circumference

The physical assessment includes assessment of the head, eyes, mouth, skin, auscultation of the heart and lungs, abdominal palpation, palpation of femoral pulses and assessment of hips. A general assessment is made of the newborn's color and appearance, skeleton, and back. An assessment of the newborn's genitalia is also indicated.

The newborn neurological assessment includes gestational assessment, if appropriate, and evaluation of the presence of Moro, suck, root, Babinski, and any other neurologic responses that may be appropriate. The newborn should exhibit an adequate sucking reflex to avoid feeding difficulties, and should show no signs of respiratory or circulatory distress.

After assessing the baby, the midwife may recommend that the family contact their family health care provider.

The midwife should discuss that the newborn be seen by a qualified health care provider within the first two weeks of life.

Postpartum Care Standards

"We are assisting not only in the birth of the baby but in the birth of a family . . . that's our focus."

Anne Froehlich

Postpartum care presupposes thorough prenatal care and education. It also presupposes preparation in the preventative sense to offset problems and difficulties that may and will arise once the baby is born. We define the postpartum period as encompassing the time between the birth of the baby and the end of the weaning.

The midwife needs to provide guidance so that parents are well prepared in terms of knowledge and confidence in their new roles. The emotional needs of the family need to be acknowledged and addressed. The postpartum environment needs to be guarded in many of the same ways as the birth environment: the home needs to be kept clean, well-supplied, and smooth running. The network of family and friends needs to be organized to ensure after-birth care and support for the family.

In recognition of the significance of the postpartum period for the physical, emotional, and spiritual well-being of the newborn, the mother and the growing family, we set forth the following guidelines.

The expectant family should receive prenatally from the midwife complete information (and resources) on the following:

BREASTFEEDING. Breastfeeding is the best way for a new mother to feed and nurture her baby. The midwife should be prepared to make La Leche League referrals, offer a variety of books and publications on the various aspects of breastfeeding, and share in her own experiences.

NUTRITION. To maintain a nutritionally sound diet is just as important in the postpartum period as it was prenatally. The continuation of the prenatal diet (including supplements) with an increase in fluid intake, protein, and calories is essential to insure maternal health and provide for successful nursing of the baby. It is important for the midwife to consider postpartum difficulties in the context of possible nutritional deficiencies.

FAMILY HEALTH CARE. The midwife should make available prenatally to the family referral to a wide array of routine and acute health care providers that could serve the family's needs postnatally, including family practitioners, pediatricians, obstetricians / gynecologists, osteopaths, chiropractors, and naturopaths.

JAUNDICE. Information needs to be given to the parents on preventing and / or minimizing newborn jaundice. Preventative care must be emphasized in cases of potential Rh and / or ABO blood incompatibility.

EYE PROPHYLACTICS AND PROPHYLACTIC VITAMIN K Expectant parents need to be educated as to what they are, the rationale for prophylactic use, indications, and pros and cons of use. If the expectant parents wish to decline their use they must be provided with an informed consent waiving their use.

STATE MANDATED NEWBORN SCREENING. Parents need to be educated as to what the current newborn screens are, how to obtain them, and, to be provided with a waiver to sign if the parent(s) choose to decline any or all of them.

CIRCUMCISION. Parents should be informed that circumcision is a surgical procedure, and as such, it carries certain risks. Written information should be available explaining the reasons why circumcision is medically unnecessary, traumatic, and potentially dangerous to the newborn.

POSTPARTUM SEXUALITY. It is important to prepare prenatally for a wide range of possibilities. Recovery is a very individual process. The effects of breastfeeding on sexuality need to be discussed. The couple needs to be encouraged in maintaining a loving attitude of mutual support, patience, and gentleness. In physical terms, intercourse should wait until the mother feels well healed and ready.

CONTRACEPTION. The parents should know that ovulation may resume rather quickly even though it is delayed for most women who exclusively breastfeed for a prolonged period of time. The midwife should provide education on the cooperative methods of contraception. Individual decisions need to be made by each couple on the advantages and disadvantages of the various methods including short and long term side effects.

BIRTH CERTIFICATES. It is the responsibility of the parents to register their baby's birth with their county's Vital Statistics office within six months following the birth. The midwife should assist the family in filling out the birth certificate.

PostpartumVisits

There should be at least one phone call at 8-16 hours postpartum and before the first visit to follow up on the events of the birth. At this point the midwife will remind the family to initiate the prearranged postpartum care plan.

The midwife needs to arrange a minimum of four postpartum visits:
The first at 18 - 36 hours postpartum
Second visit at 3 -5 days postpartum
Third visit at 7 - 14 days postpartum
Final visit at 6 weeks

More visits may be arranged if any unusual circumstances are encountered in the course of postpartum care.

The midwife is to remain on-call for the family during the first postpartum week. If she needs to leave town for any reason, arrangements should be made with another midwife and the family must be properly notified beforehand.

Early follow up care should address:

Newborn:
Cord
Skin (color/hydration)
Airway / respirations
Breastfeeding
Elimination
Sleep / awake patterns
Auscultation of heart / lungs
Weight
Muscle tone
Reflexes
Skull condition
Jaundice
Temperature
Eye discharge, if any

Mother:
Emotional state
Breasts and nipples
Fundus and lochia
Perineum
Elimination
Hygiene
Rest / sleep
Nutrition / fluid intake
Vital signs
Activity level
Abdomen
Legs

Beyond the 2 - 3 visits of the first postpartum week, phone contact should be made during those first 7 – 8 days postpartum as needed. During the first 6 weeks postpartum, the midwife continues to stay in contact with the family as needed.

Later postpartum visits should cover:

Newborn:	Mother:
Feeding / elimination	Breasts / breastfeeding
Skin	Fundus / lochia / perineum
Cord	Uterine size and position
Sleep / awake patterns	Rest and sleep pattern
Weight	Exercise / activity level
Sensory awareness	Nutrition / elimination
Jaundice	Sexuality / contraception
	Emotional adjustments

The midwife should remain available by phone during the first six postpartum weeks. If she is unavailable for any reason, arrangements need to be made so that the family can maintain phone contact / consultation throughout this period.

In case of a birth perceived to have been traumatic by either the parents or the midwife, a meeting of all persons presents at the birth needs to be arranged at 2 – 4 weeks postpartum to collectively process the events of the birth.

SIX WEEK POSTPARTUM VISIT

Every effort should be made to have this visit take place. This is the time to discuss the degree of satisfaction with the pregnancy, birth, and baby. At this time contraceptive counseling can take place. It is a time to answer questions that have come up and evaluate adjustments. Tears and repairs need to be examined to ascertain that proper healing has occurred and a pelvic exam may be done to determine uterine and pelvic involution.

Written Protocols

Each practicing midwife shall be individually responsible for maintaining protocols for the following conditions and situations:

1. Cord care
2. Jaundice
3. Newborn conjunctivitis
4. Newborn thrush
5. "Failure to Thrive" babies
6. Perineal care
7. Mastitis
8. Cystitis
9. Prolonged lochia
10. Vaginal infections
11. Uterine infections

Appendix A
Contraindications for Home Birth
Based On Health History

Conditions exist that require care outside the scope of practice of traditional midwives. Due to their potential life and health threatening nature, midwives should refer pregnant women who exhibit the following conditions to a medical health provider for prenatal care and birth attendance:

1. Regular alcohol use or drug use / abuse / dependency
2. Cardiac disease
3. Insulin Dependent Diabetes Mellitus
4. Current Renal disease
5. Current Liver disease
6. Pulmonary disease, Active Tuberculosis, or severe uncontrolled asthma
7. Unresolved seizure disorder
8. Systemic Lupus
9. Active Hepatitis
10. Marked skeletal abnormalities that would interfere with the birthing process
11. Congenital defects of the reproductive organs that would interfere with the birthing process
12. Essential Hypertension
13. Thromboembolism or thrombophlebitis
14. Mother has metabolic disease such as PKU
15. Rh negative disease as indicated by positive titers
16. Unwillingness to accept midwife's limitations, prohibitions, and responsibilities for safe practice
17. Any other condition which may preclude the possibility of a normal birth, at the midwife's discretion
18. Any other major medical problem or congenital abnormality that affects childbearing.

Appendix B

Contraindications for Homebirth

Based on Conditions Identified During Prenatal Care

At any point during prenatal care, conditions may be identified that show a contraindication for home birth. Except in emergency situations, a midwife should not assume or continue to share responsibility for prenatal and / or birth attendance for women with the following conditions:

1. Failure to document basic prenatal lab work (blood group type, RH antibody screening, hemoglobin around 28 weeks gestation) or signed refusal.
2. Rubella during the first trimester
3. Primary outbreak of genital herpes
4. Persistent pregnancy induced hypertension
5. Pre-eclampsia
6. Convulsions
7. Confirmed Central Placenta Previa at term.
8. Signs indicative of placental abruption
9. Placenta located over previous uterine scar
10. Suspected or diagnosed congenital fetal anomaly that may require immediate medical care after birth
11. Hemoglobin less than 9 at 36 weeks (can return to out of hospital midwifery care if 10 or above by onset of labor)
12. Premature labor: less than 36 weeks
13. Serious viral/bacterial infection at term
14. Documented persistent and unresolved intrauterine growth restriction or small for gestational age (IUGR/SGA)
15. Unresolved fearfulness regarding home birth or midwife care, or otherwise desires transfer of care
16. Any other condition or situation which may preclude the possibility of a healthy birth, at the midwife's discretion

Appendix C

Situations / Conditions Requiring Documented Medical Consult

During the course of midwifery care, conditions may arise that need special expertise.

Conditions which require additional help or consultation include:

1. Vaginal or urinary tract infection unresolved
2. Suspected size/dates discrepancies for 3 consecutive prenatal visits (ultrasound evaluation meets this requirement for consultation)
3. Unresolved anemia (HGB 10 or less)
4. Observed maternal cardiac irregularities
5. Suspected Pyelonephritis
6. Elevated blood glucose levels unresponsive to dietary and exercise management
7. Abnormal vaginal bleeding before onset of labor
8. Suspected Thromboembolism or Thrombophlebitis
9. FHT's not heard by 24 weeks gestation or at any later point in the pregnancy
10. Abnormal fetal heart tones detected prenatally
11. Marked decrease or cessation of fetal movement
12. Suspected or known postdates pregnancy beyond 42 weeks gestation with biophysical score of 6/8 or less
13. Active pushing longer than 4 hours on first time mother with no descent or 3 hours on subsequent births with no descent
14. Indications that the baby has died in utero
15. Indications of infection in the immediate postpartum
16. Medical significant newborn anomaly
17. Newborn temperature of 100.8 or greater for 2 consecutive readings in 1 hour
18. Newborn cardiac irregularity
19. Significant clinical evidence of prematurity
20. Birth weight of less than 5 lbs
21. 2 vessel cord
22. Jaundice within the first 24 hours
23. Failure to pass urine within the first 24 hours or failure to pass meconium within first 48 hours
24. Signs of umbilical infection unresponsive to treatment
25. Unresolved bleeding in excess of normal lochia flow
26. Subinvolution
27. Failure of laceration to heal properly or signs of infection unresponsive to treatment
28. Signs of serious postpartum depression or psychosis
29. Tremors, hyperactivity or seizures
30. The pregnant woman or midwife wishes such care or consultation
31. Significant hematological disorders, such as Sickle Cell Disease
32. Significant uterine or vaginal anomalies
33. Isoimmunization with an antibody known to cause hemolytic disease of the newborn
34. Suspected decreased amniotic fluid levels unresponsive to increased fluid intake within 24-48 hours

Appendix D

Situations / Conditions in Which Consultation With Another Midwife Is Suggested

Because the Standards of Care were written for the newly practicing midwife without years of experience, the following suggestions of when to consult are based in wisdom.

1. Recurrent / chronic situation, condition, or disease requiring regular intake of medication(s)
2. History of genetic problems
3. Previous unexplained stillbirth or neonatal death
4. History of hypertension of pregnancy (pre-eclampsia, eclampsia, or toxemia)
5. Two or more consecutive premature labors or history of low birth weight babies (less than 5 lbs.)
11. History of difficulty controlling hemorrhage with previous births, miscarriages and/or abortions, or severe postpartum hemorrhage requiring transfusion
12. History of cesarean birth
13. Family has not initiated care with attending midwife by 36th week.
14. Multiple gestation
15. Breech presentation at term
16. History of 2 or more low birth weight babies (less than 5 lb)
17. No prenatal care prior to third trimester
18. Suspected malpresentation or abnormal presentation at 36 weeks gestation or later
19. Lacerations beyond midwife's ability to repair (repair may be made in the OOH setting by another provider if the repair is within their ability and expertise to repair, otherwise transfer to a hospital is indicated. Repair should take place during the immediate postpartum period, ideally within 6 hours of birth
20. The pregnant woman and/or midwife wish for such a consultation

Appendix E

Situations / Conditions Requiring Hospital Transport

1. Cardiac arrest
2. Chest pain or cardiac irregularities
3. Signs of postpartum pre - eclampsia, or eclampsia
4. Eclampsia / maternal convulsions
5. Maternal respiratory distress
6. Unresolved signs of fetal distress
7. Cord prolapse
8. Transverse lie (in labor)
9. Heavy meconium staining and deviations in FHT's (if the expected time of birth is greater / longer than the projected transport time)
10. Foul smelling amniotic fluid
11. Infection: maternal temp. above 100.8, shaking, chills, elevated pulse
12. Excessive antepartum and intrapartum painless vaginal bleeding
13. Placental abruption
14. Suspected placenta accreta
15. Hemorrhage not responsive to treatment
16. Unresolved maternal shock
17. Apnea
18. Persistent uterine atony
19. Uterine inversion
20. Apgar score of 6 or less at 10 minutes of age and not improving
21. Unresolved respiratory distress of newborn
22. Abnormal color in newborn: persistent central cyanosis
23. Unresolved abnormal cry in newborn: weak, or high pitched
24. Obvious or suspected birth injury
25. Newborn cannot maintain body temperature
26. Projectile vomiting
27. Inability of newborn to feed well due to lethargy
28. Newborn temperature of 100.8 two consecutive readings ten minutes apart
29. Birthing woman desires transport for herself and / or her newborn

Every effort must be made to transport in good condition. The midwife will accompany the mother and / or baby to the hospital if hospitalization is necessary. If possible, the midwife may remain with the mother and / or baby to ascertain outcome and provide continuity of care. A transport form should accompany the mother and /or baby to the hospital.

Appendix F

Formulary listing the medical substances available to Minnesota Traditional Midwives

"Where Traditional Midwifery and medical treatment merge is in the treatment of emergencies. There is no emergency in IV antibiotics for GBS. We should stick to medications that treat a true emerging emergency…"

- Kim Garrett

1. Antibiotic Eye Ointment
2. Vitamin K injectable or oral
3. Rho(D) Immune Globulin
4. Oxygen
5. Suture material
6. Local Anesthetic
7. Anti Hemorrhagics:
    a. Pitocin
    b. Methergin
    c. Misoprostol (Cytotec)
8. IV fluids: Normal Saline, Lactated Ringers, and D5LR (5% Dextrose in Lactated Ringers)
9. Epinephrine for anaphylactic shock

Documentation of Annual Peer Review

The MN Midwives' Guild upholds the value of annual peer review as a supportive and educational means for midwives to ensure the safe and professional practice of midwifery. For this reason, we encourage, support, and recommend the peer review process be utilized by all midwives.

Midwives are strongly encouraged to seek the benefits of peer review opportunities, at least annually, to review practice standards and gain valuable input from the greater community of midwives in their geographical area.

Annual peer review should include (but may not be limited to):

* A review of all births attended since last review

* Evidence of current life saving certification(s)

Name_____Lic. No._____

Address_____ Date _____

Life saving certification(s) Current?____Review Completed? ___

Review approved by _____

Title/Office _____

All peer reviews should remain strictly confidential.

Minnesota Midwives' Guild Statement of Ethics

Midwifery is a feminine art and calling. It is very demanding work, both physically and emotionally. With this in mind, we set forth the following principles of proper conduct for the common good:

Each midwife shall tend to herself, to strive to be as aware of herself as she can be. In this way she will stay healthy and will keep her personal issues separate from the issues of the families she assists.

Family is the basis of traditional midwifery practice. If a midwife or her family is suffering as a result of her work, she is encouraged to step back and reevaluate/re-prioritize her situation. Midwives with a newborn or toddler of their own need to be aware of the high needs of their children and their own need to be at home.

Midwives need to respect a woman's right to choose her place of birth and attendants. Therefore, the midwife should not proselytize, persuade, or coerce a pregnant woman or her family toward choosing a home birth with a traditional midwife as an option for all women. The MMG recognizes that public education concerning the safety of home birth can be a benefit to all pregnant women considering their options.

Each midwife will disclose to every family she assists, any information they request regarding her midwifery background, training, and experience. A midwife must not attend the birth of a family she does not care for and respect.

The midwife will respect as confidential all information shared with her by the families she assists. If consultation becomes necessary, the family must be told and the consulting midwife or health care provider must respect this confidentiality. If the birth is discussed in a group meeting, the family shall remain anonymous.

While the families they serve may vary from year to year, other midwives in the community often become more permanent fixtures within their community. It is recommended that interactions be approached with consideration, and respect, and that conflicts be resolved the same way.

Interaction among midwives should happen in a supportive, cooperative way. If a family approaches a new midwife, expressing dissatisfaction with a previous midwife, the approached midwife should encourage the family to resolve their conflict with the original midwife. Aside from offering respect, this may help a family overcome any lingering anxiety that may stem from past birth experience(s). A midwife must be careful not to try to "rescue" a woman from another midwife. If a midwife finds herself in a situation where she is competing or acting disrespectfully toward another midwife, she should carefully look at herself to see whether her own sense of worth is suffering and take whatever steps may be necessary and appropriate to better care for her own emotional needs.

Before contacting the medical community for assistance, traditional midwives are first urged to utilize the resources available to them within their midwifery community as outlined in the Standards of Care guidelines, unless safety and appropriateness dictate otherwise. Traditional midwives must understand that their decisions and actions have an impact on the larger community. When safety permits, consultation within the traditional midwifery community is encouraged prior to seeking medical consultation.

Intuition may be an integral part of the midwife's practice. Respect your intuition and carefully weigh all factors.

SCOPE OF PRACTICE: PRATICES AND PROCEDURES OF TRADITIONAL MIDWIFERY SERVICES

Midwives in Minnesota provide care to childbearing women, their unborn children and newborns.

The State of Minnesota Statute 147D.01 DEFINITIONS. Subdivision 9.Traditional midwifery services. reads:

"Traditional midwifery services" means the assessment and care of a woman and newborn during pregnancy, labor, birth, and the postpartum period outside a hospital.

The State of Minnesota Statute 147D.03 MIDWIFERY. Subdivision 2.Scope of Practice reads:

The practice of traditional midwifery includes, but is not limited to:
(1) initial and ongoing assessment for suitability of traditional midwifery care;
(2) providing prenatal education and coordinating with a licensed health care provider as necessary to provide comprehensive prenatal care, including the routine monitoring of vital signs, indicators of fetal developments, and laboratory tests, as needed, with attention to the physical, nutritional, and emotional needs of the woman and her family;
(3) attending and supporting the natural process of labor and birth;
(4) postpartum care of the mother and an initial assessment of the newborn; and
(5) providing information and referrals to community resources on childbirth preparation, breast-feeding, exercise, nutrition, parenting, and care of the newborn.

The preceding scope of practice statement excerpted from Minnesota Statute 147D.03, Subdivision 2, seeks to outline what 'traditional midwifery services' include, but are not limited to. The following care may be provided by the midwife in accordance with her individual practice guidelines, her skills and knowledge, and state laws and regulations.

The following is a list of commonly accepted practices provided in the course of delivering Traditional midwifery services:

1. Prenatal Period:
    A. Provide ongoing, comprehensive risk screening for suitability for out-of-hospital birth (p. 5-10; Appendices A-F; statute 147D.03 Subdivision 2.Scope of practice, item (1)
    B. Conduct initial health history interview and assess physical exam (p. 5-10)
    C. Order or arrange for appropriate prenatal diagnostic tests including labs, and ultrasound as indicated (statute 147D.03 Subdivision 2.Scope of practice, item (2)
    D. Collect, or arrange for collection of, lab specimens, including venipuncture, pap tests and vaginal/rectal swabs (Appendix B, statute 147D.03 Subdivision 2.Scope of practice, item (2)

E. Provide education and counseling on a variety of topics relative to the woman's physical, emotional and mental health, including nutrition and supplementation (statute 147D.03 Subdivision 2.Scope of practice, item (1),(2), and (5)
F. Provide ongoing prenatal visits to assess that pregnancy is progressing normally (statute 147D.03 Subdivision 2.Scope of practice, item (1)
G. Schedule and provide care for non-routine visits for variations of normal pregnancy (statute 147D.03 Subdivision 2.Scope of practice, item (1)
H. Educate the family in preparation for birth, lactation and newborn care (statute 147D.03 Subdivision 2.Scope of practice, item (5)
I. Provide and administer Rhogam to Rh negative women with informed consent (Appendix F, Item 3: Rho(D) Immune Globulin; statute 147D.03 Subdivision 2.Scope of practice, item (2)and (4)

2. Care During Labor, Birth and Immediate Postpartum:
   A. Assess the progress of labor through observation and physical examination
   B. Monitor the fetal heart rate in response to labor
   C. Provide for physical and emotional support of the mother as needed
   D. Administer oxygen as needed (Appendix F, item 4: Oxygen)
   E. Administer intravenous fluids as needed (Appendix F, item 8: lactated ringers, normal saline, and D5LR)
   F. Perform amniotomy in the rare instances its indicated
   G. Recommend complementary and alternative modalities or techniques to facilitate progress of labor
   H. Cut episiotomy if needed (page 13 of MMG Standards of Care 2016 revision, paragraphs 4, 5 and 6)
   I. Suture perineal and vaginal lacerations, up to 2nd degree, with the administration of local anesthetic (page 11 of MMG Standards of Care 2016 revision, items 11, 12, 14 and 15; Appendix F, items 5 and 6: suture material and local anesthetic)
   J. Obtain necessary lab specimens (Appendix B, statute 147D.03 Subdivision 2.Scope of practice, item (2)

K. Administer prescriptive anti-hemorrhagic drugs to control postpartum blood loss (page 11 of MMG Standards of Care 2016 revision, item 16; Appendix F, item 7: Pitocin, Methergin, Misoprostol (Cytotech)
L. Examine the placenta (page 11 of MMG Standards of Care 2016 revision, item 10 and 14)
M. Perform manual removal of the placenta if indicated (page 11 of MMG Standards of Care 2016 revision, item 8 and 14)
N. Facilitate bonding and breastfeeding with newborn

3. Postpartum Care:
   A. Provide serial routine and non-routine postpartum visits as needed to assess the wellbeing of the mother as she recovers from delivery and transitions in to early motherhood, typically through 6 weeks after delivery
   B. Facilitate and support breastfeeding and address problem areas that adversely affect successful lactation
   C. Screen for physical risk factors in the postpartum period
   D. Screen for psychological risk factors in the postpartum period including postpartum depression
   E. Obtain lab specimens and/or orders lab tests (Appendix B, statute 147D.03 Subdivision 2.Scope of practice, item (2)
   F. Administer RhoGam to Rh negative mothers with Rh positive newborns, with informed consent (page 15 of MMG Standards of Care 2016 revision, paragraph 6; Appendix F, item 3: Rho(D) Immune Globulin
   G. Continue to provide education and counseling to women and families relative to the postpartum time period
4. Newborn Care
   A. Provide immediate care of the newborn upon delivery, including APGAR assessments (page 15 of MMG Standards of Care 2016 revision, paragraph 1)
   B. Administer appropriate resuscitative efforts (page 11 of MMG Standards of Care 2016 revision, item 16)
   C. Administer vitamin K and erythromycin eye ointment with informed consent (Appendix F, items 1 and 2: antibiotic eye ointment and Vitamin K injectable or oral)

D. Perform a comprehensive newborn examination (page 16 of MMG Standards of Care 2016 revision)
E. Collect lab specimens and order appropriate tests (Appendix B, statute 147D.03 Subdivision 2.Scope of practice, item (2)
F. Recommend comprehensive newborn screening per MDH standards
G. Make regular assessments during the newborn period (28 days) for feeding, elimination, weight gain, vital signs, umbilical stump healing, neurological responses and development (page 19-20 of MMG Standards of Care 2016 revision)
H. Provide ongoing education and counseling to parents for newborn and infant care

5. Women's Health Care (page 20 of MMG Standards of Care 2016 revision)
   A. Offer pre-conception counseling
   B. Provide fertility, family planning and contraceptive care
   C. Perform well-woman gynecological exams, including screenings for STIs, Pap collection, breast exam and nutrition education

<u>While the scope of Traditional Midwifery Practice in Minnesota does not include routine use of: amniotomy, intravenous fluids, anti-hemorrhagics, or manual removal of the placenta, the traditional midwife may use them when the rare situation warrants it.</u>