MOONLIGHT
MIDWIFERY

Guide to Homebirth Protocols

This summary is to help you understand common risk criteria and protocols for conditions that I would recommend monitoring, medication, physician consult, or planned hospital birth. It is not all-inclusive, but is intended to share my standards of care. I know some people want to reserve their right to decline testing, ultrasounds, and hospital care. There are some midwives who are more in agreement with that. However, I am disclosing these guidelines to you so that you would choose me as your midwife feeling in agreement with my safety standards and recommendations to protect the mothers and babies in my practice. Homebirth is not heroic; it's just a beautiful choice when everything points to being safe for mom and baby.

Standard screening

My professional responsibility and personal commitment to protecting women and babies is to adhere to the standard screening tests, which includes an infectious testing panel and anatomy ultrasound screen of baby. I choose to only attend homebirths with negative screenings. Additionally, I feel glucose management is very important, so gestational diabetes screening (using dye-free glucose or, in low-risk cases, grape juice) is required.

Practice protocols

My standard of care is to adhere to evidence-based practice and Nurse Midwife practice guidelines. I've been on protocol committees for birth centers, and since that is well-researched midwifery care and outcomes, I would like to maintain great outcomes by adhering to these standards. I review cases with peers, Nurse Midwives and MDs, to keep my care on track in private practice. Things can go wrong when midwives "like you too much" to draw the line for safety standards. I listen very strongly to my intuitions, but I try to keep a clear head to practice "smart."

Risk Criteria

Low Risk- if monitored and stable, homebirth is option

- ❏ Mother's age >35yo- genetic screening option, perinatal consult option
- ❏ Thyroid disorder- lab monitoring monthly, controlled with medications
- ❏ Psychological problems, anxiety or depression meds, history of postpartum depression
- ❏ Overweight- maintain normal weight, monitor for insulin and glucose impairment
- ❏ Anemia, mild- dietary changes and supplements
- ❏ Gestational diabetes, well controlled with diet, working with nutritionist
- ❏ Mother with baby #5+- risk of postpartum bleeding, active management plan using herbs or meds
- ❏ Premature/prolonged rupture of membranes- natural induction techniques by 24hrs

Medium Risk- collaborative management with perinatologist, antepartum testing, and if normal, homebirth is an option

- ❏ Previous poor pregnancy outcome- preterm, small or large size, congenital disorder- that is not a current problem, as proven through additional monitoring with perinatologist
- ❏ Obesity- manage risk factors, nutrition, monitor for glucose impairment
- ❏ Gestation 41+ weeks- twice weekly monitoring, natural induction methods by 42 wks
- ❏ Polyhydramnios- increased fluid around baby, may indicate uncontrolled blood sugars

- ❏ Macrosomia or fetal growth restriction- monitor % changes and markers for wellbeing
- ❏ Thromboembolic risk factors, clotting disorder- monitor placenta and cord flow
- ❏ Mild hypertension- monitor renal function, monitor fetal wellbeing
- ❏ Medical conditions managed with or without meds

High Risk- recommend hospital delivery, transfer care

- ❏ Gestation <37 wks or >42 weeks
- ❏ Abnormal ultrasound- anatomy defect
- ❏ Anemia, Hemoglobin <8.5
- ❏ Decreased amniotic fluid, placental function or cord flow; IUGR
- ❏ Thick meconium amniotic fluid noted in labor
- ❏ Ruptured membranes prolonged without labor 40+hrs
- ❏ Intrahepatic cholestasis (high bile acids, stillbirth risk)
- ❏ Preeclampsia
- ❏ Breech presentation*
- ❏ VBAC, history of cesarean*

*certain criteria lowers risk and homebirth may be an acceptable-risk option to midwife and mother if she is not able to obtain good hospital-based care option

Antepartum Testing

“AP testing” usually involves several methods, typically after 32wks:
-NST (Non-stress test)- fetal heart rate monitoring x20min. This can be done in my office.
-Growth scan ultrasound- monthly after 28wks to monitor changes in fetal growth percentile. Done at perinatal MD.
-BPP (Biophysical Profile) ultrasound- checks placenta, cord flow, amniotic fluid amount, fetal wellbeing. Done at perinatal MD.

Interventions

Here’s some more interventions I may use in my practice and frequency:

- Naturopathy- Herbs, homeopathy, nutraceuticals- common
- Artificial rupture of membranes- rare
- Mechanical ripening of cervix- foley bulb or laminaria- sometimes
- IV-sometimes
- Doppler- Electronic doppler is used for labor
- Vaginal exams in labor- usually I rely on other signs of labor progress. I use them to know the dynamics of the pelvic floor and fetal presentation, and what tricks are needed to help the process.
- Manual rotation- rare, but sometimes a baby doesn’t come through unless the head changes rotation
- Manual removal of placenta- rare, recommend to be in hospital setting
- Pitocin after birth- sometimes
- Suturing- I like to put things back together if they come apart; lidocaine used of course!

Newborn

Newborn meds and screenings are encouraged, but done only with informed consent. Nothing is “done” to the baby after birth, just an exam and weight at some point, and a blood sugar check if weighing >9.5lbs. If mother’s blood type is Rh neg, I initially check baby’s blood type with an Eldon card. I can verify through sending to a lab.

GBS testing & treatment

I recommend the 36week perineal swab for Group Beta Strep testing, and offer standard treatment protocol with IV Ampicillin during labor. If you decline testing, or test positive, I monitor baby closely for signs of sepsis, and parents must complete their part in monitoring baby's vitals and reporting to me. I like the baby to be seen at 24hr and 48 hr by myself and Pediatrician.

Breastfeeding

Adequate nourishment to the baby within the first week is our priority. I will ensure a good latch is obtained in the initial hours, and we will follow together the baby's output and weight gain in the first few weeks. With my experience level in breastfeeding, if I suggest a consultation is needed for tongue tie revision or lactation consultant, I hope that you will value this as an essential part of your baby's care.

Thanks for reading! Please discuss further details with me personally, Crystal Bailey CNM