Organic Midwifery Birth Plan

Name _____.

Due Date _____.

- **Midwives and birth helpers'** two midwives always plan to be at a homebirth. No restriction on birth helpers but client is counselled on having appropriate helpers such as those who are not anxious or fear based.

- **Ambulance Check** with client that she has current cover in case emergency transfer to the back up hospital is required

- **When to call midwife.** Client calls when she wants midwife to come or is worried. During the day, after 7am client to give midwife a heads up either by phone or text.
  At night, after 10pm, client to call midwife if she is having strong, regular contractions lasting 60-90 seconds every 3 minutes (as a guide), if she is worried or anxious or has reduced foetal movements. Client to call immediately if there is bleeding other than a show, ruptured membranes with green or brown fluid indicative of meconium, reduced foetal movements outside baby's usual routine after decreased FM management

- **Going past the expected date** Pregnancy from 37 weeks – 42 weeks. After 41 weeks, post dates mgt discussed. Hospital birth at >42 weeks offered. If client chooses to await birth, client offered CTG and or Ultrasound monitoring >42 weeks with back up hospital. Client also offered medical consultation with hospital medical officer (HMO). Client informed to monitor foetal movements closely and call immediately if concerned. Client is supported to birth where she feels safe and comfortable. Natural methods like acupuncture, pressure, oxytocic release, walking, swimming, anxiety release methods advocated prior to medical induction.

- **Ruptured membranes and risk of infection** Group B strep Client given information sheet on prelabour rupture of membranes and PROM. If fluid is clear or pink, midwife to assess within 18 hours of ROM or to attend client immediately if meconium stained liquor. Hospital monitoring & medical consultation offered if ROM >18 hours but client given info of increase risk of ascending infection to the baby >96 hours. Antibiotic therapy discussed and offered if over 18 hours. Client encouraged to seek natural methods of induction if she has not gone into labour within 24 hours of SROM and to take probiotics. Client advised to monitor foetal movements closely & contact midwife if concerned. Check temperature every 4 hours whilst awake and notify midwife if become febrile >37.5 degrees. Monitor fluid loss, change of fluid colour and notify midwife if vaginal odour changes. Avoid sexual penetration in the interim.
  If >96 hours, hospital induction is offered and recommended

- **Pre labour** this is normal, and to be expected. It is associated with irregular, arrhythmic contractions, short in duration and mild in intensity. Can last 2-5 days prior to established labour. Client and support team advised to maintain regular hydration, calorie intake – every 2 hours whilst awake and to sleep/doze in-between contractions. Client advised that tag team approach might be warranted especially with first babies. Client also encouraged to void every 2-4 hours to keep bladder empty. Client advised to call if wanting reassurance, or monitoring of maternal or foetal wellbeing. Daily assessment can be undertaken.

- **Vaginal examinations** Not routinely necessary but in consultation with client midwife may ask to do a VE if labouring outside normal parameters or to ensure second midwife is present for the birth. Client not obliged to accept

- **Artificial rupture of membranes** Midwives do not do this at home unless every measure has been attended to prior to transfer to medical facility in the advent of slower than normal progress in the established labour phase. Otherwise, absolutely essential that membranes remain in tact – reasons why explained to client

- **Use of Water** is encouraged, booklet and information regarding water usage and deep immersion in water given to client. Water birth discussed. Type of heater, where to have the pool and setting up of pool discussed

- **Observations in labour** if the client is in prelabour (when called to assess) a full set of observations and abdominal palpation +/- VE. In established labour, an initial set of observations is done, then 4/24 BP and temp, ½ hourly FHR (foetal heart rate) and maternal pulse. In 2nd stage, FHR auscultated after every 1-2 contractions. Monitor fluid loss & colour and monitor any maternal concerns. 3rd Stage – At least one support team member to stay with client at all times until birth of placenta. Monitor for signs of placental separation or excessive bleeding, document maternal and foetal well being every 15 minutes until 1 hour after placental birth. Client and infant wellbeing is assessed constantly until midwives leave, 2-4 hours after labour is completed or when the client is comfortable with the midwives departure.

- **Photography and video** this is encouraged. Support team member to pick up camera and take photos as appropriate. Client to state if photos are not to be taken.

- **Presence of siblings** Discussed and encouraged. Information regarding sibling preparation and logistics of supporting the child discussed. If children to leave during the labour process who takes the children, if staying who is supporting them. Midwife to support whatever the client wishes.

- **Pain management** List of pain management techniques discussed such as water, massage, music, hot packs, acupressure, mobilisation, relaxation techniques and or calm birthing, visualisation, TENS and Sterile water for injection

- **Food and fluids for mother, family and midwives** Encourage food preparation prior to labour and to eat high complex carbohydrates during pre labour and 1st stage, simple sugars during the 2nd stage. Client to keep well hydrated with a variety of drinks such as hydrolyte, labour aid, juices & water. Midwives given permission to help themselves to kitchen facilities

- **Hot packs for perineum** Offered and encouraged if not in the water. Rationale for this given to client

- **Episiotomy** NO, unless baby's life is at stake and client cannot push her baby out with encouragement

- **Discovering gender of baby** Midwife, support team or other care providers not to announce the sex of the baby.

- **Partner assisting with birth** Midwife to facilitate this option if client wishes this

- **Third stage environment** Calm & quiet, labour is not complete until the placenta & membranes are expelled. No separation of mother & baby, birth team to stay in the birth room until 3rd stage complete

- **Use of oxytocics** only if excessive bleeding or in consultation with client if labour outside normal parameters. Natural oxytocic encouraged with aid of homeopathics, eating placenta bits and breast-feeding.

- **Cutting of cord** not until placenta & membranes are expelled or if active resuscitation methods are required. Lotus birth offered.

- **Disposal of placenta** Client to decide.

- **Warmth for baby** Transition to extra uterine life and thermoregulation discussed. Advised to have ability to have warm wraps, blankets and towels after the birth. Importance of skin to skin.

- **Resuscitation of baby** Rarity of resuscitation noted but in the advent of this occurring, measures undertaken by midwives discussed. Difference between water born and land born babies discussed. Initial methods such as tactile stimulation, blowing on baby's cheeks & talking to baby -> use of bag & mask to aid lung inflation (use of air) -> bag & mask with O2 and suction of airways and CPR. Initial resuscitation to be done on client's chest or in her arms but if CPR required, then a hard flat surface close to client is used, ambulance to be called and transfer to nearest medical facilitated

- **Vitamin K** Information given to client and whether this is required. Physiological birth discussed. Types of administration discussed. Client advised when Vitamin K is recommended such as instrumental birth, trauma to baby, antibiotics in labour or given to baby, caesarean birth.

- **Unexpected outcomes at birth**: Congenital abnormality or stillborn. Any spiritual or religious considerations. Time alone with baby. Support from birth team & midwives. Transfer to hospital at some stage

- **Reasons for transfer to hospital** Non emergency transfer: for acceleration of labour, medical pain relief, maternal request, meconium in early labour with reassuring foetal heart rate, foetal jaundice within the first 24 hours. (Via car)

  Emergency transfer: Bleeding antenatally, intrapartum or postpartum not treated by initial methods of PPH mgt; meconium in labour with non reassuring FHR; foetal heart rate abnormalities; retained placenta; congenital abnormality requiring medical assessment; if infant has responded well to active resuscitation including CPR paediatric assessment should still be instigated (via ambulance)

- **Decision making process (in hospital)** Midwives to accompany client to hospital. BRAN – Benefits, risks, alternatives & now. Client to ask for time alone with support team after options have been acquired. Unsure of choices to say No in the first instance. Ask for second opinion. Midwife will advise client to accept medical recommendation if client's or wellbeing is compromised and emergency treatment is required immediately

- **Instrumental delivery- forceps / vacuum** Consideration of health provider's experience and if one is optimal over the other, midwife will advise accordingly

- **Caesarean birth**: Minimal, if any separation of the client & her baby. Skin to Skin in theatre & recovery and midwives to facilitate breast feeding. Delayed cord clamping, milking of cord or lotus birth. Record any particular requirements to facilitate individualised care.

- **Type of anaesthetic** Spinal advised. May require general anaesthetic (GA) if emergency- Discuss differences

- **Presence of partner and midwife in theatre** Midwife to accompany client to theatre and second midwife to wait in recovery. If baby requires special care or neonatal intensive care admission, second midwife to accompany client's partner & baby to that facility. Midwives to communicate with each other, to relay progress to client. If client unable to do skin to skin with her baby, this is to be done by the partner.

- **Baby care** Routine baby care to be delayed until client is present. Skin to skin and breast feeding is to be facilitated prior to weighing or measuring of the baby. Client & baby not to be separated unless client and or baby are unwell and not able to do so. Client to be given time to attend to routine baby care in her own time and not be governed by hospital policy or procedure

- **Postnatal care in hospital**: Request minimal stay. 24-48 hours post caesarean section and 4-6 hours post vaginal birth. Client to be discharged with adequate pain relief. Midwives can visit the client in hospital if desired. 24 hours on call for any questions or concerns and consistency of advice.

- **Permission from parents before any procedure** Client to call midwife at any time if the hospital is advising any blood tests or procedures to be done on the baby. BRAN to be applied. At no time should baby be taken away from the client without her permission. Cascade of intervention can be done to the baby.

- **Artificial feeds** No, not under any circumstances, client to call midwife for pursuing this course of action

- **Support after the birth** Client is encouraged to rest for 2 weeks if able, lying down as much as possible, no lifting other than her baby. Partner and family support and availability discussed and strategises devised to enable client to be with her baby and not have to worry about siblings, housework or food preparation.

- **Newborn screening test (heel prick)** this can be done at home whilst baby is being breastfed after 48 hours. It is a test for rare metabolic disorders such as cystic fibrosis, phenylketonuria and hypothyroidism and at least 40 other metabolic disorders. Any family history of blood disorders discussed.

- **Cord blood and maternal antibodies** Delayed cord clamping ensures adequate blood volume, reducing anaemia in the infant and assist the baby to make the transition from intrauterine to extrauterine life more easily. Blood is taken from the cord if the client is rhesus negative.

- **Test for jaundice SBR** Physiological and pathological jaundice discussed. Client is advised to fully expose baby to filtered sunlight for 15 minutes twice a day in the summer and as long as possible in the winter, back and front, from birth to facilitate the excretion of bilirubin and prevent or minimise physiological jaundice. Client also encouraged to give baby free and open access to the breast, feeding on demand. If the infant is showing signs of increasing jaundice and is compromised – signs of non-reassuring features of jaundice discussed, then midwife to refer client to the hospital for assessment, blood test and potential phototherapy

- **Hepatitis B vaccination** not recommended at birth, unless infant is at risk of contracting hepatitis.

Any other comments: