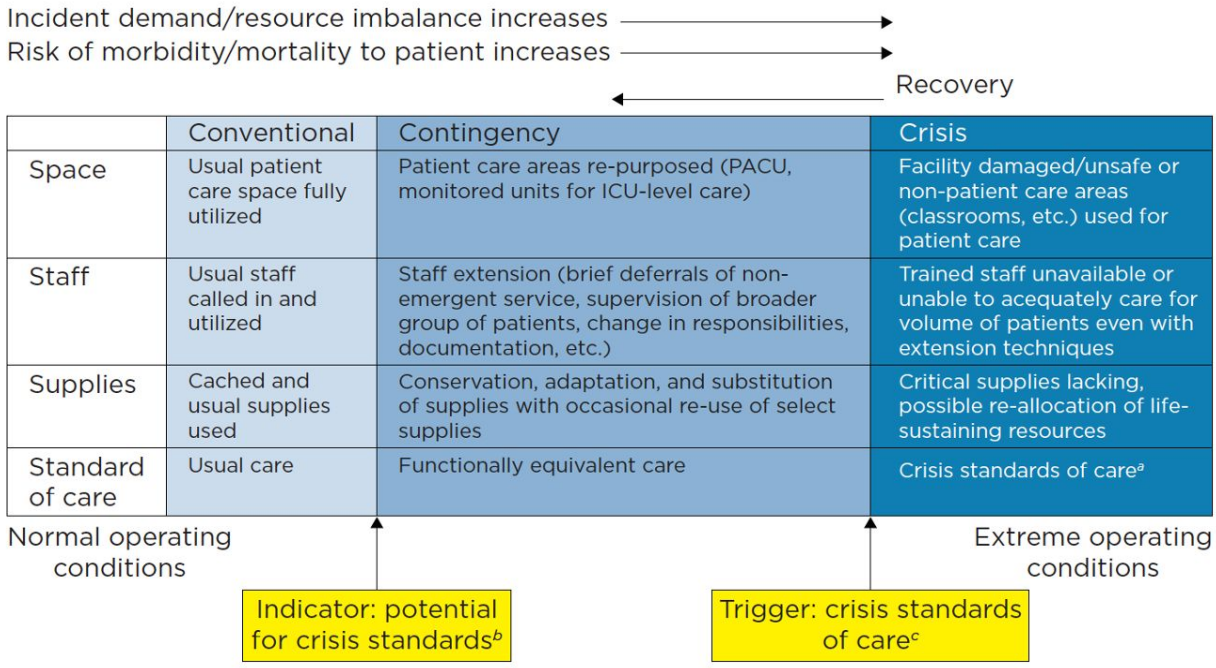
Crisis & Contingency Standards of Care: Community Midwifery Collective Policies, Procedures, & Protocols

Introduction

The unprecedented nature of the COVID-19 pandemic has strained healthcare systems, challenged health experts, and required innovative and collaborative efforts to both reduce the spread of the disease and to provide optimal health care at a time when little seems optimal. For community-based midwives, this has resulted in the challenge of rebalancing traditional individual-based care with necessary population-based public health needs and services. Therefore, the Washington State Midwifery COVID-19 Response Coalition (WSMCRC) has collaborated with public health experts to create "Crisis & Contingency Standards of Care: Community Midwifery Collective Policies, Procedures, & Protocols (PP&Ps)."



Graphic[2]

Crisis standards of care is defined by the Institute of Medicine (IOM) as "a substantial change in usual healthcare operations and the level of care it is possible to deliver, which is made necessary by a pervasive (e.g., pandemic influenza) or catastrophic (e.g., earthquake, hurricane) disaster."[1]

Contingency standards of care contemplate functionally the same standards of care provided outside of crisis settings, but with adaptations to reflect increased demand in services, and decreased or altered space, supplies, and staffing resource levels.

The goal of this document is to create a collective framework by which community-based midwives can adhere to and operate from during a state of emergency that standardizes practice at a level that is context-driven, accounts for the particular demands and/or limitations of the crisis itself, and can be clearly shared and communicated with midwives and their assistants, midwifery clientele, government officials, referring and transferring providers, billers, insurers, and others involved in the provision of health care. This document also provides a framework should alternate care facilities and/or innovative models of midwifery care, or midwifery conscription into the Public Health Reserve Corps (or the like) occur. WSMCRC recognizes that this time may require extraordinary and unprecedented service by community-based midwives, atypical of models of care we or our clientele are used to. **Crisis and contingency standards of care do not mean lower standards of care, but rather take into account the ways in which public health crises strain provider and patient autonomy, access to services and supplies, and that which is in our control to manage, mitigate, or prevent.**

This PP&P manual contains guidelines and recommendations based on the current (as of April 19, 2020) understanding of disease transmission, progression, severity, and sequelae of COVID-19, and its resultant federal, state, and local mandates, including, but not limited to the impact of stay-at-home and social distancing orders. For example, it is well-documented that crises, particularly those that result in social isolation, increase rates of intimate partner violence, postpartum and other mood and anxiety disorders, non-accidental trauma in children, and forced pregnancy. Additionally, case studies suggest that the presence of comorbidities, and the resulting rapid physical decompensation of asymptomatic pregnant or birthing people infected with coronavirus, necessitates more conservative screening and recommendations around risk factors known to increase susceptibility to poor outcomes, including but not limited to gestational diabetes mellitus, anemia, lack of immunization and/or vaccination history, lack of adequate GBS prophylaxis, and postpartum hemorrhage. We can balance the unknown elements of COVID-19 disease processes and hospital transfer availability, fear and uncertainty for healthcare providers and clients alike, and population-based public health needs with our high-quality approach to individualized, client-centered care. We urge midwives to find value in the optimal care we are striving to provide in suboptimal environments, while simultaneously acknowledging that this is not easy and no midwife should be expected to "go it alone".

This PP&P manual is intended for crisis and contingency use only, and is reflective of such. It does not supersede the individual PP&Ps or practice guidelines of midwives or professional associations outside of declared states of emergency or crisis.

References for Introduction and Executive Summary

1. Institute of Medicine. (2009). Guidance for establishing crisis standards of care for use in disaster situations: A letter report. Washington, DC: The National Academies Press.
2. Hays, K. (2020). *Shifting perspectives: The community midwife in our new public health reality*. Presented at the National Association of Certified Professional Midwives webinar on April 7, 2020. Retrieved from https://vimeo.com/405193445

Attribution and Acknowledgement

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Section 1: Care & Services

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Community Midwifery Collective Care & Services

Policy

Qualified midwives will meet certain requirements in order to provide care for low-risk clients in the community.

Procedures

Qualifications

- Licensed Midwives (LM) must have a current unrestricted license to practice in Washington State. LMs must be members in good standing with a professional organization with an established Washington State Department of Health (DOH) approved quality management program
- Certified Nurse Midwives (CNM) must have a current unrestricted license to practice in Washington State. CNMs must be members in good standing of a professional organization, and may be asked to join a professional association with an established DOH-approved quality management program
- Providers must be covered for full-service perinatal care by professional liability insurance in minimum amounts of $1,000,000 each claim and $3,000,000 annual aggregate, or be covered by the Washington State Emergency Volunteer Health Practitioner immunity from liability (RCW 70.15.110)
- Remain in good standing at all times, except as provided by state-sanctioned proclamation or mandate. Good standing includes, but is not limited to, the following: a current state provider licensure, Neonatal Resuscitation Program™ training (AAP/AHA), CPR training (health care provider level), and evidence of OSHA and bloodborne pathogen (BBP) training

General Duties and Responsibilities

- Review of Policy and Procedure Manual, and agree to work within the guidelines of said documents
- *Within a privately-owned birth center or an ad hoc COVID-19 Response birth center setting*: While credentialed midwives are not required to be employees or staff of birth centers in which they may attend clients, they are responsible to the designated birth center administrator for their actions as they relate to clients who are or have been admitted to the birth center

Clinical Responsibilities

- Provide client education or resources
- Inform clients of CDC-recommended immunizations in pregnancy
- Provide routine prenatal care as delineated in this policy manual
- Ensure that clients meet low-risk criteria as outlined in Section 3, “Client Eligibility and Risk Criteria,” of this manual
- Monitor progress of labor, birth, and postpartum and assume responsibility for making clinical decisions, providing routine and emergency labor, birth, and immediate postpartum/newborn care
- Refrain from using, in the home or birth center setting, unless adequately and appropriately trained, within the practitioner’s scope of practice, and permissible in the setting in which it occurs: drugs to induce or augment labor; forceps; vacuum extractor
- Use electronic fetal monitoring only to the health care provider’s training, experience, and scope of practice
- Maintain physical presence at birth center during all times that the client and/or newborn are present, maintain presence at home as appropriate for monitoring labor, postpartum, and newborn transition
- Have a birth assistant present for birth and immediate postpartum
- Adequately document any informed declination by client for any recommended procedure or test
- Complete charting in a timely manner and submit all required documentation, including prenatal, labor, birth, postpartum, and newborn care, and a summary for transfers of care
- Follow the step-by-step cleaning and disinfection protocols document for post-home visit and post-birth clean-up and laundry processing

Administrative Responsibilities

- *Birth center only*: Submit prenatal records of clients to birth center for review by 36 weeks or in accordance with applicable birth center guidelines
- Register each birth that occurs per Washington State law as detailed in RCW chapter 70.58.070
- Complete all required billing documents in a timely manner
- Complete timely entry of MANA statistics of all consenting clients for all providers currently enrolled in MANA statistics reporting. Providers who are not enrolled in MANA statistics may be required to do so. Providers may be also expected to contribute to other or additional data management programs as available
- Report to the midwife’s protected peer review program any maternal or neonatal morbidity or mortality, as well as any adverse or sentinel event as described by the Midwives Association of Washington State (MAWS) Quality Management Program (QMP), within a reasonable time frame, ideally within 72 hours but no later than one week following the event or prescribed by local regulations

Continuing Competency

- Commit to attend regular emergency skills drills as required or recommended by the Community Midwifery Collective (CMC), the Washington State Midwifery COVID-19 Response Coalition (WSMCRC), or another relevant body.
- Participate in approved peer review program

Policy

Midwives will practice in accordance with the Midwives Association of Washington State (hereafter referred to as MAWS) guidelines and Washington State law, and in accordance with the policies outlined in this manual and in COVID-19 Response Guidelines. They should refer to www.wamwcrc.org for updated guidelines throughout this response period.

Procedure

Midwives will care for only low-risk clients with COVID-19 response parameters, noted in the Collaborative Guidelines, and will consult or refer when deviations from normal in the parturient or the newborn are detected (RCW 18.50.010).

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Shared Decision-Making

Policy

Midwives will advocate for shared decision making, will furnish client with informed consent documents to sign and will adhere to standardized informed consents and postpartum instructions. Signatures may be obtained electronically during the COVID-19 pandemic where possible and using best available practice, to minimize client-provider contact and potential exposures.

Procedures

Midwives should

- Discuss risks, benefits, and alternatives of procedures and tests; in emergency or urgent circumstances, midwife should communicate salient information to promote client understanding
- Make informed consent documents available to clients

- Provide client with opportunity to ask questions or request clarification around any suggested procedure or test; expedited discussion may be necessary during urgent medical situations
- Explain to the client possible risks of declining standard procedures and tests, including warning signs of complications that can arise and client should be instructed to call the midwife or pediatrician in the event of a complication
- Consider implications of COVID-19 in shared decision-making, and describe the possible risks of declining some procedures or medications during the COVID-19 outbreak. These risks include, but are not limited to, current understanding of disease severity in the presence of comorbidities and the potential difficulty of accessing medical care in an emergency. Considerations should include, but are not limited to:
    - Vaccines during pregnancy or postpartum
    - Antibiotic prophylaxis for Group B Streptococcus (GBS) positive clients
    - Intramuscular Vitamin K for newborns.
    - Oxytocin or misoprostol for postpartum hemorrhage prophylaxis
- Consider implications of COVID-19 in shared decision-making, and describe the current understanding of disease severity and risk in the presence of comorbidities, including but not limited to:
    - High prepregnancy BMI
    - Respiratory conditions
    - Hypertension
    - Diabetes
- Obtain informed refusal for clients declining Vitamin K, erythromycin eye ointment, GBS antibiotic prophylaxis, or other standard procedure, test, or medication utilized during the intrapartum or immediate postpartum period
- Document shared decision-making discussions in a timely manner

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HIPAA Compliance

While HIPAA compliance has been relaxed to accommodate the unprecedented changes in healthcare during this time, midwives should continue to attempt to limit the risk of unintentionally revealing personal health information (PHI) of clients. To that end, midwives are urged to conduct telemedicine in a private space and de identify client information as much as reasonably possible. Because of the risk of lack of reasonable privacy, some platforms for telemedicine are not recommended, such as Facebook Messenger. Should conditions require that clients not have access to single-room privacy intrapartum (e.g., in a hospital tent with only screen dividers), the midwife will employ good faith efforts to ensure privacy and confidentiality.

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Financial Policy

Clients should be given a copy of a Financial Agreement to sign and submit with their registration paperwork.

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Liability Insurance

All midwives will be covered with liability insurance. Providers must be covered for full-service perinatal care by professional liability insurance in minimum amounts of $1,000,000 each claim and $3,000,000 annual aggregate. Or be covered by the WA State Emergency Volunteer Health Practitioner immunity from liability (RCW 70.15.110).

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Client Grievance

Policy

Clients have a right to report any grievances associated with their care with the Midwifery Coalition.

Procedures

- Clients should first be directed to share concerns and complaints with the administrative staff of WSMCRC at www.wamwcrc.org for the most expedited follow-up and resolution
- Clients can be directed to the Midwives Association of Washington States' website (washingtonmidwives.org) and are able to download a complaint form. They can also be directed to Washington State's Department of Health complaint process (https://www.doh.wa.gov/LicensesPermitsandCertificates/FileComplaintAboutProviderorFacility/HealthProfessionsComplaintProcess)

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Client Rights

Midwives should

- Make every effort to adhere to standard client/patient privacy practices, and employ good faith efforts when usual privacy practices are unachievable in a public health emergency environment
- Adhere to State-defined Patient Bill of Rights: https://www.doh.wa.gov/Portals/1/Documents/Pubs/655009.pdf (WAC 246-330-125)

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Birth/Death Registration

Policy

Birth/death certificates (RCW 70.58) are the responsibility of the attending midwife for each birth or death occurring under their care. These certificates should be filed in accordance with state law, or any governmental mandate in response to a public health emergency, including, but not limited to reporting requirements.

Procedure

The certificates will be mailed or sent via the internet to the local Registrar of Vital Statistics in compliance with Washington State statutes.

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Communication Needs (WAC 246-329-120(m))

Midwives will be responsible for making a good faith effort to address the devices and services / communications needs of clients, which may include interpreters, communication boards, TTY services, etc.

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Anti-Discrimination: Clients (2.4.K)

The CMC will not discriminate against any individual seeking care on the basis of sex, race, ethnicity, national origin, sexual orientation, gender identification, political/social affiliations, age, religion, economic status, or any other legally protected characteristic. Further, we will urge all providers, given advance notice, to provide interpretive services for non-English speaking clients or clients with hearing difficulties, and to provide for the availability of appropriate physical support and services for clients who are physically challenged.

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Anti-Discrimination: Employment

The CMC is an equal opportunity organization. The CMC will not discriminate and will take affirmative action measures to ensure against discrimination in employment, recruitment, advertisements for employment, compensation, termination, upgrading, promotions, and other conditions of employment against any employee or job applicant on the bases of an individual's sex, race, ethnicity, national origin, sexual orientation, gender identification, political/social affiliations, age, religion, economic status, or any other legally protected characteristic.

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Anti-Harassment

The CMC is committed in all areas to providing a work environment that is free from harassment. Harassment based upon an individual's sex, race, ethnicity, national origin, sexual orientation, gender identification, political/social affiliations, age, religion, economic status, or any other legally protected characteristics will not be tolerated. All employees, including directors, are expected and required to abide by this policy. No person will be adversely affected in employment with the CMC as a result of bringing complaints of unlawful harassment.

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Late Transfers

Policy

The CMC will accept late transfers given they have documentation showing a low-risk health status and meet guidelines meant to promote a safe birth.

Procedures

- Previous and up-to-date prenatal care chart should be made available to midwife for review prior to the initiation of care or admission to birth center or home birth
- Must be low risk, as evidenced by adherence to criteria laid out in this manual and in COVID-19 specific guidelines
- Must have had a mid pregnancy ultrasound
- If transferring after 28 completed weeks, must have had GDM screening and/or diagnostic testing, and evidence of normal blood glucose throughout pregnancy if positive. If entering care prior to the 28th week of pregnancy, the CMC will recommend a 1-step diagnostic gestational diabetes test (2 hr 75g)
- Must have had GBS testing (if transferring after 37 weeks and 6 days) and informed consent for GBS prophylaxis as appropriate
- Any standard or indicated labs that were not found in medical records may be drawn by the CMC. If there is a delay in procuring records pertaining to prenatal labs, they may be re-drawn
- All late transfers should be strongly encouraged to obtain labor/birth doula services. It is not guaranteed but may be possible for the CMC to have a list of free or low-cost doulas
- Midwives should encourage clients to prepare for an unmedicated birth through counseling during prenatal visits. Additionally, completing a childbirth preparation

education program (online or in person) or participating in self-study when preparing for an unmedicated out-of-hospital (OOH) birth for the first time should be encouraged

- If the risk for COVID-19 transmission in the hospital setting increases, or if there are insufficient inpatient beds or staffing, hospital-based providers may need to divert perinatal patients out of the hospital system into community-based care antenatally, during early labor, or within hours after birth. The hospital-based provider should consult with the CMC midwife and defer to the CMC's screening criteria in determining a client's risk status. The hospital-based provider and the receiving midwife will attempt as warm a hand-off as possible while maintaining social distancing requirements.

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Health Policies

Universal Precautions: Health & Exposure

Policy

Infection control and education is an integral part of client care. Midwives and other relevant staff should undergo annual OSHA training to minimize exposure risk, and should have documentation of an HIV/AIDS training. If clinical staff is unable to acquire any of the above-mentioned trainings due to hardship or unavailability caused by the COVID-19 crisis, an emergency waiver will be provided and signed.

Procedure

Midwives and designated staff staff should complete annual OSHA and HIV/AIDS training Individuals should maintain a record of training. Obtain emergency waiver if applicable.

Education & Training Program on BBP

Policy

BBP training is required for all midwives and staff to whom it is applicable, and may be offered as a part of orientation for the CMC. If clinical staff is unable to acquire any of the above-mentioned trainings due to hardship or unavailability caused by the COVID-19 crisis, an emergency waiver will be provided and signed.

Procedure

- Midwife and designated staff should complete annual bloodborne pathogens training
- Midwife should maintain a record of such training
- Obtain emergency waiver if applicable

Vaccination Documentation

Policy

All clinical staff must have documented Hep B immunization status (WAC 296-62-08001/ WAC 246-329-110), rubella immunization status, and a tuberculin skin test (WAC 246-329-110) (all staff who may have direct client contact); Childbirth Center Lawbook; (6.7.C) documented in their personnel file, or signed waiver of requirements. If clinical staff is unable to acquire any of the above-mentioned immunizations, screens, or tests due to hardship or unavailability caused by the COVID-19 crisis, an emergency waiver will be provided and signed.

Procedure

- Midwife should maintain documentation of Hep B immune status
- Midwife should maintain documentation TB screening results and repeat screening will be required with any known exposure or risk factor, per CDC guidelines
- Obtain emergency waiver if applicable

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Section 2: Special Policies & Procedures Related to COVID-19

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COVID-19 Health Policies & Clinical Guidance

Policy

Special precautions will be taken to reduce COVID-19 transmission, infection, and potential disease severity. Midwives and others involved in client care should take additional precautions to reduce transmission of the virus and should make a good faith effort to have contingency plans in place in case they do become ill.

Procedures

Telemedicine, Office Visits, and Safety Precautions

- Prenatal home visits are conducted rarely and only as needed, if clients have transportation or other barriers to reaching a clinic setting, and in order to assess the cleanliness and safety for home birth
- Midwives that conduct well-person visits should consider rescheduling nonessential visits in order to reduce possible COVID-19 transmission[2]
- Administrative staff should work from home when possible
- Office visits should be scheduled so there is no overlap among clients and should include additional time to adequately clean and sanitize the clinic space
    - Commonly touched surfaces and medical equipment (including, but not limited to, door knobs and handles, toilet flushers and bathroom faucet handles, chairs, exam tables, computers, dopplers, BP cuffs, stethoscopes, beds, tape measures, etc.) should be sanitized in between visits
- All decorative, cloth, non-essential, and hard to clean items (pillows, blankets, coffee table books, kids toys, etc.) should be removed from the clinic space
- Depending on clinic structure, clients should be instructed to arrive exactly on time or to call from their mode of transport to ensure no overlap
- Clients should come to visits alone whenever possible with the option to have family members/birth team join remotely
- Clients should wash their hands with soap upon entering the clinic and once again when they arrive back home. Use disposable towels in bathrooms and at sinks.
- Clients should be encouraged to follow current CDC guidelines regarding the use of face coverings when coming to clinic[4]
- Midwives should attempt to keep fingernails short, long hair tied back, and jewelry to a minimum (or not worn at all) during this time

Safety in Midwifery Practice and Screening of Midwives [2, 3]:

- Staff and midwives exhibiting symptoms will not be allowed at work. They should self-quarantine and check with their primary care provider or local health department for needed testing and for indicated next steps

- Midwives should aim to practice social distancing from other midwives, student midwives, and birth assistants, and have contingency plans in place in the event one of their staff or care team becomes ill
- Midwifery practices with multiple midwives and students/assistants may consider creating non-exchangeable pairs, so that if one pair becomes exposed and has to self-quarantine, the other midwife and assistant pair(s) can continue to practice
- Midwives and staff should participate in self-screening including symptom and elevated temperature check before coming to work. Those exhibiting symptoms or with a known exposure to COVID-19 should follow CDC and local health department recommendations for testing, isolation, and/or quarantine
- Midwives should follow current CDC guidelines regarding mask usage, as available. As of April 18, 2020, the CDC is recommending that all healthcare personnel wear non-cloth face masks at all times while they are in a healthcare facility[8]
- Midwives and staff should be screened for elevated temperature and other COVID-19 symptoms upon arrival to the clinic or birth center
- Midwives and staff who become ill and have mild symptoms can continue telemedicine, as able. They are eligible for work that does not require in-person contact, including, but not limited to, chart review, CQI activities, data entry, telephone triage, developing client education materials, conducting prenatal and postpartum visits remotely, etc.
- If a midwife becomes ill with COVID-19, all birth attendants and families who have been exposed to that midwife should follow CDC and local health department recommendations for testing, isolation, and/or quarantine
- Midwives should make a good faith effort to identify backup plans for their practices that includes at least one other, and ideally more than one, midwife/practice who can assume care and/or have care transferred to them in the event that a midwife and/or their practice tests positive or is exposed to COVID-19
- Return to work strategy follows CDC guidelines[1]:
    - *Test-base strategy.* Exclude those who developed symptoms from work until:
        - Resolution of elevated temperature without the use of elevated temperature-reducing medications **and**
        - Improvement in respiratory symptoms (eg., cough, shortness of breath) **and**
        - Negative result of an FDA Emergency Use Authorized molecular assay for COVID-19 from at least two consecutive nasopharyngeal swab specimens collected $\geq$24 hours apart (total of two negative specimens)
    - *Non-test-based strategy.* Exclude from work until:
        - "At least 3 days (72 hours) have passed *since recovery* defined as resolution of elevated temperature without the use of elevated temperature-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and,**
        - At least 7 days have passed *since symptoms first appeared*
        - If test-positive but asymptomatic, at least 7 days of self-isolation from the date of the positive test is required before returning to work.

    - If staff was diagnosed with a different illness (i.e. influenza): criteria for a return to work should be based on that diagnosis[1]
- Midwives should consider mechanisms by which to monitor and support their own emotional, spiritual, and mental health and well-being and should consider establishing care with a primary care provider to support well-being and assist with any management should a midwife become symptomatic with COVID-19. Additionally, midwives should consider the financial implications such care would require, and attempt to plan for the possibility of practice-wide or midwife illness, loss of business, and cost of care or treatment if ill

SpO2 Monitoring in Clients

- Although evidence on its utility or appropriate thresholds in COVID-19 management remains unknown, midwives may consider blood-oxygen (SpO2) level monitoring on all clients as part of their normal exam, and document results. All readings below 94 necessitate a consultation with the midwife's or CMC's available consulting physician(s) or UW MedCon at 1-800-326-5300.

COVID-19 Screening

- COVID-19 self-screening of all clients, their support team, and midwifery team through the CDC self-check at https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/index.html
- Universal symptom screening for birth team, clients, and their support people includes, but may not be limited to, the following:
    - Dry cough
    - Loss of taste and/or smell
    - Elevated temperature: ≥100 F (≥ 38 C) or higher (midwife should take and record temperatures)
    - Shortness of breath
    - Other new-onset symptoms (GI, muscle aches, fatigue, etc.)
    - Close contact with anyone who has a confirmed case (from testing or symptom profile) in the past 2 weeks

COVID-19 Testing

- Clients with symptoms of or known exposure to COVID-19 should be tested with their appropriate care provider per CDC testing criteria. Midwives should not provide tests for COVID-19 for clients, colleagues, or staff (this requirement may change as testing options evolve) unless circumstances demand and/or the midwife has access to complete appropriate personal protective equipment (PPE).

Step by Step Birth Center Cleaning Guide

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Positive COVID-19 Screen in Midwife or Client

Policy

Midwives should counsel clients on appropriate next steps, refer to appropriate care provider(s), and take steps to reduce the possibility of transmission of COVID-19, per CDC testing recommendations and guidance.

Procedures

With any positive screen, the following action items are taken (in no particular order):

- Direct client, clinical providers/and or staff, and any other individual present to immediately put on a mask and other PPE as available.
- Direct client to leave the building and wait outside, protected from the elements to the best of ability, for further instructions.
- Close the exam room door.
- Initiate immediate consultation into MedCon at 1-800-326-5300 or to the client's primary care provider to ask for directions to get the client tested and evaluated.
- Change clothing and shoes.
- Disinfect clinic including floors.
- If a positive screen occurred during a routine prenatal or postpartum visit, the remainder of the visit may be completed via telemedicine when appropriate.

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COVID-19 Client Education & Shared Decision-Making

Policy

Midwives will provide specialized counseling regarding COVID-19 to clients at the initial visit and on an ongoing basis.

Procedures

Efforts to Reduce Transmission or Progression of COVID-19

- Client education regarding precautions to reduce the risk of COVID-19 transmission include, but are not limited to, the following:
    - Avoid non-essential visits to healthcare facilities, including doctors and dentist's offices, urgent care, and hospitals

    - Practice social distancing and self-isolation as they are able to reduce the transmission of infection. Clients are encouraged to not attend group events and should minimize outings as much as possible
    - Limit all travel
    - Follow CDC guidelines on hand hygiene and prevention of infection transmission: Prevention of Coronavirus Disease 2019 (COVID-19)
    - Regularly disinfect commonly touched surfaces such as doorknobs, steering wheels, phones, light switches, and faucets
    - Support immune health and self-care practices
    - Discuss safety of OTC medications, herbs, etc., particularly as information about COVID-19 develops. Remind clients to report use of all herbal products to midwifery teams, including type and dosage
- Clients should be instructed on current COVID-19 symptoms and counseled to contact their midwife with positive symptoms or with known exposure to COVID-19

Special Considerations and Discussions

- Discussion and continued review of all indications where transfer to hospital-based care is recommended or required
- Discussion regarding potential delays in receiving higher levels of care due to COVID-19
- Discussion regarding transmission reduction procedures during care such as telemedicine. Sign consent to telemedicine document and place in client's file (IC found here: Telemedicine IC).
- Discussion of COVID-19 related health policies that are relevant to client visits and intrapartum care (such as handwashing upon entry to clinic and limiting the number of support people at births), as outlined above in this Section under "COVID-19 Health Policies and Clinical Guidance" and "Special Intrapartum Precautions to Reduce COVID-19 Transmission"
- Clients should be counseled to continue social distancing following their birth and avoid in-person introductions of their newborn to extended family and friends
- Given the anticipated financial, physical, mental, and emotional impact COVID-19, and its ensuing need for social isolation and distance, may have on expectant families, midwife may consider:
    - Utilizing the Edinburgh Postnatal Depression Scale (EPDS) or other evidence-based postpartum mood and anxiety disorder (PMAD) screening tool more frequently, including prenatally, in order to help assess the emotional status of clients
    - Screening for intimate partner violence (IPV) frequently throughout care.
    - Screening for substance use/abuse and disordered eating frequently throughout care
    - Discussing issues related to potential unforeseen financial hardship and economic impact of COVID-19, and assessing client's need for financial support
    - Screening for non-accidental trauma in children frequently throughout care.

- Discussing family planning options during the antepartum period in an effort for midwife and client to plan how client may access those services postpartum
- Discussing pregnancy options, including termination, up to the legally recognized period

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Home Visit & Home Birth Special Precautions

Policy

Midwives will take precautions to reduce the spread of COVID-19 during home visits.

Procedures

Midwives should

- Prescreen with a telephone call to pregnant person and those isolated in household as described above in "COVID-19 Health Policies and Clinical Guidance"
- Ask clients to clean and disinfect areas of the home where the midwife will be, where the birth is planned to occur, and commonly used areas such as bathrooms, doorknobs, light switches, kitchen, etc. These areas should be cleaned and maintained regularly until home visit care is discontinued
- Consider providing each client with a kit which contains single use items so that the midwife does not use tape measure, thermometer, doppler gel, blood pressure cuff, etc. at several homes, that can be used at each visit for the client and stored in the home
- Practice appropriate hygiene, and bring only essential items into the visit, in a plastic container or paper bag
- Bring a change of clothing, and consider changing clothes upon departure, wear a different lab coat or smock into each visit, or sit on a disposable pad in the client's house and/or in the midwife's car or other mode of transportation. De-gown and/or remove clothing either before leaving client's residence or prior to entering midwife's or other residence, roll up the gown and/or clothing, and place in a sealable plastic bag such as a Ziploc™. Wash and dry in high heat and dispose of sealable plastic bag
- Sanitize all equipment (doppler, fetoscope, BP cuff, stethoscope, tape measure, computer, phone, etc.), and the plastic bin before placing them back in the car
- To minimize exposure between a single family and multiple midwives, consider having the same midwife attend the prenatal home visit, the birth, and the postpartum home visit

For home birth

- Supplies designated for one birth should be placed in washable containers such as plastic bins, hardshell suitcase, Ziploc™ bags or washable bags (duffel, reusable grocery, wet bags, etc).
- Individual containers for IV start kits (including the IV bag), GBS prophylaxis kits, suture kits, postpartum hemorrhage kits, emergency medication kits, newborn exam kits, etc. should all be individually packaged into to plastic containers or ziplock bags so that if they are not opened at a birth, they can remain in the kit and the outside can be sanitized.
- Non-sterile gloves may be packaged into reusable diaper wipe containers or small Ziploc™ bags in smaller quantities for easy access.
- Birth bags that cannot be sanitized and extra supplies should remain accessible in the midwife's vehicle unless the midwife has access to UVC lights and follows the proper guideline for decontaminating the entire surface of each bag.
- Upon leaving the place of birth, all supplies and bins used at the birth should be taken outside and sanitized. The midwife should change clothes and place birth clothes into a plastic bag. Prior to loading sanitized supplies into the vehicle or mode of transport, the midwife should wash hands. Sanitize keys, phone, watch, jewelry, computer, and oxygen tank. If the midwife is unable to change clothes, the midwife should place a disposable pad over the seat in the midwife's mode of transportation. Birth clothes should be washed upon arrival at midwife's residence or clinic.
- Consider leaving the sling used to weigh the baby at the home for the postpartum home visit.

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Special Intrapartum Precautions

Policy

Midwives will take precautions to reduce the risk of COVID-19 exposure during labor and birth.

Procedures

- Handwashing is required for all clients and support people upon entrance to birth center or upon admittance to home birth.

- Only two support people may be allowed in the birth room. If at a home birth, any additional people in the home may be asked to leave but, if impossible, additional people in the home should stay at least six feet away and preferably in another room from all members of the birth team. If at all possible, no children at the birth.
- No additional people may wait in the waiting area of a birth center. Support people may be asked to stay in the birthing room at all times to avoid unanticipated interaction with others in waiting room.
- All clients and those accompanying them will be checked for elevated temperature and screened for COVID-19 symptoms, per protocol.
- Clients at less than six (6) centimeters dilation (as determined by cervical exam, unless membranes are ruptured) may not be admitted to a birth center, and the midwife may choose to not stay at the home, unless special circumstances exist, as determined by the attending midwife.
- The time spent postpartum before discharge may be abbreviated as the midwife determines is safe, but should not be less than two (2) hours follow third stage.
- The midwifery team should practice social distancing during intrapartum care to the extent it is possible and reasonable.
- If a laboring person arrives with or develops symptoms of COVID-19 during labor, follow protocols above for protection and transfer of care to the hospital immediately, per ACOG recommendations.[6] Birth team should put on a face mask, close the door to the birth room upon exit, and ensure the birth room is properly disinfected. Receiving hospital shall be notified that an incoming laboring patient is suspected to be COVID-19 positive.

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Special Considerations for Counseling PUI or Clients Diagnosed with COVID-19 in Preparation for Hospital-Based Care

Policy

Midwives will counsel and attempt to manage expectations for clients who require hospital-based care due to their COVID-19 status or risk factors (either persons under investigation (PUI) or known COVID-positive through testing).

Procedures

Midwives should

- Counsel clients regarding the variable recommendations for separating COVID-positive birthing persons or birthing PUI from their newborns, and prepare clients that each hospital will have its own policy and each provider their own perspectives, which change frequently. Midwife may consider offering clients a sample informed refusal regarding birthing person and newborn separation. Counsel on the importance of asking questions and their right to understand the care plan and course of care
- Encourage breast/chestfeeding for clients who intend to do so. Breast/chestfeeding is considered safe and should be encouraged, with the precaution of the breast/chestfeeding caregiver wearing a mask and practicing scrupulous hygiene.[5] The CDC and ACOG recommend that all lactating patients under investigation or diagnosed with COVID-19 should express colostrum/milk and a well care-giver should feed the newborn when possible
- Prepare clients that support people may be limited as hospitals evolve policies to reduce the risk for transmission, including possibility that midwife may not remain for support or accompany client to the hospital
- Prepare clients for potential increased risk for intervention such as induction of labor (early or at term) or cesarean section in people under investigation for or diagnosed with COVID-19 due to clinical concerns or iatrogenic causes[7]

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Midwife's Attendance in Hospital in the Event of Transfer

See Section 7, "Transfer Policies and Procedures," of this manual

Special Charting Criteria Related to COVID-19

See Section 8, "Charting Criteria," of this manual

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Section 2 References

1. Centers for Disease Control and Prevention. (2020, March). Coronavirus disease 2019 (COVID-19): Return-to-work criteria for healthcare workers. Retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html
2. Centers for Disease Control (2020a, March). Coronavirus disease 2019 (COVID-19): How to protect yourself. Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fprepare%2Fprevention.html
3. Centers for Disease Control and Prevention (CDC). (2020, March). Coronavirus Disease 2019 (COVID-19): Interim infection prevention and control recommendations. Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control.html
4. Centers for Disease Control and Prevention (CDC). (2020, April 4). Coronavirus Disease 2019 (COVID-19): Recommendation regarding the use of cloth face coverings, especially in areas of significant community-based transmission. Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover.html
5. World Health Organization. (2020, March 13). Clinical management of severe acute respiratory infection when novel coronavirus (nCoV) infection is suspected. Retrieved from https://www.who.int/publications-detail/clinical-management-of-severe-acute-respiratory-infection-when-novel-coronavirus-(ncov)-infection- is-suspected?fbclid=IwAR3SnY9JFS1QmUiWX_akjKqdzag2HzWoHYTPIqcRCl7tP3knHwl4orEtUsc
6. American College of Obstetricians and Gynecologists. (2020, March). Outpatient assessment and management for pregnant women with suspected or confirmed novel Coronavirus (COVID-19). Retrieved from https://www.acog.org/-/media/project/acog/acogorg/files/pdfs/clinical-guidance/practice-advisory/covid-19-algorithm.pdf?la=en&hash=2D9E7F62C97F8231561616FFDCA3B1A6
7. Dekker, R. (2020, March). Coronavirus COVID-19: Evidence based birth resource page. Retrieved from https://evidencebasedbirth.com/covid19/
8. Centers for Disease Control (CDC). 2020, April 13). Coronavirus disease 2019: Infection control guidance. Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

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Section 3: Client Eligibility & Risk Criteria

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Client Eligibility for OOH Birth

Policy

A basic requirement of safe OOH delivery is the determination that the client is at "low-risk" for obstetrical complications. The CMC adheres to the Washington State Department of Health (DOH)'s definition of low risk (WAC 246-329-010(18)(c)), as well as community Standards of Practice determined by MAWS. There is emerging evidence that pregnant people with comorbidities, including but not limited to poor blood glucose control and hypertension, are at higher risk for poor outcomes from COVID-19. For this reason, assessment of risk, and recommendation for the safest birth location, may differ from non-COVID pandemic care. The CMC's guidelines are updated as relevant information is released.

Per the DOH definition of low-risk, clients are eligible for OOH delivery if they are:

- Term gestation, between 37 and 42 weeks
- In good health and have had an uncomplicated prenatal course
- In progressive labor
- Appropriate "for setting where methods of anesthesia are limited"

Clients are **not** eligible for OOH birth if they meet any of the criteria in "Criteria for Transfer" below of the criteria listed below requiring transfer.

Procedure

- The midwife, in collaboration with the CMC, will make final determination of eligibility for admission to OOH birth, preferably based upon a review of client prenatal records between 35 and 37 weeks. If the client is admitted to care after this time frame, the review of prenatal records will take place then.
- In cases where the CMC, DOH definition, and MAWS guidelines do not match, the more conservative policy will hold.

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Indications for Discussion, Consultation, and Transfer

Please see Midwives' Association of Washington State INDICATIONS FOR DISCUSSION, CONSULTATION, AND TRANSFER OF CARE IN A HOME OR BIRTH CENTER for further description of terms.

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Criteria for Discussion

Initial History Findings Requiring Discussion[1]:

Policy

Midwives should have a **discussion** with another provider in the event of the following conditions found on the initial history:

- Family history of significant genetic disorders, hereditary disease, or congenital anomalies
- History of pre-term birth (<36 weeks)
- History of IUGR
- History of severe postpartum hemorrhage
- History of severe pre-eclampsia or HELLP
- History of gestational diabetes requiring oral hypoglycemic or insulin
- No prenatal care prior to third trimester
- BMI>35
- History of lap band, gastroplasty or other bariatric (weight loss) surgery
- Previous unexplained neonatal mortality or stillbirth

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Intrapartum Findings Requiring Discussion:

Policy

Midwives should have a **discussion** with another provider in the event of the following conditions during labor:

- Protracted active labor, defined as:
  - <1-2 cm cervical dilation per hour in a nulliparous client who is > 6 cm dilated OR
  - <0.5-1 cm cervical dilation per hour in a multiparous client who is >6cm dilated [10, 11, 12, 13, 14, 15]
- >1 hour of active pushing without significant change in a multiparous client and >3 hours for a nulliparous client [13,16]

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Criteria for Consultation

Initial History Findings Requiring Consultation[1]:

Policy

If resources and availability of hospital based staff permit, midwives should **consult** for any clients with any of the following conditions during pregnancy:

- Absent prenatal care at term
- History of seizure disorder in adulthood
- History of HELLP[3]
- History of uterine surgery, including myomectomy
- Significant history of or current cardiovascular, renal, hepatic, neurological or severe gastrointestinal disorder or disease[4]
- Significant history of or current endocrine disorder (excluding controlled mild hypothyroidism)
- Pulmonary disease/active tuberculosis/severe asthma
- Collagen vascular diseases
- Significant hematological disorders
- Current or recent diagnosis of cancer requiring chemotherapy
- History of cervical cerclage
- History of 3 consecutive spontaneous abortions (excluding clients who present to care with viable pregnancy at gestation >14wks and beyond previous miscarriage)
- Significant uterine anomalies
- Essential hypertension
- History of eclampsia
- History of postpartum hemorrhage requiring transfusion
- Current severe psychiatric illness
- Current seizure disorder
- Presentation other than cephalic at 37 weeks

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Antepartum Findings Requiring Consultation[1]:

Policy

If resources and availability of hospital based staff permit, midwives should **consult** for any clients with any of the following conditions during pregnancy:

- Reportable sexually transmitted infection
- Significant abnormal Pap
- Significant abnormal breast lump
- Urinary tract infection unresponsive to treatment
- Fetal demise after 14 weeks gestation
- SpO2 levels measuring below 94 on the pulse oximeter
- Significant infection the treatment of which is beyond the midwife's scope of practice
- Significant abnormal ultrasound finding
- Significant abnormal laboratory finding
- Unresolved size/dates discrepancies
- 42 completed weeks with reassuring fetal surveillance including AFI and BPP with NST
- COVID-19 diagnosis, known exposure, or symptoms indicative of COVID-19 infection including, but not limited to, dry cough, loss of taste and smell, elevated temperature, or shortness of breath. Clients with these symptoms should be tested at their local hospital or primary care provider. Midwives should not provide tests for COVID-19 for clients, colleagues, or staff (this requirement may change as testing options evolve) unless circumstances demand and/or the midwife has access to complete appropriate personal protective equipment (PPE)
    - During the course of the client's infection, midwives should not participate in direct, hands-on care but may participate in telehealth visits.
    - Clients may be eligible for return to care if their COVID-19 diagnosis has resolved, they have no symptoms, and risk for viral shedding is no longer a concern.

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Postpartum Findings Requiring Consultation (Birthing Person)[1]:

Policy

If resources and availability of hospital based staff permit, midwives should **consult** for any clients with any of the following conditions during pregnancy:

- SpO2 levels measuring below 94 by pulse oximeter
- Urinary tract infection unresponsive to treatment
- Mastitis (including breast/chest abscess) unresponsive to treatment
- Reportable sexually transmitted infections

- Retained products/unresolved sub-involution/prolonged or excessive lochia
- Significant abnormal Pap
- Significant postpartum depression

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Postpartum Findings Requiring Consultation (Newborn)[1]:

Policy

If resources and availability of hospital based staff permit, midwives should **consult** for any clients with any of the following conditions during pregnancy:

- Low birth weight newborn (< 2500 g = 5#5)
- SpO2 levels measuring below 90 on the pulse oximeter after ten minutes of life
- Loss of greater than 10% of birth weight
- Prolonged asymptomatic jaundice
- Persistent cardiac arrhythmias or murmurs
- Significant clinical evidence of prematurity
- Failure to thrive
- Feeding difficulties unresponsive to midwife's management
- Hypoglycemia
- Significant or symptomatic jaundice beyond the first 24 hours
- Positive critical congenital heart disease screening (CCHD)

Neonate consultation: Seattle Children's Hospital Provider-to-provider line 1-206-987-7777

More information is available at http://www.seattlechildrens.org/healthcare-professionals/

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Criteria Requiring Documented Consultation

Initial History Requiring Documented Consultation:

Policy

Clients with the following documented medical conditions ***require documented consultation confirming low-risk status*** prior to be being eligible for OOH birth:

- Adult episodes of epilepsy, seizure disorder, or unknown etiology
- Diagnosed Hepatitis B, if the midwife does not stock HIB or HBV
- Hyperthyroidism
- Current severe infectious disease

- Primary herpes infection
- Significant history of or current endocrine disorder
- Severe mental health problem requiring medication
- Severe chronic auto-immune disorder
- Other serious medical problems

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Antepartum History Requiring Documented Consultation:

Policy

Clients with the following antepartum documented medical conditions at term ***require documented consultation confirming low-risk status and appropriateness*** for OOH birth.

- Uterine or placental anomalies
- History of uterine fibroids
- Significant fetal anomalies
- Diagnosed Hepatitis B if the midwife does not stock HIB or HBV

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Criteria for Transfer

Antepartum Findings Requiring Transfer[1]:

Policy

Clients with the following documented medical conditions are **not** eligible for birth with the CMC and require a **transfer** of care:

<u>Pre-existing Conditions and Initial History</u>

- Cardiovascular:
  - Compromising heart affectation
  - Preexisting hypertension
  - Pulmonary embolus
  - Symptomatic congenital heart defects
- Cognitive function: Any traumatic injury or underlying disorder that affects cognitive function to the extent it impairs ability to participate in informed decision making.
- Endocrine: Pre-existing insulin-dependent diabetes mellitus
- Psycho-neurological: Epilepsy or seizure disorders requiring use of anticonvulsant drugs
- Urinary System: Moderate to severe renal disease with failure
- Immune: significant autoimmune disorder or current immunosuppressive drug regimen
- Other:

- Compromising hemolytic disease
- Low platelet count (<100,000)
- HIV infection[9]
- Previous major uterine wall surgery
- Uncontrolled asthma

Antepartum conditions

- Anemia (hemoglobin <9.5)
- Anemia unresponsive to treatment
- Active alcohol addiction in pregnancy
- Active illegal and/or prescription drug addiction in pregnancy
- Deep vein thrombosis*
- Documented vasa previa
- Irregular prenatal course
- IUGR
- Pyelonephritis
- Fetal abnormality incompatible with life
- Known clinically significant placental abruption
- Laboratory evidence of sensitization in Rh negative woman with unknown or Rh positive baby
- Low platelet count <100,000/uL
- Medication-dependent Gestational Diabetes Mellitus (GDM), lack of adequate documentation indicating diet controlled GDM under adequate control, or no documentation of GDM testing status if client is ≥29 weeks
- Multiple gestation
- Narcotic use at term
- Persistent (at term) polyhydramnios or oligohydramnios (per WAC 246-329-010(18)(c))
- Placenta previa, or low-lying placenta (< 2 cm from cervical os) at term
- Pre-eclampsia, eclampsia, or persistent hypertension*
- Unstable mental health
- Lack of documentation showing Group B Streptococcus (GBS) test results if client is ≥37 weeks gestation
- Lack of documentation of mid pregnancy ultrasound
- Significant vaginal bleeding
- Hemoglobinopathies
- Persistent abnormal fetal heart rate or rhythm
- Non-reassuring fetal surveillance
- Ectopic pregnancy
- Molar pregnancy
- Premature pre-labor rupture of membranes (PPROM)
- Documented persistent/unresolved intrauterine growth restriction (IUGR)
- Placenta previa at term
- Isoimmunization with an antibody known to cause hemolytic disease of the newborn

- Clinically significant placental abruption
- Deep vein thrombosis
- Cardiac or renal disease with failure
- Gestational diabetes requiring management with medication; consultation in lieu of transfer if co-managing metformin with physician
- Known fetal anomaly or condition that requires physician management during or immediately after delivery
- 42 weeks completed gestation
- Significant placental abnormalities
- Unresolved Covid-19 illness as determined by Covid-19 diagnosis or symptoms indicative of Covid-19 infection including, but not limited to, elevated temperature or shortness of breath. Clients with these symptoms should be screened by the appropriate providers. Midwives should not participate in screening for Covid-19 nor should they participate in direct, hands on care with clients infected with Covid-19.
- Any significant, unresolved respiratory illness, even with a negative COVID-19 diagnosis.
- SpO2 reading of less than 90

Procedure

See Section 7, "Transfer Policies and Procedures," of this manual

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Intrapartum Findings Requiring Transfer[1]:

Policy

The following findings or conditions require a **transfer** of the client to the hospital:

- Labor at <37 weeks gestation, or >42 weeks gestation
- Abnormal bleeding
- Cord prolapse
- Decision by attending midwife that birth would best be accomplished in a hospital. This may include, but is not limited to, failure to meet responsibilities of families for OOH birth, or need for pharmacologic induction or augmentation of labor, instrumental delivery, or continuous electronic fetal monitoring, unless provider is adequately and appropriately trained in the aforementioned, it is within the practitioner's scope of practice, and permissible in the setting in which it occurs.
- EFW less than 2500 g (5#5)
- Evidence of active infectious process indicative of chorioamnionitis including, but not limited to tachycardia, fetal tachycardia, temperature >100° F, uterine tenderness, purulent or malodorous amniotic fluid

- elevated temperature ≥ 100° F, persisting despite thermoregulation efforts such as removing client from tub, aggressive hydration etc.
- Suspected genital herpes outbreak
- Undiagnosed multiple gestation
- Hypertension: ≥ 140 systolic or 90 diastolic twice, 1 hour apart
- Non-progressing active labor
- Non-progressing second stage of labor
- Non-reassuring FHT or fetal status unresponsive to treatment
- Presence of meconium in amniotic fluid (in the absence of imminent birth) [2, 3, 4, 5]
- Non-vertex presentation in labor
- ROM >24 hours without labor [6, 7, 8, 9]
- Significant allergic reaction
- Sudden onset severe hypertension ≥160 systolic or ≥ 110 diastolic
- Seizure
- Suspected pre-eclampsia (e.g. hypertension with proteinuria)
- Suspected placental abruption or uterine rupture
- Birthing person exhaustion unresponsive to rest/hydration
- Request from birthing person for transfer
- COVID-19 diagnosis, known COVID-19 exposure, or symptoms indicative of COVID-19 infection including, but not limited to, elevated temperature or shortness of breath.
- SpO2 reading of less than 90

Procedure

See Section 7, "Transfer Policies and Procedures," of this manual

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Postpartum Findings Requiring Transfer (Birthing Person)[1]:

Policy

Clients with the following postpartum findings require a **transfer** of care:

- Any condition requiring extended, continuous post-birth observation where the client will be best cared for in the hospital. The midwife and receiving hospital-based provider will consider hospital staffing, the risks of COVID-19 transmission at the receiving hospital, and the client's condition in order to determine the safest place for the client to continue receiving care.
- Cervical or uterine prolapse
- Hemorrhage unresponsive to treatment
- Laceration greater than 2nd degree and/or beyond the midwife's ability to repair

- Birthing person and/or support person(s) demonstrate or express inability to competently monitor birthing person well-being in the home setting
- Persistent vertigo
- Retained placenta ≥ one hour
- Significant or enlarging hematoma
- Persistent unstable vital signs
- Unusual or unexplained significant pain or dyspnea
- Endometritis
- Seizure
- Anaphylaxis
- elevated temperature (>100) that persists > 1 hour within the first 72 hours postpartum
- Persistent hypertension in the first 72 hours postpartum (≥ 140 systolic or 90 diastolic twice, 1 hour apart)
- SpO2 reading of less than 90
- Postpartum psychosis

Procedure

See Section 7, "Transfer Policies and Procedures," of this manual.

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Postpartum Findings Requiring Transfer (Newborn)[1]:

Policy

Newborns with the following findings require a **transfer** of care:

- Any condition requiring extended, continuous post-birth observation where the client will be best cared for in the hospital. The midwife and receiving hospital-based provider will consider hospital staffing, the risks of COVID-19 transmission at the receiving hospital, and the client's condition in order to determine the safest place for the client to continue receiving care.
- Seizure
- Immediate jaundice (<24 hours of age)
- Persistent respiratory distress
- Persistent central cyanosis or pallor or persistent low oxygen saturation level
- Persistent temperature instability
- Persistent hypoglycemia
- Significant bruising, petechiae, or purpura
- Apgar score 6 or less at ten minutes of age
- Major congenital anomalies affecting well-being

- Birth injury requiring medical attention
- Parents and/or guardians demonstrate or express inability to competently monitor newborn well-being in the home setting

Procedure

See Section 7, "Transfer Policies and Procedures," of this manual.

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Section 3 References

1. Midwives Association of Washington State. (2016, December 19). Indications for discussion, consultation and transfer of care in a home or birth center midwifery practice. Retrieved from https://www.washingtonmidwives.org/uploads/1/1/3/8/113879963/maws-indications-2016.pdf
2. Hiersch, L., Melamed, N., Rosen, H., Peled, Y., Wiznitzer, A., & Yogev, Y. (2013). New onset of meconium during labor versus primary meconium-stained amniotic fluid: Is there a difference in pregnancy outcome? *The Journal of Maternal-Fetal & Neonatal Medicine, 27*(13), 1361-1367. doi:10.3109/14767058.2013.858320
3. Ierland, Y. V., Boer, M. D., & Beaufort, A. J. (2009). Meconium-stained amniotic fluid: Discharge vigorous newborns. *Archives of Disease in Childhood - Fetal and Neonatal Edition, 95*(1). doi:10.1136/adc.2008.150425
4. Locatelli, A., Regalia, A. L., Patregnani, C., Ratti, M., Toso, L., Ghidini, A. (2005, July). Prognostic value of change in amniotic fluid color during labor. *Fetal Diagnosis and Therapy, 20*(1), 5-9.
5. Mundhra, R. (2013). Fetal outcome in meconium stained deliveries. *Journal of Clinical and Diagnostic Research*. doi:10.7860/jcdr/2013/6509.3781
6. Dekker, R. (2017). Evidence on: Premature rupture of membranes. Retrieved online from http://evidencebasedbirth.com/evidence-inducing-labor-water-breaks-term/
7. Hannah M. E., Ohlsson A., Farine D., Hewson S. A., Hodnett E. D., Myhr T. L., et al. (1996). Induction of labor compared with expectant management for prelabor rupture of the membranes at term. *New England Journal of Medicine, 334*(16),1005-1010.
8. Middleton, P., Shepherd, E., Flenady, V., McBain, R. D.& Crowther, C. A. (2017). Planned early birth versus expectant management (waiting) for prelabour rupture of membranes at term (37 weeks or more). Cochrane Database of Systematic Reviews, 2017(1). doi:10.1002/14651858.CD005302.pub3
9. Scorza, W.E. (2018). Management of prelabor rupture of the fetal membranes at term. In C.J. Lockwood's (Ed.), *UpToDate.* Retrieved November 2, 2018 from http://www.uptodate.com.buproxy.bastyr.edu:2048/contents/management-of-prematreRupture-of-the-fetal-membranes-at-term
10. Ehsanipoor, R. M. & Satin, A. J. (2020, March 26). Normal and abnormal labor progression. In V. A. Barss (Ed.), *UpToDate*. https://www-uptodate-com.buproxy.bastyr.edu/contents/normal-and-abnormal-labor-progression?search=second%20stage%20labor&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1#H2601216057
11. Spong, C. Y., Berghella, V., Wenstrom, K. D., Mercer, B. M., & Saade, G. R. (2012). Preventing the first cesarean delivery: summary of a joint Eunice Kennedy Shriver national institute of child health and human development, society for maternal-fetal medicine, and American college of obstetricians and gynecologists workshop. *Obstetrics and gynecology*, *120*(5), 1181.
12. Zhang, J., Troendle, J. F., & Yancey, M. K. (2002). Reassessing the labor curve in nulliparous women. *American journal of obstetrics and gynecology*, *187*(4), 824-828.

13. Zhang, J., Landy, H. J., Branch, D. W., Burkman, R., Haberman, S., Gregory, K. D., ... & Hibbard, J. U. (2010). Contemporary patterns of spontaneous labor with normal neonatal outcomes. *Obstetrics and Gynecology*, *116*(6), 1281.
14. Zhang, J., Troendle, J., Mikolajczyk, R., Sundaram, R., Beaver, J., & Fraser, W. (2010). The natural history of the normal first stage of labor. *Obstetrics & Gynecology*, *115*(4), 705-710.
15. Kilpatrick, S. & Garrison, E. (2017). Normal labor and delivery. In S. Gabbe, J. Niebyl, J. L. Simpson, M. B. Landon, H. L. Galan, E. R. Jauniaux, D. A. Driscoll, C. Berghella, W. A. Grobman (Eds.), Obstetrics: Normal and problem pregnancies. (7th edition) Retrieved from https://www-clinicalkey-com.buproxy.bastyr.edu/#!/browse/book/3-s2.0-C2013000408 2
16. American College of Obstetricians. (2019, February). ACOG committee opinion number 766: Approaches to limit intervention during labor and birth. Retrieved from https://www.acog.org/en/Clinical/Clinical%20Guidance/Committee%20Opinion/Articles /2019/02/Approaches%20to%20Limit%20Intervention%20During%20Labor%20and% 20Birth

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Section 4: Antepartum Care

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Antepartum: Content of Care

Policy

Midwives will provide information and discussion, and will refer clients to programs of education as needed, to promote antepartum well-being and knowledge about pregnancy, birth, family planning, postpartum, breast/chestfeeding, and parenting.

Midwives should consult and/or refer, as appropriate, for any deviation from normal during the antenatal course of care, as detailed in this policy manual.

Midwives should adhere to the Midwives Model of Care™, which states:

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

- *Monitoring the physical, psychological, and social well-being of the pregnant person throughout the childbearing cycle*
- *Providing the pregnant person with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support*
- *Minimizing technological interventions*
- *Identifying and referring clients who require obstetrical attention*

The application of this individual-centered model of care has been proven to reduce the incidence of birth injury, trauma, and cesarean section. *Copyright (c) 1996-2008, Midwifery Task Force, Inc., All Rights Reserved.*

Procedures

Counseling and discussions with clients should cover the following topics as appropriate to gestational age of pregnancy:

- Pregnancy
- Prenatal genetic screening
- Range of recommended weight gain
- Labor and birth

- Pain relief options for labor, including risks/benefits of each and locations where each is available
- Interventions that may be indicated (epidural, cesarean birth, instrument assisted vaginal birth) to inform later decision making
- Breast/chestfeeding
- Newborn assessment and care
- Parenting
- Self care/self-help
- Sibling preparation, as needed
- Smoking cessation, as indicated
- Restriction of alcohol and drug use, as indicated
- Nutrition
- Best practices around limiting COVID-19 transmission and exposure
- Indications for hospital transfer including urgent vs non-urgent and protocols around transfering, potential delays in transferring/accessing higher level health care, and the client's willingness to transfer if/when clinically indicated
- CDC recommendations for vaccinations in pregnancy (including but not limited to Tdap and influenza) and discussion pertaining to the increased severity of COVID-19 infections in those with comorbidities;
- Shared decision-making discussion involving active management of the third stage of labor, including administration of intramuscular or intravenous oxytocin;
- Qualifications and responsibilities of the midwifery staff and of the client during the course of care;
- The potential need for medical consultation or referral in the event of complications beyond the scope of midwifery practice
- The potential risks inherent in pregnancy and birth as well as those specific to birth in an OOH setting, with special attention to the implications of the COVID-19 strain on healthcare systems, and the known and developing risks of comorbidities in disease severity and progression
- Procedures for the emergency transfer of birthing person or infant and acknowledgement that during the COVID-19 public health emergency, the typical EMS response availability may be altered unpredictably
- Information regarding personnel and services available to clients, including role of student midwives, and required intrapartum midwifery team personnel potentially unknown to clients (but approved by the CMC)
- Use of client records
- Procedures for addressing client grievance
- Procedures for termination of client-midwife relationship
- Standard laboratory testing during the perinatal period (including HIV)
- Developing a plan of care in cooperation with the client
- Risks, procedures, and policies related to COVID-19
- Family planning

Standard procedures during antepartum care

- Obtaining a complete health history
- A physical examination, including pelvic, or obtaining documentation of recent examination. Physical examinations may need to be limited due to the COVID-19 public health emergency recommendations for social distancing
- Obtaining laboratory studies to establish the health status of the client
- GBS testing or agreement to intrapartum antibiotics if GBS status is unknown
- Gestational diabetes testing utilizing the 75 gram diagnostic test and management of gestational diabetes resulting in controlled blood sugars
- A mid-pregnancy ultrasound
- Screening for IPV and client's personal safety at home and/or work
- Initial screening and on-going risk assessment for pregnancy and non-pregnancy complications and COVID-19
- Given the possible uncertainty in the postpartum care schedule due to the COVID-19 pandemic, for Rh negative clients the midwife can consider offering the non pregnant biological parent blood typing in the antepartum period in order to help assess the need for administering RhIG to the client during the prenatal and postpartum time

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Childbirth Education & Doula Support

Policy

Midwives should encourage clients to prepare for an unmedicated birth through counseling during prenatal visits, and referrals to online childbirth education classes or pre-recorded videos. Midwives support and encourage clients to have doulas, as feasible or desired, and suggest midwives have a robust referral list for doulas to share with clients.

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Prenatal Visit Schedule

Policy

Midwives will conduct thorough, clinically based prenatal care that take special considerations in order to reduce COVID-19 transmission.

Procedure

In-Person Visits

- Initial prenatal visit: 10-12 weeks gestation or sooner as clinically indicated.
    - Midwives may consider providing or instructing clients to procure a home blood pressure cuff, doppler/fetoscope, and tape measure for self physical assessment during telemedicine visits.
    - Client education pertaining to COVID-19 transmission reduction and special precautions and procedures adopted during midwifery care in light of the COVID-19 pandemic as outlined in Section 2, "Special Policies and Procedures Related to COVID-19," of this manual.
- Routine prenatal visits:
    - 20 (*if fetal survey ultrasound is performed, telemedicine visit may be offered instead) 28, 32, 36, 37, 38, 39, 40, and 41 weeks.
    - Visits in the third trimester should be primarily in person, as health permits, in order for the midwife to assess fetal position, growth, and for signs/symptoms of preeclampsia or other prenatal concerns in screening for appropriateness for OOH birth.
    - Clients should be instructed in palpating their symphysis pubis and fundus to complete fundal height measurements independently during telemedicine visits.
    - Any acute visit deemed clinically appropriate in-person by the midwife and the client, or that requires lab work or physical assessment.

Telemedicine Visits (via phone or video platforms such as Zoom, Facetime, Skype, Google Hangouts, WhatsApp, etc.):

- Consultation visits and birth center tours.
- Routine prenatal visits: 14/16, 20, 24, 30, and 34 weeks.
- Other visits as deemed appropriate if the client is sick or has been exposed to COVID-19 and is on self-quarantine or self-isolation precautions.
- When possible, HIPAA compliant telemedicine platforms should be utilized.

Weeks	**10-12**	**14-16**	**20***	**24**	**28**	**30**	**32**	**34**	**36 +**
In person	X		X		X		X		X
Telemed		X		X		X		X	

*If fetal fetal survey ultrasound performed, this visit may be offered via telemedicine

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Special Precautions to Reduce Antepartum COVID-19 Transmission

See Section 2, "COVID-19 Client Education" and "COVID-19 Guidance for Midwives," of this manual.

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Section 5: Intrapartum & Immediate Postpartum Care

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Birth Room Setup

Policy

Midwife, or student or birth assistant or other personnel as deemed available and appropriate under supervision, will prepare birth room prior to delivery.

Procedures

- Make environment comfortable and welcoming: turn on lights, turn up heat, etc. as needed.
- Confirm that all necessary supplies and equipment are in working order and accessible
    - Ensure emergency medications are readily available.
    - Prepare birth tray/bowl
    - Set up newborn resuscitation station: check level of and functioning of oxygen tank and ensure proper functioning of infant resuscitation equipment
    - Set up receiving blanket and heating pad

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Admission to Birth Center or Home Birth

Policy

A record of client history, physical examination, and risk assessment will be recorded upon admission for birth, as outlined in Section 8, “Charting Criteria,” of this manual.

Procedures

General Admission Procedures

- Clients should be encouraged to labor at home with their support team until active labor, if clinically appropriate.[11] Labor triaging should be done via telemedicine to limit potential exposure time unless clinically indicated.
- Active labor is defined as 6 centimeters dilation[11]
- The prenatal record should be reviewed
- Risk criteria assessment will be performed and documented, including COVID-19 symptom and temperature check of client and their support persons
- Birthing person status will be recorded, as outlined in Section 6, "Charting Criteria," of this manual
- Fetal status will be recorded, as outlined in Section 6, "Charting Criteria," of this manual
- Clients in active labor should be admitted for birth, preferably as determined by a cervical exam (unless membranes are ruptured) indicating dilation of six (6) centimeters
- Clients in latent labor should be discharged to home per the midwife's judgment
- Documentation of consultation and/or transfer of care will occur if client does not meet OOH birth risk criteria at admission
- A plan will be established to have a birth assistant present for birth and postpartum period
- During birth center births, a LM or CNM must be present at all times when the birthing person or newborn is at the birth center

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Special Intrapartum Precautions to Reduce COVID-19 Transmission

See Section 2, "Special Policies and Procedures Related to COVID-19," of this manual

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Routine Intrapartum Care

Policy

The midwife will provide intrapartum care aimed at ongoing assessment of risk status, early identification of complications, and promotion of a positive experience for the family. Electronic fetal monitors, drugs for induction or augmentation of labor, vacuum extractors, and forceps will not be used during labor unless the provider is adequately and appropriately trained, it is within the practitioner's scope of practice, and permissible in the setting in which it occurs. Midwife will document client's intrapartum care per State regulations (WAC 246-329-140) and guidelines in this manual.

Procedures

General Intrapartum Care Procedures

- Blood pressure, temperature, pulse, and respiratory rate of birthing person on admission and at least every four (4) hours
- Although evidence on its utility or appropriate thresholds in COVID-19 management remains unknown, midwives may consider blood-oxygen (SpO2) level monitoring on all clients as part of their normal exam, and document results. All readings below 94 necessitate a consultation with the midwife's or CMC's available consulting physician(s) or UW MedCon at 1-800-326-5300.
- Temperature of support team and midwifery team on admission
- Increased frequency of vital signs in the presence of risk factors (e.g., ROM, borderline BP, birthing person elevated temperature, etc.).
    - If ≥140 systolic and/or ≥90 diastolic, repeat within 1 hour and refer to risk assessment guidelines
- Client may choose a position of comfort at all times, including immersion in water, unless there is a specific contraindication
- Client may eat and/or drink as desired
- Ability to use nitrous oxide, if available, will be determined based on current evidence, expert opinion, supplies/cleaning protocol in place, and clinical judgment of the midwife
- Discourage smoking/vaping during labor
- During labor, midwife will review client's decision pertaining to Active Management of the Third Stage of Labor (AMTSL), in the context of current blood supply, availability of EMS transport, and capacity of higher level care. If client has not made a decision regarding active management, midwife should have a shared decision making discussion around this procedure

Auscultation of Fetal Heart Tones (FHTs) [4, 5]

- **Baseline upon admission**: auscultated for at least 2 minutes before, during, and after at least once contraction
    - Note presence of accelerations or decelerations (and if so, any relation to UC)
    - Clicks/heart valves should be auscultated, document birthing person's pulse at the same time
- Reassess baseline every 4 hours throughout early labor, if midwife is in attendance
- Reassess baseline every 1 hour throughout active labor.
- **1st stage**, active labor: every 30 minutes or more frequently as indicated by the presence of risk factors (e.g., concerning heart rate patterns, prolonged labor)
- **2nd stage**: every 10 - 15 minutes, or after every-other contractions, whichever is sooner, or more frequently as indicated by the presence of risk factors

Midwives, or person(s) under supervision of midwives, should

- Facilitate involvement of family members during labor and birth.

- Offer prophylactic IV antibiotics for Group B Strep positive birthing persons per CDC guidelines. If client declines, midwife will have an informed refusal discussion, including the possible risk of being unable to access emergent medical care in a timely manner during the COVID-19 outbreak.
- Consult and/or refer to physician for significant and persistent deviations from normal.
- Only perform an amniotomy when clinically safe to do so, including an assessment and documentation that the fetus' head is well applied to the cervix and/or at a station of 0 or lower and that there is no evidence of significant polyhydramnios.[6] FHTs will be auscultated throughout the procedure. Midwife should consider the risks and benefits of amniotomy given the client's labor status, cervical dilation, and GBS status.

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Standard Care During Birth

Policy

Midwife and student, birth assistant, or other personnel as deemed available and appropriate under supervision will assist family as needed to provide for the safety of parturient and newborn, and to allow for maximum control by the parturient of the birth experience.

Procedures

General Birth Care Procedures

- Birth assistant and/or qualified student will assist midwife as appropriate and not depart until the midwife agrees
- Birth in water will be negotiated between the client and the midwife, per the midwife's knowledge of current recommendations regarding COVID-19, PPE availability (long gloves, etc.), and midwife's comfort level

Midwives, or person(s) under supervision of midwives, should

- Attempt to have at least one birth assistant and/or qualified student present for the birth
- Wash hands for at least 20 seconds with soap and water and put on gloves
- Cut episiotomy only as indicated
- Assist as client delivers newborn
- Promote thermoregulation of newborn
- Assign one (1) and five (5) minute APGAR scores, and 10 minute APGAR score if five (5) minute is <7

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Intrapartum & Immediate Postpartum: Crisis Standards of Care[13]

Policy

Crisis standards of care require midwives to manage any number of births that present themselves, to the best of their abilities, and with the personnel, space, and equipment available at the time. There is no known or predictable midwife:client ratio in crisis. Under crisis standards of care, midwives should prioritize care for critical moments, as able.

Procedures

Midwives should prioritize the following events

- Admission to birth center or home birth, including fetal and birthing person well-being assessment and cervical dilation, per these protocols
- Clean, dry location for delivery
- Management of third stage
- Immediate postpartum observation of newborn (~1-2 minutes to assess need for resuscitation)
- Neonatal resuscitation
- Genital and cervical exam within one (1) hour after birth to assess need and/or desire for repair
- Complications, as they arise
- Newborn exam before discharge
- Birthing person postpartum vital signs before discharge

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Intrapartum & Immediate Postpartum: Contingency Standards of Care

Policy

Contingency standards of care contemplate functionally the same standards of care provided outside of crisis settings, with adaptations to reflect increased demand in services, and decreased space, supplies, and staff resource levels. The feasible and safe midwife:client ratio is dependent on available space, supplies, and staffing, including experience and skill level of support staff. Midwives should aim to operate at a ratio that ensures at least 10 minutes of client contact per hour by the midwife.

Procedure

Midwives should assess experience and skill of birth team, and space and supplies available when considering intrapartum and immediate postpartum client load at any given time. Midwives should consider calling in backup midwife(ves) as available should the midwife:client ratio appear untenable by the midwife's assessment.

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Criteria for Intrapartum & Immediate Postpartum Emergent & Non-Emergent Transfer

See Section 7, "Transfer Policy and Procedures," of this manual

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Routine Immediate Postpartum Care (Birthing Person)

Policy

Postpartum care is aimed at ensuring the well-being of the birthing person after birth, promoting the family-infant attachment process, and evaluating eligibility for discharge. Assessment should include the monitoring of vital signs done in a manner that does not interfere with bonding while still maintaining safety. Consistent with WHO guidelines, birthing person and newborn should be monitored for no less than two hours following placental delivery.[12]

Procedures

Midwives, or person(s) under supervision of midwives, should

- Offer and perform active management of the third stage, unless client has declined, after thorough discussion of local blood supply limits, delays to urgent transport, and capacity of transferring hospital
- Assist in placental delivery and wait for signs of placental separation, in the absence of significant bleeding
- Assess bleeding and uterine tone on an ongoing basis to determine need for medications and/or interventions. This should take place, at the minimum:
    - Ongoing and as indicated within the first 30 minutes after birth
    - At one hour postpartum
    - Once an hour for four (4) hours or until client is discharged, whichever is sooner
    - Prior to discharge

- Assess uterine tone, fundal height and lochia more frequently than stated above if clinically indicated
- Administer medications and perform maneuvers, as needed, to control excessive postpartum bleeding
- Examine placenta and membranes for completeness and abnormalities, and package for client to keep or for transport. For clients who desire to keep their placenta, discuss risks of BBP and unknown or undocumented potential risks of COVID-19 on placental transport outside of biohazard-maintained means, and/or placental consumption
- Assess postpartum person's vitals: blood pressure, temperature, respiratory rate, and pulse at appropriate intervals until vitals signs have returned to baseline.
  Recommended timing of postpartum person vitals:
    - Once in the first 30 minutes after birth
    - At one hour postpartum
    - Once an hour for 4 hours or until client is discharged, whichever is sooner
    - One set prior to discharge
- Assess vital signs more frequently than stated above when clinically indicated (e.g. postpartum hemorrhage, birthing person elevated temperature, syncope, etc).
- Consider continuous SpO2 monitoring per guidelines in this manual (see Section 2, "Special Policies and Procedures Related to COVID-19," of this manual).
- Perform ongoing risk assessment, as outlined in Section 3, "Client Eligibility and Risk Criteria," of this manual. Initiate transfer if indicated as outlined in Section 6, "Transfer Policies and Procedures," of this manual
- Encourage food and fluids for the postpartum person
- Encourage breast/chestfeeding (if client is choosing to breast/chestfeed), and family bonding. If client is not breast/chestfeeding, ensure at least one bottle feeding has occurred with artificial milk ("formula") and/or donor milk before discharge
- Examine vulva, perineum, and vagina for lacerations and repair as indicated
- Inspect cervix for lacerations as clinically indicated and repair or refer as indicated
- Assess bladder status and assist client to void before departure
- Collect postpartum person's blood for Indirect Coombs test, if client is Rh negative. If necessary, administer RhIG after blood draw but before discharge (if timely follow-up in-person visit within 72 hours may not occur)
- Make reasonable efforts to ensure that the 24-48 hour visit and the one (1) week visit be completed in person due to the necessary newborn assessment and timing of critical tests/procedures
- Make reasonable efforts to utilize Quantitative Blood Loss (QBL) procedures via weighing of all lochia as opposed to visual assessment alone [7, 8]
- Chart all events, procedures, and vital signs in a timely fashion, as outlined in Section 8, "Charting Criteria," of this manual.

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Routine Immediate Postpartum Care (Newborn)

Policy

Initial newborn care is aimed at ensuring the well-being of the newborn, promoting the family/infant attachment process and, ultimately, evaluating eligibility for discharge.

Procedures

Midwives, or person(s) under supervision of midwives, should

- Dry, stimulate and suction airway if necessary until adequate respirations have been established, applying warm hat and blankets
- Assign one (1) and five (5) minute APGAR scores, and 10 minute APGAR score if five (5) minute is <7
- Resuscitate newborn per current AAP guidelines adapted to the OOH birth setting as indicated
- Collect cord blood specimens for newborn blood typing and Direct Coombs if birthing person is Rh negative
- Promote thermoregulation of newborn
- Monitor temperature, heart rate and respirations as needed to ensure well-being. Recommended timing of infant vitals:
    - Once in the first 30 minutes after birth
    - At one hour postpartum
    - Once an hour until client is discharged
    - One set prior to discharge
- Assess vitals more frequently than stated above if clinically indicated (e.g., abnormal vital signs or behavior, poor color or tone, poor feeding)
- Perform ongoing risk assessment, as outlined in Section 3, “Client Eligibility and Risk Criteria,” of this manual. Initiate transfer if indicated as outlined in Section 6, “Transfer Policies and Procedures,” of this manual
- Assist postpartum person/baby in initiation of breast/chestfeeding or preparation of artificial milk (“formula”) and/or donor milk for bottle feeding
- Administer eye prophylaxis and vitamin K 1mg IM before family departs unless birth parent and/or guardian declines (signed informed refusal declining procedure must be included in the chart)
- Perform newborn exam. Contact pediatrician or family physician regarding significant abnormal findings, if indicated
- Administer or make referrals as necessary to help Hepatitis B positive clients obtain HBIg and HB vaccine for their newborns
- Monitor newborn blood glucose and manage neonatal hypoglycemia consistent with national guidelines, if indicated
- Schedule in-person 24-48h and one (1) week postpartum follow-up visits to monitor newborn well-being (including evaluation of feeding/weight), provide newborn and

hearing screenings, critical congenital heart defect (CCHD) screening, and complete birth certificate. If midwife or other trained healthcare worker is unable to accomplish these two (2) visits in person, arrange for client and newborn to be seen by another midwife or a pediatric provider.

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Client Discharge from Birth Center or Home Birth

Policy

The typical length of postpartum stay is three to four (3-4) hours but two to three (2-3) hours is optimal for a stable dyad in order to reduce the time frame during which COVID-19 could be transmitted. During either a transfer or routine discharge, the newborn will at all times be accompanied by either a parent/guardian, midwife, or person under supervision of the midwife. If there are deviations from normal for either parturient or newborn, consultation and/or transfer should be initiated, as appropriate.

Procedures

Birthing person and baby will be considered eligible for discharge from the birth center to their home if the following criteria have been met:

- Birthing person is
    - afebrile, normotensive, has normal pulse and normal respirations;
    - lochia and fundal tone are normal;
    - able to walk with minimal support
- Baby has breast/chestfed adequately, or was able to take artificial milk and/or donor milk from a bottle successfully
- Newborn
    - exam has revealed no abnormalities or concerning signs;
    - is exhibiting no signs of hypoglycemia or temperature instability;
    - has normal tone, color, respirations, pulse, and reflexes
- Postpartum and newborn instructions have been given and documented, emphasizing emergent conditions, and stressing importance of phoning midwife with questions/concerns or warning signs
- Follow-up appointment has been made for within 48 hours of the birth
- Arrangements have been made for:
    - Newborn screening (WAC 246-650 and RCW 70.83.020)
    - Newborn CCHD screening
    - Completion of the birth certificate

    - Reporting of complications and sentinel birth defects under RCW 70.58.
- Arrangements have been made for the administration of a rubella vaccine for non-immune clients
- Arrangements have been made for the provision of RhIG for unsensitized Rh-negative clients who delivered Rh-positive infants
- Family has been instructed to contact pediatric care provider within 14 days postpartum for an appointment, or sooner if indicated, including if exposure to COVID-2019 has occurred
- Family has been informed of newborn hearing screening recommendation
- Newborn has been safely secured in infant car seat.

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Discharge Checklist

Policy

The midwife retains primary care for the postpartum client and newborn after discharge, unless either have been transferred to another facility, and another care provider has assumed responsibility for postpartum follow-up.

Procedures

The following plans will be ***documented*** in the client's chart:

- Self-care at home
- Newborn care at home, including infant feeding education and support
- A follow-up visit for both mother postpartum client and newborn
- Neonatal screening tests or refusal
- Any indicated COVID-19 education or components as described in this manual

Discharge Checklist

- ❏ Birth certificate filled out completely by parent(s) and/or guardian(s) or arrangements made
    - ❏ Paternity affidavit given, if applicable
- ❏ Postpartum care, newborn care, and feeding instructions given
    - ❏ Oral instructions
    - ❏ Handout given

- ❏ Refusal forms signed, on file (if applicable)
    - ❏ Vitamin K refusal
    - ❏ Eye Ointment refusal
- ❏ GBS (if applicable)
    - ❏ GBS prophylaxis refusal
    - ❏ Inadequate GBS prophylaxis acknowledgement and homecare education provided
- ❏ Safe sleeping information provided
    - ❏ Oral education
    - ❏ Handout given
- ❏ 24-48 hour visit scheduled for client and newborn, which may include, but is not limited to:
    - ❏ Newborn Screen
    - ❏ Newborn CCHD Screen
    - ❏ Newborn Hearing Screen (or arrangements made)
    - ❏ RhIG, as needed

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Labor & Birth charting

See Section 8, "Charting Criteria," of this manual

Intrapartum & Immediate Postpartum Transfers

See Section 7, "Transfer Policies & Procedures," of this manual

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Section 5 References

1. American College of Obstetricians & Gynecologists. (2020, March). Outpatient assessment and management for pregnant women with suspected or confirmed novel Coronavirus (Covid-19). Retrieved from https://www.acog.org/-/media/project/acog/acogorg/files/pdfs/clinical-guidance/practice-advisory/covid-19-algorithm.pdf?la=en&hash=2D9E7F62C97F8231561616FFDCA3B1A6
2. American Academy of Pediatrics. (n. d.). Newborn screening: Critical congenital heart defects. Retrieved from https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/PEHDIC/Pages/Newborn-Screening-for-CCHD.aspx
3. Washington State Department of Healthy. (2019, October). Health care provider manual: Newborn screening program. Retrieved from https://www.doh.wa.gov/Portals/1/Documents/5220/ProviderManual.pdf
4. Society of Obstetricians and Gynaegologists of Canada. (2008). SOGC - BCPHP fetal health surveillance: Antepartum and intrapartum consensus guidelines. Retreived from http://www.perinatalservicesbc.ca/Documents/Guidelines-Standards/Maternal/FHSConsensusGuideline.pdf
5. Ehman, W., Keesey, A., Lauzon, L., Morin, F., Yee, J., Rivard, L., & Walker, J. (2018). *Fundamentals of Fetal Health Surveillance: Online Manual.* Retrieved from University of British Columbia, Faculty of Medicine's Continuing Professional Development (UBC CPD) website https://elearning.ubccpd.ca/pluginfile.php/8102/mod_resource/content/3/Fetal%20Health%20Surveillance%20Online%20Module%20Print%20Version.pdf
6. Grobman, W. (2020, March 10). Induction of labor with oxytocin. In C. J. Lockwood's *UpToDate.* Retrieved from https://www-uptodate-com.buproxy.bastyr.edu/contents/induction-of-labor-with-oxytocin?search=amniotomy&source=search_result&selectedTitle=2~20&usage_type=default&display_rank=2#H7537841
7. Hancock, A., Weeks, A. D., & Lavender, D. T. (2015). Is accurate and reliable blood loss estimation the crucial step in early detection of postpartum haemorrhage: An integrative review of the literature. *BMC Pregnancy and Childbirth, 15*(1). doi:10.1186/s12884-015-0653-6 retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4587838/
8. Lilley, G., Burkett-St-Laurent, D., Precious, E., Bruynseels, D., Kaye, A., Sanders, J., Alikhan, R., Collins, P. W., Hall, J. E., & Collis, R. E. (2015). Measurement of blood loss during postpartum haemorrhage. *International Journal of Obstetric Anesthesia*, *24*(1), 8–14. https://doi.org/10.1016/j.ijoa.2014.07.009
9. Qasim, H., Karim, Z. A., Rivera, J. O., Khasawneh, F. T., & Alshbool, F. Z. (2017, August 30). Impact of electronic cigarettes on the cardiovascular system. *Journal of the*

American Heart Association 6(9). Retireved from https://www.ahajournals.org/doi/full/10.1161/jaha.117.006353
10. Kutlu, T., Ozkaya, E., Sanverdi, I., Cakar, E., Ayvaci, H., Devranoglu, B. & Karateke, A. (2016, August 10). Acute fetal heart rate tracing changes secondary to cigarette smoking in third trimester pregnancies. *Journal of Maternal and Neonatal Medicine, 12.* Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/27440435
11. American College of Obstetricians. (2019, February). ACOG committee opinion number 766: Approaches to limit intervention during labor and birth. Retrieved from https://www.acog.org/en/Clinical/Clinical%20Guidance/Committee%20Opinion/Articles/2019/02/Approaches%20to%20Limit%20Intervention%20During%20Labor%20and%20Birth
12. World Health Organization. (2015). *Pregnancy, childbirth, postpartum, and newborn care: A guide for essential practice*. WHO Library Cataloguing-in-Publication Data.
13. Hays, K. (April 17, 2020). Personal communication.

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Section 6: Postpartum Care

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Routine Postpartum Care (Birthing Person)

Policy

Midwives will provide clinically indicated postpartum follow up for the postpartum person.

Procedures

Midwives should

- Assess vital signs, including blood pressure, pulse, respiratory rate, and temperature
- Assess lochia, uterine involution, perineal or cesarean incision healing and hematoma (if present)
- Assess of client mental and emotional health, and screen for PMADs
- Refer to appropriate care providers as indicated for deviations from normal
- Follow up from antepartum or intrapartum findings, as appropriate, including but not limited to lab work for anemia, thyroid function, glucose control, etc.
- Assess for urinary retention and urinary/fecal incontinence
- Counsel clients on postpartum care and parenting, including but not limited to, the following:
    - Family planning
    - Breast/chest feeding and/or alternative feeding
    - Nutrition and hydration in the postpartum and/or lactating period
    - Comfort measures, general counseling, and warning signs for possible physiological phenomena in the postpartum period (such as uterine afterpains, nipple tenderness, fatigue, constipation, hemorrhoids, etc.)
    - Normal perineal and cesarean incision healing progress and warning signs
    - Normal newborn behavior, feeding schedule, weight gain etc.
    - Normal lochia
    - Normal mood changes and support measures
- Inform clients of warning signs and indications that warrant calling the midwife or other care provider

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Routine Newborn Care

Policy

Midwives will provide clinically indicated postpartum follow up for the newborn.

Procedures

Midwives should

- Assess number of urine and stool diapers
- Assess newborn feeding and latch and evaluate feeding difficulties
- Provide a jaundice assessment, including bilirubin check when indicated
- Assess newborn's weight gain
- Provide an assessment of normal newborn behavior, including but not limited to sleep/wake cycles, alertness, stooling/urination, and feeding behaviors
- Ensure newborn has the opportunity to have normal screenings at the appropriate time including the CCHD screen, newborn screen, hearing screen, and feeding assessment
- Inform clients of warning signs and indications that warrant calling the midwife or other care provider

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Postpartum Visit Schedule

Policy

Midwives will conduct thorough, clinically-based postpartum care that takes special considerations in order to reduce COVID-19 transmission.

Procedures

Postpartum visit schedule

- 24-48 hour visit
    - Client and newborn to come to clinic or be seen at home by provider. Partner may attend as well. All precautions for COVID-19 transmission should be in place to protect midwife and families and utilizing telemedicine whenever possible to manage postpartum complaints, per these protocols

- Day three to five (3-5) to support lactation and breast/chestfeeding. This may be a telemedicine visit if midwife is able to adequately hear and assess latch, position, and suck/swallow, among other indicators.
- One (1) week visit in person unless able to assess via telemedicine
- Three (3) week visit by phone or virtually
- Six (6) week visit generally by phone or virtually. Six (6) week visit may also be conducted in person if clinically indicated and/or for contraception care
- Other visits, virtually or in person, as clinically indicated
- Midwives may consider collaborating with or referring care to a lactation specialist and or pediatric provider for the 3-5 day postpartum visit.

Special Precautions to Reduce COVID-19 Transmission

See Section 2, "Special Policies and Procedures Related to COVID-19," of this manual

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Vaccinations

Policy

Clients who are not current on recommended vaccinations should be counseled on the current CDC recommendations. Discussion should include any current evidence about the presence of comorbidities related to vaccine-preventable diseases and COVID-19 susceptibility and severity.

Procedures

- Midwives should have a full shared decision-making discussion around indicated vaccinations in the postpartum period. This discussion should also include the increased severity of COVID-19 infections in those with comorbidities
- Midwives should refer clients appropriately to obtain desired vaccinations.
- Standard vaccines that may be discussed includes but is not limited to the following: influenza, MMR, and Tdap

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Rh-Negative Status

Policy

Midwife will offer RhIG, with informed consent, to Rh-negative clients with an Rh-positive newborn within 72 hours of birth.

Procedures

- Obtain birthing person blood type and Rh labs on entry to care
- Obtain newborn and birthing person blood in the immediate postpartum for Direct/Indirect Coombs and other blood studies, as indicated
- Administer RhIG to Rh-negative client within 72 hours of birth, upon consent, as indicated
- If client declines, a signed informed refusal should be obtained and attached to client chart
- Offer testing to other biological parent if blood type is unknown to determine whether RhIG can be given prior to discharge

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Gestational Diabetes Follow-Up

Policy

Gestational diabetes mellitus (GDM) follow-up will be offered to all clients who tested positive for gestational diabetes in pregnancy. GDM that remained well-managed such that a pregnant and birthing person could remain in midwifery care will need to continue to remain well-managed in the postpartum period.

Procedure

Midwife will have a shared decision-making discussion related to gestational diabetes and the recommendation for follow up screening between 6-12 weeks postpartum.[1] Midwife will offer this follow up test or refer the client to the appropriate care provider.

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Section 6 References

1. American College of Obstetricians and Gynecologists. (2013). *Gestational Diabetes Mellitus - Practice Bulletin* (Vol. 122, Publication No. 137).

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Section 7: Transfer Policies & Procedures

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Transfer Policy & Procedures

Midwife's Attendance in Hospital in the Event of Transfer

Policy

The decision as to whether the midwife will accompany the client will be a collaborative decision between the midwife, EMS transport team (when indicated), and the accepting provider, in order to reduce risk for COVID-19 transmission.

Procedures

Midwives should

- Make an effort to be aware of their local hospital(s) capacity and preferences to facilitate transfer of care as needed
- Ensure transferring provider has access to client chart
- Be available via telephone for questions from the receiving provider or client should the midwife not accompany the client to the hospital or stay in attendance at the hospital
- Minimize time spent at hospital and take precautions to reduce risk for transmission of COVID-19
- Carry a copy of their midwifery license with them
- Consider a lower threshold for intrapartum transfer due to anticipated delays in EMS support and availability of beds in labor & delivery units in the hospital. Discussions regarding transfer should be started earlier when possible and shared decision-making should occur regarding the risks/benefits of staying OOH versus transferring into the hospital as many clients may be concerned regarding the increased risk for exposure to COVID-19 in a hospital setting

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Intrapartum & Immediate Postpartum Emergency Transfer

Policy

Per Washington State law (RCW 18.50), LMs will file an annual plan with the DOH regarding emergency transport of a patient from an OOH setting to a hospital. Midwife will initiate emergency transfer in the event of significant deviation from normal as described in this manual. Midwife should report transfer to birth center administrator, if the client was cared for at the birth center, and/or utilize appropriate forms for the midwifery group they are working with, if applicable. Following transfer, midwife will facilitate plan for follow-up, including newborn care.

Procedures

Criteria

- Examples requiring intrapartum emergency transport via EMS or ambulance include, but are not limited to:
    - Cord prolapse
    - Birthing person seizures
    - Severe fetal distress
    - Any transport required when birth appears imminent
    - Any situation in which it is the midwife's judgment that transport is best accomplished via EMS vehicle or ambulance
- Examples requiring emergency transport via EMS or ambulance during the immediate postpartum period include, but are not limited to:
    - Uncontrollable hemorrhage
    - Birthing person seizures
    - Newborn requiring continued resuscitation
    - Any situation in which it is the midwife's judgment that transport is best accomplished via EMS vehicle or ambulance

Procedural Steps

- Contact EMS via a 911 call, ideally using the landline
- Provide concise, clear summary of situation including indication for transfer
- Stabilize client to the degree possible until EMS arrival
- Utilize the MAWS transport forms and/or the Homebirth Summit Best Practice Guidelines: Transfer from Planned Home Birth to Hospital to complete and send along with transferring clients[1]
- Alert the charge nurse, CNM, physician, obstetrician, pediatrician, or other receiving provider (as appropriate) at a local receiving hospital if time and circumstances permit

- stating and documenting how midwife plans to resume care, provide adjunctive care, and/or to provide other care as needed
- Document transfer with birth center administrator and/or other indicated personnel
- Document transfer per Section 8, “Charting Criteria,” of this manual

Transfer is facilitated by the midwife. All pertinent information requested by the receiving provider should be provided, including but not limited to:

- Name, age, parity of client
- Significant relevant history
- Nature of current problem
- Emergency measures already instituted
- Estimated time of arrival
- Expected management upon arrival, as indicated

Upon arrival at the hospital, it is the role of the midwife to facilitate the safest and most satisfying experience for the client without compromising the relationship between the medical/hospital personnel and client or midwife, or the quality of care. To this end, the midwife should:

- Make client chart available to hospital staff and provide any additional information
- Assist hospital staff in explaining procedures to the client and soliciting client’s trust and cooperation
- Support the client and the family
- Chart salient hospital events and retain original chart

During the COVID-19 public health emergency, the EMS system response may be unpredictably delayed. Transfer of newborn may need to take place in a private vehicle, observed continuously and monitored by the midwife in a car seat, if EMS wait time might endanger neonatal well-being. Transfer by EMS should be attempted first, and deviations out of necessity should be charted with midwife’s rationale.

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Intrapartum & Immediate Postpartum Non-Emergent Transfer

Policy

In the event of a non-emergent transfer, client may be transported by private automobile or by ambulance, depending on which is the most appropriate means of transport as determined by the judgment of the midwife. Midwife should report transfer to birth center administrator, if the client was cared for at the birth center, and/or utilize appropriate forms for the midwifery group they are working with, if applicable. Following transfer, midwife should facilitate plan for follow-up, including newborn care. Following transfer, midwife should facilitate plan for follow-up, including newborn care.

Procedures

Criteria

- Examples requiring transfer that are not emergent in nature and do not require EMS or ambulance transport include, but are not limited to:
    - Client desire for pain relief
    - Need for pharmacologic augmentation of labor
    - Suspected COVID-19 infection with non-urgent presenting symptoms
    - Meconium in amniotic fluid, birth not imminent[11]

Procedural Steps

- Contact receiving hospital and make arrangements for transfer
- Utilize the MAWS transport forms and/or the Homebirth Summit Best Practice Guidelines: Transfer from Planned Home Birth to Hospital to complete and send along with transferring clients[1]
- Facilitate plan for follow-up, documenting how and when midwife plans to resume care, provide adjunctive care, and/or to provide other care as needed, including newborn care
- Document transfer with birth center administrator and/or other indicated personnel
- Document transfer per Section 8, “Charting Criteria,” of this manual

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Section 7 References

1. Home Birth Summit. (n. d.). Best practice guidelines: Transfer from planned home birth to hospital. Retrieved from https://www.homebirthsummit.org/best-practice-transfer-guidelines/

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Section 8: Charting Criteria

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Special Charting Criteria Related to COVID-19

Policy

The midwife will document COVID-19 related signs, symptoms, possible exposures, and other information pertinent to COVID-19 transmission and illness. If a birth assistant and/or student and/or other personnel are also charting, the midwife will confirm accuracy.

Procedures

The following COVID-related assessments and elements should be included in all telemedicine or in-person clinic visits, or labor admit SOAP notes:

- Before the beginning of each client chart note, documentation of negative COVID-19 screening status of midwifery care team present for the visit (e.g., "*Care team present for visit exhibits no s/sx of COVID-19, and abides by federal, state and/or local guidelines for transmission reduction."*)
- Subjective
    - COVID-19 screening questions and responses of client and support team (e.g., *"Denies SOB, cough, elevated temperature, recent contact with known infected person";* or *"self-isolating while awaiting coronavirus test results"*)
- Objective
    - Screening temperature within 2 hours before in-person contact with midwifery team
    - SpO2 (if available)
    - If telemedicine, document client vigor or habitus, or other available criteria to determine assessment of wellness (e.g., *"voice weak," "pallor noted," "skin appears flushed," "diaphoretic" or "appears fatigued")*
    - COVID-19 or other recent respiratory illness test results
- Assessment
    - COVID-19 suspected illness or exposure (e.g., *"No COVID-19 sxs present in self or others in the home"* or *"No COVID-19 sxs present but son has undx'd cough"*)
- Plan
    - Provider and client PPE and social distancing considerations for future visits or during labor/birth (e.g., *"Usual PPE protocol"* or *"Usual PPE protocol + all present at labor/birth will wear mask, including client as tolerated; son cannot come to BC."*)

- Commitment by care team, client and support persons to abide by federal, state, and/or local guidelines for COVID-19 transmission reduction, including by not limited to stay-at-home orders and/or social distancing

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Charting Criteria for Medications Administered

Policy

The midwife will accurately document all medications administered. If a birth assistant and/or student and/or other personnel are also charting, the midwife will confirm accuracy.

Procedure

The following elements should be included for all medications administered:

- Rationale, summary of shared decision-making discussion (or lack thereof d/t emergency), patient signed or verbal consent, as appropriate
- Dose, route, lot number, expiration date, location of administration, and who administered
- Client/newborn monitoring and response

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Antepartum Charting Criteria

Policy

The midwife will accurately document the course of prenatal care. If an assistant and/or student and/or other personnel are also charting, the midwife will confirm accuracy.

Procedures

The following elements should be documented in the antepartum record, plus any other significant information not listed here:

<u>For initial visit</u>

- Demographic information
- Orientation to birth center (if appropriate)
- Signed informed consent for care
- Chief complaints and History of Present Illness (HPI)
- Systematic review of Systems (ROS) for current sx

- Assessment of COVID-19 s/sx, per this protocol
- Past Medical History (PMHx), including but not limited to:
    - General health status
    - Diseases/illnesses
    - Hospitalizations
    - Surgeries
    - Allergies
    - Immunizations
    - Systemic health status review for past health conditions and diagnoses may include, but is not limited to:
        - HEENT
        - CV
        - Respiratory
        - GI
        - GU
        - Endocrine
        - Hematologic
        - Lymphatic
        - Neurologic
        - Musculoskeletal
        - Integumentary
        - Psychologic
- Present pregnancy
    - Dating
    - Plans, support, emotional response
    - Exposures
- Menstrual hx
    - Age at menarche
    - LMP
    - Menstrual pattern
- Reproductive health hx
    - Sexual health hx (e.g., current number of sexual partners/past sexual partners, sexual practices, hx of STI diagnoses and tx, STI prevention practices, current testing status)
    - Breast/chest exams and self-breast/chest exams
    - Breast/chestfeeding hx, if applicable
    - Past contraceptive use
    - Most recent Pap and hx of Pap results
    - Infertility hx, if applicable
    - Past pregnancy hx (e.g., mode of delivery, gestational age at delivery, birthing person/neonatal complications, length of labor, birth weight, laceration/episiotomy, anesthesia)
- Psych/social hx

    - Nutrition
    - Exercise
    - Sleep
    - Current medications and/or herbs and/or supplements
    - Substance use (historical and current)
    - Stress, sources of stress
    - Current safety status and/or concerns
    - Past hx of IPV, trauma, abuse
    - Environmental safety/hazards or concerns (e.g., firearms in the home/work, seatbelt use, use of helmets, use of smoke alarms, etc.)
    - Primary relationship/support system
    - Financial status/stability, status of job
- Family hx
    - Significant illnesses of family members
    - Known hereditary conditions
    - Known congenital conditions
    - Family obstetric hx
- Physical exam
    - Given the limited amount of in-person contact anticipated during the COVID-19 pandemic, midwives should consider doing a thorough, complete physical exam during this in-person visit to assess health and pregnancy status, *even if* a recent exam has been done by a previous provider. This provides the midwife their own baseline from which to assess future potential risks and appropriate place of delivery.

<u>Throughout prenatal care, includes but not limited to</u>

- Assessment of COVID-19 s/sx, per this protocol
- Risk status/eligibility at least once every trimester, but ideally with each visit (e.g., *low-risk and appropriate for OOH birth*)
- Standard prenatal care elements (vital signs, fundal height, FHR, etc.)
- Standard of care testing offered and documented (glucose screening, GBS, etc.), including signed informed consent and/or refusal
- Medications administered, as applicable
- Laboratory studies performed or ordered (with results when available and informing client of results)
- Evaluation of mental health status and needs assessment
- Review of warning signs, normal and abnormal findings, and number to call
- Plan for next prenatal follow-up visit (timing, with whom and where)
- Consultation or collaboration for any indication

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Intrapartum (IP) Charting Criteria

Policy

The midwife will document the course of a client's intrapartum care. If a birth assistant and/or student and/or other personnel are also charting, the midwife will confirm accuracy.

Procedure

Narrative (with assessment and plan) or SOAP note should be written during the intrapartum moments as follows:

- On admission
- At least every 2-4 hours throughout labor and every 30 minutes during 2nd stage
    - Include labor status (with or without cervical exam), occurrence of any significant event, anticipated progress (e.g., anticipate NSVD), low risk status, etc.
    - Second stage progress, interventions, how client and fetus are tolerating, continued low risk status, etc.
- Delivery note
- Newborn exam and feeding
- Discharge note

The following elements should be included in all intrapartum charts

<u>Upon admission to birth center or home birth</u>

- Client summary, including but not limited to:
    - Name, age, GP, gestational age, Rh status, GBS status
    - Latent or active labor status
    - Low risk, uncomplicated pregnancy (for example: GDM negative, most recent laboratory findings (e.g., CBC)
    - Notable prenatal care findings (e.g., rubella non-immune, resolved low lying placenta, etc.)
    - Prenatal plans for intrapartum preferences and procedures
    - Any complicating circumstances prn
- Labor status, including but not limited to:
    - Labor onset
    - Status of membranes, color of amniotic fluid if membranes ruptured
    - Frequency, duration, and intensity of contractions
    - Cervical exam, in the absence of ROM or client refusal
    - Fetal position and station, in the absence of ROM or client refusal
- Birthing person status, including but not limited to:
    - Assessment of COVID-19 s/sx, per this protocol

    - Vital signs including blood pressure, pulse, respiratory rate and temperature (document location of temperature, e.g., "*PO*," "*temporal*," or "*axillary*")
    - Coping & mental/emotional health
    - Assessment of COVID-19 s/sx, per this protocol
    - Nutritional and hydration status (during time before admission i.e. "reports drank a lot of water through early labor, had smoothie in morning and banana an hour ago")
    - Support people and roles, including
        - Document temperature (objective or subjective) and lack of Covid-19 s/sx of all support people
- Fetal status, including but not limited to::
    - FHTs baseline upon admission, per criteria outlined in Section 5, "Intrapartum & Immediate Postpartum Care," of this manual
    - Estimated fetal weight (EFW) (by pounds or designate "large", "appropriate" or "small" for gestational age)
    - Fetal movement (if not current, then most recent occurence)
    - Position and presentation
        - Cephalic presentation confirmed via abdominal or cervical exam, and/or bedside ultrasound if available
- Risk status assessment (eligibility for OOH birth) (e.g., *"Low risk, presumed COVID-negative, and appropriate for midwifery care and [home or birth center] birth*")

<u>Labor Progress</u>

- Birthing person status, including but not limited to:
    - Assessment of COVID-19 s/sx, per this protocol
    - Coping, mood, energy level, etc.
    - Vital signs including blood pressure, pulse, respiratory rate and temperature, to be completed per protocol as indicated in Section 5, "Intrapartum & Immediate Postpartum Care," of this manual (document location of temperature, e.g., "*PO*," "*temporal*," or "*axillary*")
    - Food/fluid intake and voiding/BMs
    - Vaginal bleeding, bloody show, etc.
    - Membranes status and color of amniotic fluid (if applicable)
    - Contraction frequency, duration, and intensity
    - Cervical dilation and effacement, and fetal position and station, as determined by cervical exam, in the absence of ROM or client refusal. Cervical exams should be offered at a frequency outlined in Section 5, "Intrapartum & Immediate Postpartum Care," of this manual
- Fetal status, including but not limited to:
    - Fetal movement reported by birthing person, seen by midwife, and/or palpated by midwife.
    - FHT auscultation, baseline, and findings, per criteria outlined in Section 5, "Intrapartum & Immediate Postpartum Care," of this manual

- Risk status assessment (eligibility for OOH birth) (e.g., *"Low risk and appropriate for midwifery care and [home or birth center] birth*")
- Laboratory studies done and results, when available
- Interventions to promote birthing person or fetal well-being
- Stages of labor, time of birth, and any maneuvers done to facilitate birth of the newborn (e.g., shoulder dystocia, nuchal cord, episiotomy)

Interventions, as applicable

- Rationale, recommendation, shared decision-making discussion (including risks, benefits, alternatives, etc.), and client-midwife agreement or disagreement
- For IVs:
    - Location, number of attempts, client tolerance of procedure
    - Solution, rate of flow, intermittent documentation of milliliters of fluid infused
    - Rationale for and time IV is discontinued
    - Catheter intact
- Any other medication administered, per criteria in "Charting Criteria for Medications Administered," of this manual

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Immediate Postpartum Charting Criteria

Policy

The midwife will document the course of a client's immediate postpartum care. If a birth assistant and/or student and/or other personnel are also charting, the midwife will confirm accuracy.

Procedures

Timing of the below elements is outlined in Section 5, "Intrapartum and Immediate Postpartum Care," of this manual:

Documentation for birthing person

- Assessment of COVID-19 s/sx, per this protocol
- Minimum three (3) sets of vital signs (BP, temperature, pulse, respiratory rate), including location of temperature, (e.g., "*PO*," "*temporal*," or "*axillary*")
- SpO2 readings taken, if performed
- PPH assessments/interventions:
    - Fundal height, uterine firmness, and lochia
    - Placenta/membranes condition (if not intact, actions taken)
    - Medications administered, if applicable, and charted per protocol
- Intake and output:

    - Oral fluids/food and/or IV
    - Voiding/BMs, including estimated quantity of urine (e.g., small, moderate, large)
- Ambulation, stability while upright
- Perineal status, intact or degree of laceration
    - Laceration repair, if applicable, including:
        - Confirmation of allergy status to local anesthetic
        - Lidocaine percentage, dose, lot number, and expiration date
        - Who performed repair
        - Client tolerance
        - Time started and ended

Documentation for newborn

- Minimum three (3) sets of vital signs (HR, respiratory rate, and temperature), including location of temperature, (e.g., "*temporal*," or "*axillary*")
- APGARs at one (1), five (5), and, if indicated, 10 minutes
- SpO2 and perfusion, as indicated
- Resuscitation measures taken, if applicable
- Full physical exam including measurements and gestational age assessment
- Medications administered, and charted per protocol
- Assessment of newborn feeding
    - Length of time at breast/chest, latch adequacy
    - If feeding with formula and/or donor milk, type and amount taken
- Glucose evaluation or other assessments, as indicated

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Labor & Birth Summary Charting Criteria

Policy

The midwife will document a labor and birth summary. If a birth assistant and/or student and/or other personnel are also charting, the midwife will confirm accuracy.

Procedure

The following elements should be included in labor and birth summaries:

- Date and time of birth
- Length of each stage of labor and total labor
- Total duration of ROM and color of amniotic fluid
- Examination of placenta and cord
- Fetal position, any specific management indicated (e.g., shoulder dystocia and/or maneuvers or nuchal cord)
- Fundus/uterus status immediately after birth, QBL

- Status and care of perineum, description of episiotomy or lacerations and repair
- Newborn data, including, but not limited to: APGARs, sex, weight, feeding observation, output
- Notable procedures/interventions performed and rationale/indication
- Neonatal resuscitation summarized, if indicated
- Summary of any intrapartum, postpartum, or neonatal abnormal findings or complications, and management undertaken

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Labor Discharge Charting Criteria

Policy

The midwife will document the status of the birthing person and newborn immediately prior to discharge. If a birth assistant and/or student and/or other personnel are also charting, the midwife will confirm accuracy.

Procedure

The following elements should be included in discharge notes:

- Newborn meets criteria for discharge, per protocols and practice guidelines
- Birthing person meets criteria for discharge, per protocols and practice guidelines
- Birthing person and newborn vital signs have occurred and are WNL within 30 minutes of discharge
- Infant feeding accomplished (or if not, explain why not and document f/u plan)
- Safe sleep recommendations given
- Newborn is placed in car seat
- Anticipatory guidance about newborn care, feeding and warning s/sx of respiratory distress, infection, abnormal jaundice, lethargy, etc., and handouts given
- Counseling about birthing person home care and warning s/sx of infection, delayed PPH, engorgement, etc., and handouts given
- Questions answered and concerns addressed
- Summary of intrapartum, postpartum, and neonatal course and any complications or special needs
- Risk status assessment (eligibility for discharge) (e.g., *"Low risk, presumed COVID-negative, and appropriate for discharge to home*")
- Plans for follow-up visits, timing, and content

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Postpartum & Newborn Visit Charting Criteria

Policy

The midwife will document the course of a birthing person's postpartum care, and a newborn's care. If an assistant and/or student and/or other personnel are also charting, the midwife will confirm accuracy.

Procedure

Throughout postpartum and newborn care, includes but not limited to

- Assessment of COVID-19 s/sx, per this protocol
- Risk status/eligibility with each visit (e.g., *low-risk and appropriate for midwifery care*)
- Standard postpartum care elements (vital signs, client physical/emotional changes and recovery, newborn status, laboratory studies, physical exams, etc.). See Section 6, "Postpartum Care," of this manual)
- Standard of care testing offered and documented (newborn screen, hearing screen, CCHD screening, etc.), including signed informed consent and/or refusal
- Medications administered, as applicable
- Laboratory studies performed or ordered (with results when available and informing client of results)
- Evaluation of mental health status and needs assessment
- Review of warning signs, normal and abnormal findings, and number to call
- Plan for next postpartum and/or newborn follow-up visit (timing, with whom and where)
- Consultation or collaboration for any indication

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Transfer Charting Criteria

Policy

The midwife will document the course of a client's transfer to a higher level of care. Birth assistants and/or students and/or other personnel may not chart these elements, although the midwife may refer to birth assistants and/or students and/or other personnel notes taken during the course of care.

Procedure

Telephone calls when transferring IP

- If EMS utilized, a summary of the call including time of initiation
- Telephone calls to hospital
    - Reason for call
    - Name and titles of person receiving call
    - What was discussed
    - Agreed upon plan
        - If disagreement between midwife and receiving provider, midwife should chart details, midwife's plan, and their rationale for doing so (e.g., if hospital declines transfer but midwife is going anyway d/t urgency)

Documentation **following** IP transfers

- Type of birth (NSVD, assisted, operative); if assisted, identify forceps and/or vacuum; provide indications for assisted or operative delivery
- Condition or disposition of birthing person
- Condition or disposition of newborn, including APGAR scores
- Any IP, postpartum, or newborn complications and interventions, including NICU or ICU admission and indications
- Plan for follow-up postpartum and newborn care after hospital discharge (timing, with whom and where)

The following elements should be included in all transfer charts

- Indication for transfer
    - Discussion with client/family
        - Any client disagreements should be noted, especially if midwife recommends transfer and client declines due to concern for increased risk of COVID-19 exposure in the hospital
- Mode of transport
- Times of:
    - Decision to transfer
    - Receiving unit notified
    - Consultations with medical professionals, if applicable
    - EMS or ambulance called, arrival, and departure, if applicable
    - Arrival at hospital
- Persons accompanying client/newborn to hospital
- Interventions, including IVs and medications, prior to transport or en route
- Status of client/fetus/newborn upon leaving home or birth center (vital signs, FHTs, etc.)
- Transport forms to be provided and chart faxed when able

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