New Life Birth Services Midwifery Protocols

Mission Statement - Association of Texas Midwives
To Advance the quality and accessibility of midwifery in Texas

Image Statement - Association of Texas Midwives
ATM nurtures the profession and traditions of midwifery in Texas

Statement of Philosophy
As midwives, we believe the practice of midwifery to be distinct from the practice of medicine. Midwifery is a discipline pertaining to a normal cycle of life, the childbearing years. We base our profession on the midwifery model of care:

1. Pregnancy and birth are a fundamentally healthy process.
2. Each woman is unique and her care should be tailored to meet her individual needs.
3. Attending to the emotional and spiritual components of childbearing are as important as appropriate antepartum, intrapartum and postpartum physical care.
4. Midwives should be trained by other midwives, be that training in a school or through apprenticeship.
5. Midwives should maintain a professional attitude and practice which promotes collegial relationships between physicians, midwives and students.
6. The relationship between midwives and their clients are collaborative in nature.

International Definition of Midwifery
World Health Organization
(2nd Revised Edition)

A midwife is a person who, having been regularly admitted to a midwifery educational program fully recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.

She must be able to give the necessary supervision, care and advice to women during pregnancy, labor and postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance, and the execution of emergency measures in the absence of medical help.

She has an important task in counseling and education- not only for patients, also within the family and community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynecology, family planning and childcare.

She may practice in hospitals, clinics, health units, domiciliary conditions or any other service.
Code for Ethical Midwifery Practice

A. Client Rights

An ethical midwife will respect the personal rights of her clients.

1. The right to be treated with respect and dignity, without prejudice.
2. The right to informed consent regarding her care, with access to relevant information upon which to base decisions
3. The right to freedom from coercion in decision-making
4. The right to accept or refuse treatment.
5. The right to full disclosure of the costs of her care.
6. The right to know who will participate in her care and to obtain additional consultation of her choice
7. The right to absolute confidentiality except where this right is preempted by law.

B. Midwife Rights

A midwife recognizes the importance of respect for her own rights as a care provider.

1. The right to refuse care to clients with whom no midwife/client relationship has been established
2. The right to discharge clients from her care, provided adequate referral to other care is extended
3. The right to receive honest, relevant information from clients upon which to base care
4. The right to receive reasonable compensation for services rendered
5. The right to refuse care if the client acts irresponsibly, in any way that would cause the client to become high risk
6. The right to refuse care if terms of the contract between client and midwife are not adhered to

C. Unprofessional Conduct

Conduct by a midwife which is likely to deceive, defraud, or injure clients, or which results from conscious disregard for the health and welfare of the client under the midwife’s care.

1. Knowingly or consistently faily to accurately document a client’s condition, responses, progress or other information obtained during care. This includes failing to make, destroying, or falsifying entries in records pertaining to midwifery care.
2. Performing or attempting midwifery techniques or procedures which are outside the midwife’s limitations
3. Failing to give care in a reasonable and professional manner, including maintaining a client load which does not allow for personalized care by the primary attendant
4. Leaving a client intrapartum without providing adequate care for the mother and infant
5. Delegation of midwifery care or responsibilities to a person who lacks the ability or knowledge to perform the function or responsibility in question
6. Manipulating or affecting a client’s decision by withholding or misrepresenting information, in violation of the client’s right to make informed choices in her health care
7. Failure to report to the applicable state board or the appropriate authority in the Association of Texas Midwives, within a reasonable time, the occurrence of any violation of any legal or professional code

D. Violations

Violations of this code should be reported to the Association of Texas Midwives for investigation through the grievance procedure. Findings from this investigation will be used to assist the midwife in improving her practice and to restrict incompetent practitioners, if necessary.
**Midwife Responsibilities**

A midwife recognized certain obligations and responsibilities.

1. The obligation to serve as the guardian of normal birth, alert to possible complications but always on guard against arbitrary interference

2. The obligation to honor the absolute confidentiality of the information and details of the client’s condition

3. The obligation to provide complete, accurate and relevant information to the client (and obtain a written consent form) so that she can make informed choices regarding her health care

4. The obligation, when referring a client to another health care provider, to remain responsible for the client until she is either discharged or formally transferred

5. The responsibility to develop and utilize a sale and efficient mechanism for medical consultation, collaboration and referral

6. The obligation to continue professional development through ongoing evaluation of knowledge and skills, and continuing education, including diligent study of all subjects relevant to midwifery practice

7. The obligation to know and comply with all legal requirements related to midwifery practice within the state of Texas, and to work within the law to provide for the unobstructed practice of midwifery within the state

8. The responsibility to maintain accountability for all midwifery care delivered under her supervision; assignment and delegation of duties to other midwives or apprentices should be equal to their educational preparation and demonstrated proficiency

9. The obligation to accurately document the client’s history, condition, physical progress and other viral information obtained during client care
Client Responsibility

Midwives and their clients share in the responsibility of pregnancy, birth and postpartum care. A birth in an out-of-hospital setting implies a level of responsibility for health care that may not be found in the hospital. A thorough commitment from the client and her family is necessary to ensure the safety and well being of mother and baby. Most clients seeking a birth at home or in a birth center accept responsibility for their health, sharing information about changes in their pregnancy and matters that may affect their pregnancy and birth. It is important to maintain communication in order to respond to the particular needs a pregnant client may have during this special time in her life.

A client who demonstrates an appropriate level of responsibility:

1. Will work with the midwife to change or improve diet and health habits, if needed
2. Will agree to additional screening, tests or physician visits if needed due to family, medical, or obstetrical history
3. Will adhere to her appointment schedule, changing times only when necessary and with suitable notification
4. Will discuss and abide by a financial agreement
5. Will make a commitment to learn about her body, the changes that occur during pregnancy, and the birth process
6. Will agree to a transport of transfer of care, if necessary, after all aspects of the situation are considered and discussed
7. Will respect the scheduling difficulties of a midwife’s professional and personal life
8. Will try not to put unnecessary demands on the midwife’s time and energy by requesting services that fall outside of the midwife’s “Normal Care”
ANTEPARTUM CRITERIA

Absolute Contraindications or Co-Management:

1. Essential hypertension
2. Preeclampsia, PIH
3. Rh sensitization
4. Pregnancy induced carbohydrate intolerance
5. Heart disease, excluding grade I and II systolic murmurs
6. Chronic liver and renal disease
7. Any severe medical problem (i.e., convulsive disorder, active TB, hepatitis, drug addiction, active syphilis, severe psychiatric disorder, alcoholism)
8. Multiple gestation
9. Evidence of placenta previa
10. Surgical problems during current pregnancy
11. Fetal demise

Guidelines for Consultation

1. Excessive vaginal bleeding- frank
2. Persistent vomiting or vomiting with ketonuria unrelieved by measures listed
3. Visual disturbances
4. If any two of the following conditions present:
   a. Elevation of blood pressure: rise of more than 30mm Hg systolic and/or 15mm Hg diastolic and/or a sustained pressure of above 140/90
   b. Albuminuria 2+ or more, not related to contamination of specimen or UTI
   c. Edema of hand, face or legs: if excessive, persistent or associated with urinary symptoms or other signs of preeclampsia
5. Hypertension without signs or symptoms of preeclampsia
6. Loss of consciousness
7. Abnormal nonstress test
8. Headaches: severe and/or unrelieved by measures listed
9. Absence of FHT’s or movement after 24 weeks
10. Unusual findings on abdominal palpitation: questionable multiple gestation, polyhydramnios, unusual presentation after 38 weeks

11. Hematocrit under 30% or hemoglobin less than 10 gm if unresponsive to measures listed

12. Two or more premature infants

**ANTEPARTUM MANAGEMENT PROTOCOL**

**Common Problems**

**Anemia**

Routine on all clients:

a. Baseline hemoglobin and hematocrit upon initial visit
b. Supplemental prenatal vitamins
c. Nutritional counseling: instruction regarding foods high in iron, protein, and Vitamin C

If hematocrit is less than 30% or hemoglobin is less than 10 mg %

1. Rule out the following and deal with appropriately

   a. Iron and vitamin compliance
   b. Poor nutrition
   c. Persistent infection (i.e., UTI)
   d. Bleeding
   e. Pica

2. Repeat hematocrit after four weeks

3. If no improvement after appropriate management, consider following hematology workup

   a. CBC
   b. Indices: MCV, MCH, MCHC (Differential)
   c. Total iron, if indicated
   d. Total iron binding capacity, if indicated
   e. Stool for ova and parasites, as indicated
   f. Sickle cell, as indicated
   g. Folic acid, as indicated
   h. Serum ferritin
   i. Reticulocyte count

4. Nutritional reassessment

5. Medications and Herbal Remedies

   a. Prenatal vitamins
   b. Liquid Iron, with Folic Acid, Vitamin B12 (NF Formulas) 1 t daily with meals
   c. Nettles tea, tincture or capsules, 3 times daily
   d. Chlorophyll liquid, 1-3 T daily
   e. Folic Acid, 1 mg daily
**Backache**

1. Rule out pathology (i.e., positive CVAT)
   a. Consider Beta Strep culture

2. Instruct about:
   a. Body mechanics and preventative measures
   b. Heat, massage and pelvic rock

3. Consider chiropractic adjustment

**Bleeding**

1. First trimester bleeding: (pelvic rest and extra intake of water until evaluated)
   a. Assess any lower abdominal pain, cramping
   b. Review chart and obtain history to rule out vaginitis, cervicitis, vulvitis, polyps, coitus, over-exertion, hemorrhoids, UTI, ectopic pregnancy, abnormal cytology, habitual miscarriage, blunt trauma, recent pelvic examination
   c. Assessment of the following:
      1) vital signs
      2) fetal heart tones, if after 9-10 weeks
      3) fundal height
   d. Gentle, sterile speculum exam, if indicated. Defer if heavy bleeding; perineal Inspection only
   e. Ultrasound, if indicated
   f. Consult with physician as needed

2. Second Trimester Bleeding: (pelvic rest and extra water intake until evaluated)
   a. Evaluate as indicated for first trimester bleeding
   b. Rule out molar pregnancy, ectopic, previa and others listed under first trimester
   c. Ultrasound, if indicated
   d. Consult and/or refer to physician as needed

3. Third Trimester Bleeding
   a. Review history/chart
   b. Rule out labor, previa, abruption, and others previously indicated
   c. Ultrasound and refer as indicated

4. Threatened Abortion
   As indicated:
   a. Check for products of conception in vagina and cervix
   b. Check for dilation of internal os
   c. If neither of the above are present:
      1) Send home on bedrest for 24 hours and pelvic rest as indicated
      2) No douche, no sex until pelvic bleeding has ceased
      3) Order HcG level, as indicated
      4) Ultrasound, as indicated

**Breech - Suspected**

1. Pelvic rock exercises
2. Breech exercise
3. Consider external version
4. Counsel client regarding possible outcomes
5. Consider Webster technique with trained chiropractor

Candidiasis (Monilia)

1. History
   a. Vaginal itching
   b. Red, inflamed vulva and or vagina
   c. Curdy, cheesy discharge
   d. Yeasty smell
   e. Sexual partner may exhibit similar symptoms
   f. May report painful intercourse and burning upon urination
   g. Occasional spotting

2. Physical Examination
   a. Red, inflamed pink vulva and/or vagina
   b. Plaques of cottage cheese-like discharge revealed on speculum exam
   c. Mycelia present on wet prep

3. Management and Education
   a. Wear only cotton underwear. Wear no underwear at night
   b. Proper hygiene; wipe only front to back, thorough hand washing
   c. Avoid scented or colored toilet paper, feminine deodorant sprays, scented douches, scented soaps, and scented sanitary pads
   d. Avoid tight jeans, girdles and pantyhose
   e. Educate client about over the counter antifungals (tea tree oil, Gyne-Lotrimin, Monistat) and the proper use of these treatments
   f. Utilize natural remedies
      1) daily bathing-2-3 times daily
      2) Go without underwear whenever possible
      3) Eliminate all simple sugars from diet
      4) Try douching for 10 days-twice daily (vinegar and water in AM, live yogurt and water or acidophilus and water in PM). Educate client about the importance of using the "low douche" methods, which are gentle enough for use in pregnancy.
      5) Try A&D ointment, Desitin, Vagisil or vitamin E applied to external itchy areas
   g. If no improvement after above, consult with physician for diagnosis and Rx antifungal treatment
   h. Educate on the need for sexual partner to treat for Candidiasis to avoid recontamination

Congenital Anomalies, History of

1. Counsel and offer genetic studies
   a. CVS at 9-10 weeks
   b. AFP testing at 16-18 weeks
   c. Aminocentesis (preferred 16-17 weeks, but less than 22 weeks)
   Refer for further counseling if appropriate

2. Ultrasound, as indicated
Chlamydia

1. History
   a. Recent exposure to infected sexual partner
   b. Sexual history including multiple partners
   c. Presence of grayish or mucoid or clear non-specific vaginal discharge (may be asymptomatic)
   d. Urinary symptoms as dysuria and frequency
   e. Vulvar soreness
   f. Presence of PID symptoms

2. Physical Examination
   a. Assess for PID
   b. Observe cervix for mucopurulent or grayish mucoid discharge
   c. Observe cervix for friability or signs of inflammation

3. Laboratory Studies
   a. Ascertain vaginal pH-5
   b. Perform wet mount- r/o monilia, trich, bacterial vaginosis
   c. Culture cervix for gonorrhea and chlamydia

4. Differential Diagnosis
   a. Other vaginal infection
   b. Other STD
   c. Cervicitis from other causes

5. Refer for appropriate antibiotic therapy
   a. NOT DURING PREGNANCY
      1) Zithromax 1 gm (4-250 mg caps taken at one time)
      2) Tetracycline HCl, 500 mg, QID x7 days (take on empty stomach)
      3) Doxycycline, 100 mg BID x7 days
   b. During pregnancy
      1) Erythromycin, 500 mg QID x 7 days or if nauseated, 250 mg QID x14 days
      2) Flagyl, 2 gm single dose
      3) Zithromax, 1 gm, single dose

6. Management and teaching
   a. Education on need to take entire course of antibiotics to avoid development of serious infection
   b. Testing and treatment of partner
   c. Pelvic rest until cured or use a condom
   d. Return for followup exam only if reinfection is suspected

Constipation

1. Nutrition and fluid counseling (increase fiber and fluid intake)
2. Exercise
3. If no improvement:
   a. Move EZ by Trilight Herbs ½-1 t every 3-4 hours as needed
   b. Metamucil 4-7 gm, 1-3 time daily as needed
Diabetes-Suspected

1. Offer fasting blood sugar finger-stick in the morning. Have client go out for a high protein, high carb breakfast, then go for a moderate walk. Return for a second finger-stick 2 hours after finishing meal (postprandial). If abnormal have client change diet and give following test in 3 days.
   a. Offer 50 gm glucose and a one hour blood draw OR
   b. A 2 hour postprandial
2. If the value is greater than normal for diagnostic method used, a 3 hour GTT should be scheduled. If two of the four values exceed normal range, the woman should be:
   a. Referred to a physician and nutritionist to see if it can be controlled with diet, OR
   b. Have a nutritionist/naturopath examine client and try to improve balance in body by nutritional supplements (Borderline case)
4. Offer initial screen and 24-28 week screen:
   a. Maternal family history of diabetes
   b. Previous baby greater than 4000 gms
   c. Greater than 2 spontaneous abortions
   d. Unexplained stillbirth
   e. Glycosuria x2 (1+ and above) not explained by dietary intake
   f. Previous gestational diabetic
   g. Unresponsive vaginitis or existent UTI
   h. Obese patient
5. Appropriate dietary and exercise instructions to be given to client during all phases of testing.

Diarrhea

1. Review history to determine source, duration, severity
2. Check temperature
3. Nutritional counseling
   a. Clear liquids x24 hours
   b. Proceed gradually to soft, bland diet, increasing to regular diet. Food list: Cream of wheat (no milk), rice, bananas, decaffeinated tea with honey, or Brown rice with extra rice water with honey or sugar for 24 hours then add Bananas, dry toast, boiled chicken.
   c. Avoid sweets, caffeine, high roughage foods and fatty foods
4. Approved anti-diarrheal agents
   a. Kapectate, 2 T per each loose stool for 24 hours
   b. Parapectolin, 1-2 T per each loose stool, with consultation

Ectopic Pregnancy (Tubal)

1. History
   a. Pain can be unilateral, bilateral in upper or lower abdominal quadrant or referred to neck or shoulders
   b. Vaginal bleeding, scant, persistent
   c. History of amenorrhea
   d. Diarrhea
e. Nausea
g. Dizzy spells, feels faint
h. History of ectopic pregnancies
i. History of PID or Chlamydia

2. Physical Examination
   a. Adnexal mass
   b. Examination of pelvis and abdomen elicits pain
   c. Signs and symptoms of shock
   d. Consider ultrasound

3. Laboratory Studies
   a. Positive pregnancy test with low HcG
   b. Negative pregnancy test

4. Management and Treatment
   a. Refer to physician
   b. If emergency situation:
      1) Engage EMS
      2) Treat for shock

Edema

1. Rule out generalized edema
2. a. Appropriate diet counseling, encourage increased protein, increased fluids, moderate salt
   c. Lateral bedrest, three times a day or as needed
   d. Elevation of dependent part, when possible

Fetal Demise

1. Cessation of fetal movement-no FHT’s
2. Cramping
3. SROM
4. Bloody or foul discharge
5. Painful, firm abdomen
6. Thick meconium staining
7. Offer referral for ultrasound
8. Consult with physician, if available
9. Discuss appropriate action with family
   a. Induction in hospital
   b. Continue with home birth plan
   NOTE: If baby is retained for a prolonged time refer to a physician as this can lead to severe hemorrhage and/or disseminated intravascular coagulation (DIC)
10. Assist family with the grief and healing process
11. Help set up Coroner or Justice of the Peace arrangements, if needed, funeral home arrangements (burial or cremation), clergy or other spiritual support
12. Be prepared for longer follow up for clients in grief
13. Allow yourself to receive support

Gonorrhea, Positive Culture

1. Client states partner has a thick, purulent discharge from his penis (can be asymptomatic)
2. If symptomatic, will show signs 7-21 days after exposure
a. Tingling around urethra
b. Reddened genitalia
c. Pustulant vaginal discharge
d. Rectal discomfort
e. Urinary frequency
f. Burning upon urination
g. Dysuria
h. Itching vulva
i. Pain (Bartholin’s Glands may be swollen)
j. Symptoms of pelvic inflammatory disease

3. Management and Education
   a. Refer to physician or health clinic for antibiotic treatment
   b. Notify Health Department
   c. Treatment required for all sexual contacts
   d. Do a repeat smear following treatment to assure no reinfection or resistance
ten treatment has occurred
   e. Encourage client to be diligent with good nutrition, get extra rest, provide
      concurrent treatment with natural remedies and change unhealthy life-style

**Group B Strep**

Group B Streptococcus is currently the most common cause of septicemia, pneumonia, and
meningitis in the neonate. Mortality can be as high as 50%. Overall, neonatal infection rate is
1-4/1000 live births. Early onset disease presents within 48 hours (mean age 20 hours). Late
onset occurs beyond the initial 7 day period (mean age 24 days). Overall early onset disease
occurs in 1 infant per 100-200 colonized women.

Maternal morbidity from GBS includes antepartum urinary tract infection, PROM,
chorioamnionitis, postpartum endometritis and puerperal sepsis. Colonization rates from the
genital tract of the pregnant women range from 4-25%. Rectal and urethral carriage are
thought to provide reservoirs for recurrent cervical and vaginal colonization. Carriage patterns
in pregnancy can be transient (20-25%), intermittent (15%), or persistent (30-50%).

Fluctuations in the presence of the organism make effective prenatal antibiotic therapy difficult
to evaluate and carries the risk of producing bacteria resistant to antibiotics. Evidence and
information are conflicting on the effectiveness of ante- or intrapartal chemoprophylaxis in
preventing neonatal disease. Standards of treatment of maternal carriage vary from one
medical practice to another. The American Academy of Pediatrics has recommended that
GBS treatment be considered on an individual or hospital basis. Their expert committee notes
that parenteral does of ampicillin to high risk colonized pregnant women throughout labor has
shown reduced rates of transmission of GBS and disease in the neonate. GBS is believed to
be sexually transmitted. The question of zoonosis has been raised in which human cases are
linked with dairy products.

**Antepartum**

1. Asymptomatic carrier
   a. Discuss with client implications of GBS in the mother, neonate and
      partner.
   b. Advise use of condoms to prevent transmission and or reinfection.
   c. Consult with physician to consider antepartal antibiotic prophylaxis with
      followup cultures.
   d. Offer alternative views on GBS and alternative remedies (to be followed
      up with cultures)

2. Symptomatic women: Refer to physician for treatment
NOTE: Treating asymptomatic women with antibiotics antepartum has not been shown to be effective in eradicating GBS.

Intrapartum
CDC recommends that Health Care Providers follow one of these two GBS prevention strategies:
1. One strategy is to screen all pregnant women between the 35th and 37th week of pregnancy by collecting a swab from the vagina and rectum. Women with GBS found in prenatal cultures are offered antibiotics during labor.
2. A second strategy is to treat women with antibiotics during labor based on obstetric risk factors, without collection of prenatal screening cultures. Women with one of the following conditions are given antibiotics during labor:
   - Fever during labor
   - Rupture of membranes 18 hours or more before delivery
   - Labor or rupture of membranes before 37 weeks

In both strategies women with the following conditions should receive antibiotics during labor:
   - Previous baby with GBS disease
   - Urinary tract infection due to GBS

Postpartum
1. Symptomatic women and/or neonates: Refer to physician for treatment.

**Headaches**
1. Assess headaches; thorough symptom analysis
2. Acetaminophen 325-650 mg, q 4 hours, not to exceed 8 tabs or 2.6 gm daily
3. If headaches are unrelieved by above, or accompanied by visual disturbances, consult with physician.

**Heartburn**
1. Instruct client regarding:
   a. Nutritional counseling—i.e., small, frequent meals, fluids at least 30 minutes prior to a meal instead of with a meal.
   b. Postural counseling
   c. Papaya enzyme tablets, 2-3 chewed as needed.

**Hemorrhoids**
1. Nutritional counseling to prevent constipation
2. Sitz baths, PRN
3. Witch hazel compresses, as indicated
4. Bio-Rutin or Rutin with bioflavonoids 100 mg TID
5. If unrelieved by above measures:
   a. Nupercaine ointment, apply 2 to 4 times daily
   b. Anusol suppositories or cream, 1 per rectum BID and PRN
   c. Preparation H to rectum PRN
6. If unresponsive to above, consult
7. If acute onset of severe pain, consult for possible thrombosis
Hepatitis B

1. History
   A. History of high-risk sexual behavior
   B. History of IV drug use
   C. Client from locations where Hepatitis B is endemic
   D. Client is a health care worker
   E. Symptoms of disease are:
      1) No symptoms
      2) Mild flu-like symptoms
      3) Joint pain
      4) Fulminating illness
         a) Fever
         b) Jaundice
         c) Hepatomegaly
         d) Pain in right flank

2. Laboratory Studies
   A. Positive Hepatitis B surface antigen (HBsAg)

3. Management and Education
   A. Hepatitis B Carrier, no symptoms
      1) Inform client and educate:
         a) No higher incidence of complications for mother
         b) Infected newborns have 80-90% risk of becoming carriers
            Indefinitely
         c) Carriers face a 1 in 4 risk of dying from liver disease
      2) Report to Health Department
      3) Plan for Universal Precautions during birth
      4) Infant will need prophylactic treatment at birth and physician supervision
   B. Ill with Symptoms
      1) Refer to physician (no specific treatment is available but
         supportive care may be indicated
      2) Discuss range of alternative treatments
      3) Infant can be treated prophylactically with Hepatitis B
         immunoglobulin given within the first twelve hours after birth.
         Follow with a series of
         injections of vaccine during the first and second weeks of life, at
         one month, 3 months and 6 months.

Herpes (HSV)

1. History
   A. Client relates history of herpetic lesions with confirmed positive culture.
   B. Client c/o genital sores with or without accompanying fever, swelling at site,
      swollen inguinal lymphatic nodes in the groin, general malaise
   C. Referred pain (sometimes like sciatica)

2. Physical Examination
   A. Grape-like vesicles with small blister formations and/or healing ulcerations

3. Management and Education
   A. Client with History of Herpetic Lesions
      1) Suggest comfort measures if client is less than 36 weeks gestation
         Don’t wear tight pants
         Stress reduction techniques
      2) Suggest dietary and natural remedies for prevention of outbreaks
a) taking 500-1000 mg. lysine daily along with 1 capsule acidophilis. Increase this if outbreak occurs or is threatening to occur
b) garlic capsules TID
c) Olive leaf capsules TID
3) If client is very stressed or threatening to have outbreak: avoid foods high in arginine, such as meat, nuts, seeds, chocolate and processed foods
4) If client is greater than 36 weeks, examine and confirm appearance of lesion and culture
5) If client begins labor, examine lesions. Lesions must be completely healed and client must be able to report no symptoms of lesions in order to proceed with a vaginal birth. If lesions are present, transfer care to a physician

B. Client Without History of Herpetic Lesions
1) Examine lesions
2) Culture lesions
3) Suggest comfort measures
4) Consult with physician. Primary outbreaks of herpes in the first and third trimester can be dangerous

Note: The primary outbreak is very dangerous to the neonate, but recurrent outbreaks may be less dangerous due to antibodies in the mother’s bloodstream, which may protect the baby. Discuss with client and physician.

HIV (Human Immunodeficiency Virus)
1. All clients of New Life Birth Services will be encouraged to be tested for HIV on the initial prenatal profile. She will sign a permission form stating her compliance.
2. Positive HIV client
   A. Management and Education
      1) Explain that there is no known cure.
      2) Notify the woman and set up a plan of management, consultation and referral with her
      3) Practitioners should familiarize themselves with legal status regarding patient rights of confidentiality in the case of a positive screen
      4) Counsel individuals at risk regarding behaviors that reduce that risk
         a) IV drug use should be stopped
         b) Teach prevention through safe sex practices, e.g. use of condoms
         c) Advise women to avoid sexual contact with persons known to have AIDS or at high risk to contract AIDS
      5) Provide emotional support measures and refer to support groups as appropriate
      6) Reaffirm confidentiality of laboratory results

Hyperemesis Gravidarum
1. Excessive and pernicious vomiting of pregnancy, usually in first trimester.
2. Client reports continual vomiting.
   A. Has ketonuria greater than 1+, by dipstick
   B. Weight loss
   C. Failure to gain weight
   D. Signs of dehydration-decreased skin turgor, dry mucous membranes, ketoacidosis
   E. Pulse may be rapid and BP lower than normal baseline.
3. Management and Education
   a. Advise to try Morning Soothe as well as ginger capsules before arising, then at the first sign of nausea
   b. If no improvement, try 100 mg Unisom with 50 mg B-6 four times daily.
   c. If still no improvement, refer to physician and/or L&D for IV rehydration and Rx for Phenergan or Compazine.
   d. Follow client closely, counsel on nutrition, possible stress situations

**IUGR**
1. Suspect IUGR in women with poor weight gain, poor fungal growth, and for gross size/date discrepancy
2. Interview closely regarding: Coital history, menstrual history, contraceptive and medical history
3. Diet counseling
4. If suspect IUGR, offer ultrasound for head/abd. Ratios
5. If positive IUGR, consult physician for plan of care

**Labor-Premature, History of**
1. Clients who have had one or more premature births before 35 weeks gestation
   A. Discuss possibility of cervical cerclage by 12 weeks with physician
2. If client demonstrates signs of premature labor and cervix > 2 cm and 100% effaced, consult and or refer for physician management
3. Vaginal exams as indicated

**Medical Treatment, Refusal**
1. Discuss with client the importance of medical treatment being refused
2. Offer for client to sign “Against Medical Advise or Waiver Form”
3. Consult with physician and or refer to physician as indicated

**Miscarriage (Threatened) Up to 20 weeks**
1. Client reports cramping and/or bleeding.
2. May have cessation of pregnancy symptoms.
3. Ascertain amount of bleeding; rule out anal or urinary in origin
4. Check for fetal heart tones if after 10-12 weeks
5. Rule out possible placenta previa, abruption, cervical polyps, ectopic pregnancy
6. Offer client immediate physician transfer of care or expectant management if not contraindicated.
   a. Monitor blood loss, vital signs, bed rest, pelvic rest, extra fluids
   b. Consider natural remedies
   c. Consider ultrasound
   d. Consider HCG levels (Quantitative)

**Multiple Pregnancy**
1. Suspect with accelerated growth usually occurring at 20-24 weeks; fundal height consistently greater than dates
2. Unusually large uterus
3. Auscultations of 2 distinct heartbeats differing by 10 or more bpm
4. Sonogram reveals multiple pregnancy
5. Consult with physician for co-management of care and/or transfer of care
6. Anticipatory guidance regarding:
   a. Nutritional counseling
   b. Relief of minor discomforts
   c. Possible fetal/maternal risks
   d. Preparation for labor/delivery/parenting
   e. Possibility of hospital delivery
   f. Suggested reading for family
   g. Possible prolonged bed rest

Placenta Previa
1. Low implantation of the placenta that is partially or totally completely covering the cervical os
   a. Discovered by sonogram; Can have bleeding during pregnancy. More common in 3rd trimester.
2. Management and Counseling
   a. Repeat sono as pregnancy continues to determine degree of previa, if any
   b. No digital exams
   c. Pelvic rest
   d. If complete, or doesn’t change as pregnancy continues, refer to physician for diagnosis and treatment. Possible transfer of care.
   e. Client education regarding prenatal cautions, nutrition and birth management
   f. Educate client about C-section and what to expect

Postmaturity (greater than 42 weeks by established dates)
1. Review chart regarding:
   - Last menstrual period
   - Contraceptive use
   - Quickening date
   - Fetal heart tones, via Doppler and/or fetascope (date)
   - Ultrasound
   - Date of positive pregnancy test
   - Size at initial exam
   - Personal and familial history or prolonged previous pregnancy
2. Client teaching regarding fetal movement from 36 weeks for baseline
3. Offer vaginal exam at 42 weeks to evaluate inducability (Bishop’s score)
4. Offer biophysical profile and/or NST
5. Utilize natural remedies to promote labor
6. After 42 weeks consider consultation with physician as needed.

Preeclampsia
1. Guidelines
   a. Elevation in blood pressure: 30mm HG systolic, 15mm Hg Diastolic
   b. Proteinuria greater than 2+
   c. Edema greater than 2+ pitting
   d. Increased reflexes
2. If more than two of above, manage accordingly
   a. Review danger signs and symptoms with client
   b. Advise and assess high protein, adequate calorie diet
   c. Increase fluids to 3 qts - 1 gallon daily
   d. Calcium rich diet: supplementation of 1200 mg to 2 gm daily
   e. Increase rest in left lateral position BID or TID for one hour
   f. Consider other natural remedies
   g. Labs-CBC, liver function if indicated
   h. If symptoms are severe, refer to physician or transport to hospital immediately
Pregnancy Induced Hypertension

1. Guidelines
   a. Elevated blood pressure (to 140/90) or an increase of 30/15 mmHg over baseline
   b. +1 to +2 proteinuria
   c. Sudden excessive weight gain
   d. Greater than 1+ pitting edema as differentiated from edema in the lower extremities
   e. Increased reflexes
   f. Headaches
   g. Visual disturbances

2. Management Plan
   a. Advise and assess a high protein, high calorie diet
   b. Salt to taste
   c. 3 qt. to 1 gallon water/day
   d. Calcium rich diet: 1200mg/day or supplementation of 2 g calcium daily for women with poor dietary intake
   e. Increase rest in left lateral position to one hour 2-3 times daily. Bed rest facilitates sodium excretion
   f. Educate client of danger signs: epigastric pain, severe headache, severe visual disturbances, light sensitivity
   g. Follow up in three days
   h. Consult with physician if signs or symptoms persist or increase
   i. Consider natural remedies and/or chiropractic

Premature Rupture of Membranes (PROM)

1. Determine source of fluid (rule out urine, retained bathwater in vagina, etc), monitor for foul odor or meconium
2. Check fluid with nitrazine paper or positive ferning
3. Check FHT’s
4. Determine need for consult with physician
5. Inform parents of potential risk
6. Maternal hygiene
   a. Check temp. every 2 hours
   b. Use sterile sanitary pads and change often
   c. Pelvic rest (no intercourse)
   d. No tub baths
   e. Wipe from front to back
   f. No vaginal exams
7. Maintain hydration and nutritional intake
8. Consider inducing contractions with natural remedies and breast stimulation
9. Consider natural remedies for preventing infection
10. If no labor after 24 hours, obtain CBC with diff. Repeat every day. Some rise is normal and values of 18,000 to 25,000 can be body’s natural immune response.
11. Group B Strep culture if has not been done recently.
12. Offer transport for all clients with PROM and no labor after 24 hours.

RH Negative Mothers

1. Initially order Rh and direct Coombs for all clients
2. If Rh-, screen for antibodies at 28 weeks
3. Inform and counsel client regarding antenatal RhoGAM at 28 weeks
4. RhoGAM administered at 28 weeks if desired by client
   a. If refused, client will sign waiver. Antibody screening test repeated at 36 weeks.
   b. If antibodies present, refer to physician
5. Postpartum plan
   a. Take cord blood sample, use Eldon card and send to lab for blood group and type
b. If baby is positive, RhoGAM administered to mother by 72 hours
c. If RhoGam refused, mother signs waiver stating she was fully informed of the dangers
to subsequent pregnancies and future transfusions
d. If baby is Rh-, mother is informed of baby's blood type and that no RhoGam is indicated

RPR-Positive
1. RPR part of initial prenatal labs.
2. If positive, FTA testing is final confirmation
3. Refer to physician for treatment

Rubella: Non Immune
1. Initial Rubella titers are obtained for each pregnant client
2. If non-immune, inform client
3. Document status and indicate need for postpartum vaccine
4. Counsel client; if exposed during pregnancy, draw sample immediately and another 2 weeks later. (Hold first until 2nd is obtained. Send both at same time. Four-fold increase indicates recent exposure
5. Encourage vaccination at 6 months postpartum

Trichomoniasis
1. Symptoms:
   a. runny, greenish, foul smelling discharge
   b. Painful intercourse
   c. Itching and burning
   d. Partner may have symptoms also
   e. Past history of trichomoniasis
2. Labs
   a. Pap and GC culture
   b. Wet mount smear
   c. KOH smear to rule out BV
   d. UA to rule out increased bacteria
3. Management and Counseling
   a. Suggest natural remedies
   b. Teaching
   c. Recommend use of condoms to avoid reinfection
   d. Offer consult with physician for Rx of Flagyl if after 20 weeks gestation
   e. Refer to physician if unsure or PID suspected
   f. Refer all sexual partners for treatment
   g. Follow up care in postpartum period

UTI (Urinary Tract Infection)
1. Clean catch dipstick indicates presence of leukocytes, blood, nitrites and elevated pH
2. May or may not complain of CVA tenderness, fatigue, pain on urination
3. Offer natural remedies
   a. unsweetened cranberry juice
   b. Cranberry capsules, 1-2 every 3-4 hours with plenty of water
   c. Apple cider vinegar 1-2 t with honey in water
   d. AZO standard for pain on urination
   e. Extra vitamin C with bioflavoids (500 mg every 2-3 hours)
   f. Uricare with Cranberry as directed
4. Consult with physician if indicated
5. Client education concerning:
   a. increased fluid intake
   b. review diet
   c. avoid sugar, processed foods, caffeine
d. eat only small amounts of wheat, meat and dairy
  e. never delay emptying bladder
  f. hygiene-wipe from front to back
  g. empty bladder before and after intercourse

**URI (Upper Respiratory Infection-Suspected)**
A. Increase fluids, especially hot drinks, soups, vitamin C juices
B. Increase bedrest and naps
C. Advise saline gargle TID
D. Consider natural remedies
   1. Respacial every 2-4 hours
   2. Extra vitamins and minerals as needed
E. Acetaminophen 1-2 tab every 4 hours, not to exceed 8 in 24 hours
F. Consider consultation with physician for Rx
G. If temperature is greater than 101, offer consultation with physician

**Intrapartum Care Schedule and Protocols**
A. Initial Evaluation to Include
   1. History of this labor, including
      a. First sign of labor
      b. Time contractions began
      c. Frequency of contractions
      d. Where contractions are felt
      e. Strength of contraction
      f. Type of discharge, if any
      g. Any fluid leakage
      h. Fetal activity
      i. History of dietary and fluid intake/history of voiding and BM
      j. How much rest has she had
   2. Maternal condition
      a. Pulse
      b. Blood pressure
      c. Respirations
      d. Edema
      e. Temperature
      f. Nausea and/or vomiting
      g. Urine dipstick
      h. Abdominal palpation
         A. Position and lie
         B. Engagement
         C. Contraction strength
         D. Fundal height
   3. Vaginal exam, if indicated
      A. Cervical effacement, dilation and softness
      B. Condition of bag of waters
      C. Fetal presentation, station and position
      D. Application of fetal head to cervix
   4. Fetal Heart rate evaluation.
      A. Establish baseline by listening to FHT for a full 1-2 minutes
      B. Listen to FHT through 1-2 contractions and for 30 sec. after contraction

**B. On-going Care to include**
a. Monitor maternal blood pressure every 2 hours. If membranes are ruptured, monitor
b. Temperature and pulse every 4 hours
c. Monitor for maternal exhaustion
d. Provide sufficient, easily digested calories, especially in early labor
e. Maintain maternal hydration
f. Encourage rest in early labor
g. If prodromal labor, especially in middle of night, offer small glass of wine and hot bath to encourage sleep for mother
h. Monitor urinary output. Encourage mother to empty bladder every 2 hours or more often. Check with dipstick every 4 hours
i. Check fetal heart rate
   • Every 2 hours in early labor, when in attendance or prn
   • Every 1 hour to 30 minutes in active labor and transition, or as indicated by heart rate pattern or prn
   • After each or every other contraction during second stage or prn
   • When membranes rupture
   • With sudden pain
   • With bleeding
   • When labor pattern shifts
j. Perform vaginal exams as indicated
k. Assist in delivery of baby. Perform immediate evaluation of mother and baby and take necessary steps.
l. Assist in delivery of the placenta. Assess maternal status and take necessary steps.
m. Encourage family bonding process

C. Management for Women in Labor
1. The focus of care will be on encouraging and supporting the natural forces of labor with a calm, assuring, nonintervening approach
2. Family and friends may be present as desired by the mother
3. Ambulation is encouraged if indicated
4. Amniotomy (not done routinely) vertex presentation with head firmly applied to cervix

D. Criteria for Transportation to the Hospital
1. Regardless of careful prenatal screening and the degree of responsibility a woman takes for her own physical condition during the pregnancy, there will be occasions when the risk level will change during labor. Should an intrapartum problem evolve, the woman may be transferred to the hospital
2. The criteria to be used for making such a transfer could include:
   • Temperature greater than 101.4 taken orally on 2 or more occasions
   • Abnormal heart rate pattern
   • Dysfunctional labor unresolved by midwife management
   • Significant vaginal bleeding, either before or after delivery, if unable to control
   • Prolapse of umbilical cord
   • Malpresentation or position
3. Emergency Measures
   a. to be instituted by midwife awaiting hospital transfer of patient
   b. Bimanual compression and/or uterine exploration for immediate postpartum hemorrhage
   c. Manual removal of placenta for third stage hemorrhage
   d. Suprapubic pressure, Wood’s screw maneuver, and/or fracture of the clavicle for shoulder dystocia
   e. May begin IV fluids in preparation for transfer to hospital
E. Postpartum Care

1. Care of the mother for the first two hours postpartum
2. Families will remain together
3. Postpartum care and recovery of the mother will include:
   a. Temperature
   b. Pulse, respiration, blood pressure every hour or prn
   c. Fundal massage or lochia check prn after delivery of placenta
   d. Urination encouraged, may catheterize client, if indicated
   e. Breastfeeding begun
   f. Personal care of woman
   g. Ice packs for perineum as needed
4. Midwife will stay with family for a minimum of 2 hours post delivery
5. Care of the baby for the first two hours postpartum may include:
   a. DeLee, as indicated
   b. Apgars at 1 and 5 minutes
   c. Newborn physical exam and gestational age assessment
   d. Resuscitative measures, as indicated
   e. Vital signs: initial and every hour
   f. Cord blood for RPR, Rh and type
   g. 1 mg vitamin K (0.5 ml)IM as directed by pedi and/or parents
   h. Erythromycin ophthalmic ointment, as directed by pedi and/or parent
6. Postpartum Medications
   a. RhoGam for Rh negative clients
   b. Rubella vaccine recommended as needed
   c. Ibuprofen 400-600mg every 6 hours, prn
   d. Prenatal vitamins and iron, 1 po qd of each as indicated
7. Natural remedies for bleeding, after birth cramping, muscle soreness.

F. Care of the Family

The experience of bringing a new baby into the family group is a gradual process beginning before conception and continuing far beyond the most dramatic moment of birth itself. Care of the mother, the newborn baby, and the family must continue during the days following discharge. The welfare of the newborn baby and the mother and the coping of the family with the addition of a new member will be assessed by the midwife or appropriately trained labor assistant.

24-48 hours after birth, the home visit could include the following:

1. Physical assessment of the baby to detect deviations from normal
2. Weight of baby
3. Maternal fundus, lochia, perineum, temperature, breasts
4. Vital signs for both mother and baby
5. Comfort, mood, reactions to newborn
6. Review of breastfeeding
7. Bonding continued
8. Review baby care and assessment
9. Check on home support-is adequate help available
10. Review birth experience with mother and father
11. Family adaptation, siblings
12. Review normal newborn behavior, feeding, sleeping
13. Bowel and urinary patterns and care
14. Need for additional education or support
Three to four day Postpartum exam could include:
1. Physical assessment of baby and mother
2. Weight of baby
3. Vital signs for mother and baby
4. Breastfeeding difficulties or questions
5. Newborn screen performed on baby
6. Any of the above as indicated

Two week postpartum exam could include:
1. Physical assessment of mother and baby
2. Weight of baby and mother
3. Vital signs for mother
4. Review of breastfeeding concerns and frequency
5. Newborn screen of baby

Six Week Postpartum Exam could include:
1. Complete physical exam of mother
2. Routine vital signs of mother
3. Weight
4. Lab work
5. Pap smear
6. CBC, as indicated
7. Other labs, as indicated
8. Teaching on breastfeeding, nutrition, family planning, exercise
9. Weight of baby
10. Emotional issues
11. Satisfaction with birth
12. Resumption of sexual activity counseling

Complications of Antepartum Period

Bimanual Compression
1. Only used as a last resort to control immediate postpartum hemorrhage.
2. Call EMS. Call ahead to hospital.
3. Give O2 by mask
4. Using sterile technique, place one sterile gloved hand inside the vagina and make a fist against the uterus. Press other hand deeply into the abdomen behind uterus and compress the body of the uterus hard between your hand and fist.
5. Transport immediately. Do not remove hands during transport unless bleeding stops
6. Give emotional support and explain what has happened. Encourage communication.

Dehydration in Labor
A. Client shows signs of dehydration
   1. decreased urinary output
   2. excessive vomiting
   3. inadequate fluid intake
   4. tachycardia
   5. Ketonuria/fruity odor on breath
   6. Fever
B. Management
   1. Rehydrate with 2-4 oz. water, sports drink, or laborade every 20-30 minutes.
   2. If vomiting, use homeopathic lpecac: one dose every 15 minutes until vomiting stops
   3. Try Classic Coke to quickly alleviate ketones
   4. Try enema of ½ to 1 c warm water with ½ t salt, 1 t sugar, ¼ t cream of tartar. Give very slowly. Encourage client to retain as long as possible. Repeat every 2 hours as needed.
   5. Vital signs every 15 minutes until maternal improvement
   6. If no improvement, consult physician
**Fetal Distress**

A. Fetal heart rate abnormalities
   1. tachycardia; moderate 161-180 bpm, marked 180+
   2. bradycardia: moderate 110-119 bpm marked less than 100
   3. Deceleration patterns
      1) Early decels: common in late 2nd stage, head compression, WNL rate should not be lower than 100 bpm
      2) Late decels: can be due to placental insufficiency. Begins at peak or later. Baseline usually high normal or tachycardia
      3) Variable decels: due to cord compression. Different onsets; can last a few seconds or minutes
   4. Dangerous patterns
      1) Marked tachycardia followed by marked bradycardia. If moderate not considered adverse pattern
      2) Progressive decrease in beat to beat variability, with an abnormal baseline
      3) Late decels, especially with baseline tachycardia or bradycardia and/or poor variability
      4) Prolonged variable decels, with abnormality in baseline rate

B. Management Plan
   1. Frequent monitoring of FHT before, during and after contractions, checking beat to beat variability in 5 second intervals for one minute
   2. Change of position, especially left lateral or knee-chest
   3. Slow controlled breathing with O2, 10 liters per min. as needed
   4. Brisk massage on mother’s abdomen to stimulate baby
   5. More ominous if mother in early or active labor with FHT below 100 and progressively slower recoveries than if decals occur in late transition or pushing.
   6. Vaginally stimulate fetal scalp. Increased FHT is good sign.
   7. If distress is severe or unresponsive to measures:
   8. If birth is imminent, deliver as quickly as possible. Episiotomy may be indicated. Be prepared for infant resuscitation.
   9. If birth not imminent, transport with mother in left lateral position and O2. Call hospital before and explain situation.
   10. Give information and emotional support to clients and husbands.

**Nuchal Cord (Tight)**

A. After birth of head tight nuchal cord is found, wrapped once or more times around.
B. Cord cannot be easily loosened, over the head or down the shoulder
C. Tight cord prevents birth of shoulders and/or body
D. Management Plan
   1. Somersault Maneuver (Jack-knife)
      a. support baby’s head holding it gently toward mother’s thigh
      b. shoulders will continue to birth
      c. guide the baby out and flip over the cord without head coming any further away from the mother than it was initially.
      d. Unwrap cord from neck or body
      e. Assess baby and resuscitate as needed
   2. Clamp and Cut the cord
      a. Tell mother to not push, help her pant if necessary
      b. Using sterile technique, place 2 hemostats 1 inch apart on the most available loop of cord. Use 4 hemostats if several loops must be cut.
      c. Take care not to clamp mother’s pubic hair or skin
      d. Use blunt tipped, short scissors to cut cord
      e. Unwrap cord from around neck
      f. Ask mother to push; assist in delivery of shoulders as needed
E. Notes:
1. Baby may be at increased risk for jaundice
2. Mother may be at increased risk for postpartum hemorrhage

Oxygen in Labor

A. Indications for procedure
1. Mother feels very tired
2. Mother feels air-hungry, faint
3. Mother has been pushing hard for awhile
4. Increase in maternal pulse rate, pain, exhaustion
5. Decrease in FHT or flat baseline
6. Maternal hemorrhaging
7. Cord prolapse
8. Maternal distress

B. Management Plan
1. Pain: Give O2 at 6-8 liters/minute (1/m) for as long as useful along with emotional support
2. Exhaustion: Same as #1
3. Fetal distress: Turn mother on left side and give O2 through face mask at 6-8 l/m until condition is stable or mother is transported to a hospital
4. Maternal hemorrhage: Five O2 through a mask at 6-8 l/m or enough to inflate reservoir until vitals are stable or mother is transported
5. Cord prolapse: Give O2 through a mask at 6-8 l/m. Treat prolapse cord per protocol

Perineal Laceration

1. Assess degree of laceration and need for repair.
2. If first or second degree, repair:
   a. Question mother about history of allergic reaction to local anesthetics
   b. Use injectable Xylocaine or Lidocaine and/or Cetacaine gel.
   c. If tear is bleeding moderately to severely, use anesthetic with epinephrine. Use as little as possible to affect numbness and not induce swelling.
   d. If 3rd or 4th degree laceration, refer to appropriate care provider for repair.
3. Instruct mother on perineal care, ice perineum for first 24 hours and follow with sitz baths 2-3 times daily
4. Inspect perineum ata 24 hour visit as well as 3-4 day visit to check for signs of infection or breakdown of repair.
5. Instruct mother to sit with legs together and on her hip rather than bottom. Encourage her to stay in bed for the first week as much as possible.

Postpartum Hemorrhage

1. Bleeding estimated to get greater than 500 cc
2. Pulse is rising and greater than 20 points above baseline or above 120
3. Diastolic BP decreases 15 mmHg from prone to sitting
4. Mother may appear pale and or sweating
5. Mother may c/o lips tingling, numbness or dizziness, ringing in ears. She may be weak, graying-out or fainting
6. Management Plan

a. Hasten delivery of placenta if not already delivered
b. If, despite treatment, placental fragments and/or membranes with uncontrolled bleeding
   1) Consult physician
   2) Arrange for transport
   3) Consider 02 and IV therapy and other treatments for shock while waiting for help to arrive
   4) Perform bimanual compression to stop bleeding
c. After delivery of placenta
   1) Apply fundal massage until uterus is firm and 2-3 FB below umbilicus. Hold uterus up with suprapubic pressure while applying massage
   2) Catheterize urinary bladder, if full.
   3) Give 10 IU Pitocin IM. Can be repeated a total of 3X q 15 minutes.
   4) Give 0.2 mg Methergine IM
   5) Administer 02
d. If client unstable, arrange for transport and while waiting,
   1) Continue fundal massage if boggy
   2) Keep direct pressure on any bleeding lacerations or enlarging hematomas
   3) Assess vital signs q 15 minutes
   4) Treat for shock
e. If uncontrolled bleeding perform bimanual compression of uterus to stop bleeding
   1) For mild postpartum hemorrhage (persistent prolonged moderate bleeding)
   2) Teach clients how to massage uterus
   3) Utilize natural remedies/herbs, such as ice packs on lower abdomen
   4) Methergine tablets, 0.2 mg, 1 tab q 6 hr. for 24 hr.
   5) Frequent nursing
   6) Keep bladder empty
   7) Keep expressing any clots which may form. Signs of clots include pain with no bleeding
   8) Confirm that placenta and membranes are intact. Manual removal of retained pieces may be necessary

Prolapsed Cord

1. Management plan
   a. Inform mother of nature of emergency
   b. Place mother in knee-chest or Trendelenburg position
   c. Administer 02
   d. Using sterile technique, manually elevated presenting part off the cord.
   e. Do not remove hand until delivery is imminent. Do not remove during transport.
   f. If cord extends outside of vagina, wrap it with sterile gauze soaked in warm sterile saline, if available, OR if not much cord presents, gently insert cord back into vagina for warmth and moisture
   g. Transport immediately to nearest hospital
   h. Call ahead to prepare for emergency C-Section
   i. Support woman to stay calm, breathing deeply. Offer emotional support.
Protocol References

Myles Textbook for Midwives, 13th Edition
Varney’s Midwifery, 3rd Edition
Heart and Hands, 3rd Edition
Understanding Diagnostic Tests in the Childbearing Year, 6th Edition
Holistic Midwifery, Volume 1
Basic Life Support for Healthcare Providers, American Heart Association

Protocols Covered by Texas Law
- Use of Eye Prophylaxis
- Neonatal Resuscitation
- Newborn Screening