

California College of Midwives
State Chapter ~ American College of Community Midwives

Section 3 G

Minimum Practice Requirement ~ INTRAPARTUM CARE

~ to define and clarify minimum practice requirements for the safe care for women and infants during the **INTRAPARTUM** period

☞ Aseptic technique and universal precautions will be used while rendering care.

During active labor, the Midwife of record (or an appropriate designate) shall remain present to monitor and support the spontaneous process of labor and birth, employing evidence-based principles of physiological management. The Midwife shall also provide appropriate psychological and social support to assist the laboring woman and her family members to cope with the natural stress of active labor.

A. With the permission of the client, the Midwife shall assess mother and baby throughout the stages and phases of labor, including but not limited to:

1. Assess, monitors and charts fetal wellbeing. While in attendance, the Midwife assesses fetal heart tones (FHTs), in conjunction with characteristics of the amniotic fluid, to determine fetal status during active labor. Fetal wellbeing is defined by evidenced-based parameters. Currently (circa 2004) a reassuring fetal heart tone pattern consists of:

- a. normal baseline -- 110 to 156
- b. normal variability – baseline variations ranging from 6 to 25 **beats per minute** (bpm)
- c. periodic *presence* of accelerations – an increase above baseline equaling 15 (or more) bpm for 15 (or more) consecutive seconds
- d. *absence* of decelerations -- a decrease below baseline equaling 15 (or more) bpm for 15 (or more) consecutive seconds

Baseline rate, long-term beat-to-beat variability, normal accelerations and, if present, decelerations can be detected via intermittent auscultation (IA) or electronic fetal monitoring (EFM). The method commonly recommended for IA is to listen with a fetoscope or electronic doptone for a minimum of 60 seconds (during labor listen immediately following a contraction) and counting FHTs in five-second sets (i.e., a series of 12 or more samplings). For example, a normal baseline of 144 bpm will produce a pattern that is predominantly sets of 12s, with an occasional set of 10, 11 or 13. Normal accelerations, if present, will produce a series of three (or more) consecutive sets of 13s, 14s or 15s. Decels, if present, will manifest as three (or more) consecutive sets of 9 (or less) beats per unit. Based on the numerical pattern of these sampling sets, it is possible to confirm all four parameters of a 'reassuring' FHT pattern or to detect non-reassuring patterns by using intermittent auscultation. An alternative method to confirm a reassuring fetal heart tone pattern is the episodic use of EFM.

The following schedule for monitoring FHTs via IA or episodic EFM is recommended:

- a. latent labor: at least once every 2 hours or as indicated
- b. early 1st stage of labor: at least once every hour or as indicated
- c. active 1st stage of labor: every 30 minutes or as indicated
- d. early 2nd stage of labor: every 20 minutes or as indicated
- e. active pushing & perineal phase: every 10 minutes or after every 3rd UC, more frequently as indicated

Note: Occasional variable decels that are infrequent, brief in length and mild in depth or head compression decels occurring during rapid fetal decent and the pushing phase and which display good recovery, are generally benign. Medicalization is usually not indicated unless these decelerations progress to a more serious status as evidenced by a deeper nadir, longer duration, more frequent occurrence and/or longer period of recovery or are associated with other evidence of fetal distress such as baseline abnormality, fresh or more concentrated meconium or abnormal vaginal bleeding.

2. While in attendance, assesses, monitors and charts maternal wellbeing as follows:

- a. monitor vital signs every four hours (with maternal permission) or as otherwise indicated
 - b. monitor the progress of labor, noting length, force and frequency of uterine contractions and maternal response to the stress of labor
 - c. monitor amniotic membrane status for rupture, relative fluid volume, odor, and color of amniotic fluid
 - d. monitor hydration status, encourage adequate fluid intake, check for signs of maternal fatigue
 - e. monitor voiding and if indicated, check for bladder distention
 - f. whenever vaginal examinations are performed to assess the progress of labor, they will be kept to a minimum to reduce the risk of infection and performed only with permission of the mother. Attention shall be directed toward aseptic technique, with following information noted and documented in client's chart:
 - 1) cervical placement and consistency
 - 2) presence of 'bloody' show
 - 3) presence and characteristics of amniotic fluid
 - 4) dilatation and effacement of cervix
 - 5) fetal station, presentation and position
3. Assist the mother to give birth spontaneously and receive her newborn baby
 4. Immediately observe the neonate to establish its transitional status, keep baby warm, provide stimulation or neonatal resuscitation if indicated
 5. Immediately observe maternal status, estimate maternal blood loss and monitor vaginal bleeding
 6. Deliver the placenta using gentle cord traction or helping mother to squat over a container
 7. Check the perineum for lacerations, if indicated, check the vaginal vault and or the cervix and make appropriate referral for suturing when necessary
 8. Inspect the placenta and membranes, noting condition of placenta and condition of the umbilical cord including its length, number of vessel and other notable features
 9. Obtain a cord blood specimen, if feasible, which shall accompany the infant in case of transport or in the case of Rh negative mother, shall be sent to the lab for blood typing and Coombs
 10. Manage any variations, deviations or problems in accordance with individual practice protocols and manage any complications in accordance with guidelines cited elsewhere in this document