Cambridge Midwives
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Website: cambridgemidwives.ca

Ontario Midwives provide primary care for low risk pregnancies. Our philosophy is based on informed choice by the woman, choice of birthplace, and continuity of care.

The attached information is intended to provide you with knowledge of our education, training and experience, and the services provided for you through midwifery care in Ontario. As a midwifery client, we hope you will develop a trust and confidence in your midwife and in yourself that will enable you to take responsibility for your own well-being. You will make the decisions and choices about your care based on information and education received through your midwife and other sources, and you will receive support for the choices you make.

Cambridge Midwives Privacy Statement

This Midwifery Practice Group is bound by law and professional ethics to safeguard your privacy and the confidentiality of your personal information. This includes:

Collection of Personal Health Information

You will be asked to sign a consent form so that we may collect personal health information about you directly from you or from the person acting on your behalf. The personal health information that we collect may include, for example, your name, date of birth, address, health history, records of your visits to Cambridge Midwives and the care that you received during those visits. Occasionally, we collect personal health information about you from other sources if we have obtained your consent to do so or if the law permits.

Uses and Disclosures of personal Health Information

We use and disclose your personal health information to:

- Treat and care for you
- Get payment for your treatment and care from (Lang's Farm Village Association)
- Plan, administer and manage our internal operations
- Conduct risk management and quality improvement activities
- Teach
- Conduct research
- Compile statistics
- Comply with legal and regulatory requirements
- Fulfill other purposes permitted or required by law

Your Choices

You may access and correct your personal health records, or withdraw your consent for some of the above uses and disclosures by contacting us (subject to legal exceptions).

Important Information

- We take steps to protect your personal health information from theft, loss and unauthorized access, copying, modification, use disclosure and disposal
- We conduct audits and complete investigations to monitor and manage our privacy compliance
- We take steps to ensure that everyone who performs services for us protect your privacy and only use your personal health information for the purposes you have consented to.

How to Contact Us

Our privacy contact is Cathy Grant

For more information about our privacy protection practices, or to raise a concern you have with our practices, contact us at:

22 George Street North
Cambridge On N1S 2M8
Telephone: 1-519-624-9708
Fax: 1-519-624-1493
e-mail: cmidwives@bellnet.ca

You have the right to complain to the Information and Privacy Commissioner/Ontario if you think we have violated your rights. The Commissioner can be reached at:

Information and Privacy Commissioner /Ontario
2 Bloor Street East, Suite 1400
Toronto, Ontario M4W 1A8
Toronto Area (416/local905): (416) 326-3333
Long distance: 1-800-387-0073 Fax: (416) 325-9195

Table of Contents

COLLEGE OF MIDWIVES OF ONTARIO
PHILOSOPHY OF MIDWIFERY CARE IN ONTARIO

Midwifery care is based on a respect for pregnancy as a state of health and childbirth as a normal physiologic process and a profound event in a woman's life.

Midwifery care respects the diversity of women's needs and the variety of personal and cultural meanings, which women, families and communities bring to the pregnancy, birth, and early parenting experience.

The maintenance and promotion of health throughout the childbearing cycle are central to midwifery care. Midwives focus on preventive care and the appropriate use of technology.

Care is continuous, personalized and non-authoritarian. It responds to a woman's social, emotional and cultural as well as physical needs.

Midwives respect the woman's rights to choice of caregiver and place of birth in accordance with the Standards of Practice of the College of Midwives. Midwives are willing to attend birth in a variety of settings, including birth at home.

Midwives encourage the women to actively participate in her care throughout pregnancy, birth and postpartum period and make choices about the manner in which her care is provided.

Midwives care includes education and counseling, enabling a woman to make informed choices.

Midwives promote decision-making as a shared responsibility, between the woman, her family (as defined by the woman) and her caregivers. The woman is recognized as the primary decision maker.

Midwives regard the interests of the woman and the fetus as compatible. They focus their care on the mother to obtain the best outcomes for the woman and her newborn.

Fundamental to midwifery care is the understanding that a woman's caregivers respect and support her so that she may give birth safely, with power and dignity.

General Information About Midwifery, the Midwifery Scope of Practice, and Cambridge Midwives

Midwifery

"The practice of midwifery is the assessment and monitoring of women during pregnancy, labour and post- partum period and of their newborn babies, the provision of care during the post-partum period and the conducting of spontaneous normal vaginal deliveries." (From Midwifery Act, 1991)

The midwifery bill was passed December 31, 1993 making 1994 the first year of regulated midwifery, and the full function of the College of Midwives. September 1993 began the first midwifery education programme for new midwives at McMaster, Ryerson and Laurentian Universities.

Midwives carry liability insurance through their membership in the Association of Ontario Midwives. They are bound by the standards and regulations of their governing body, The College of Midwives. Midwives are funded by the Community Health Branch of the Ministry of Health. From 1994 through March 1998, funds flowed through the Lebel Midwifery Care Organization (L.M.C.O) named after one of the midwives for the Dionne quintuplets in the 1930s. From April 1998 on, funds have flowed through local transfer payment agencies. The transfer payment agency for Cambridge Midwives is Lang's Farm Village Association.

The Midwifery Scope of Practice

The scope of practice includes full care for the duration of pregnancy until six weeks post-partum for you and your baby. Should problems develop during the course of care which necessitate that care be transferred to a physician, midwives will

continue to function in a supportive role until care can be transferred back. Apart from indications for mandatory consultation or transfer of care you will not be expected to see a physician for any care related to your pregnancy, childbirth or postpartum period. Your family physician will resume care of you and your baby between 6 and 8 weeks postpartum.

Midwives order and receive results for routine laboratory investigations and ultrasounds. They can order certain medications. Midwives certify in both Cardiopulmonary Resuscitation and Neonatal Resuscitation on an annual basis, and are expected to maintain current privileges in their local hospital.

Cambridge Midwives

In January of 2000, Cambridge Midwives opened its doors. Prior to this time, Cambridge women who desired midwifery care were required to travel to Kitchener or Guelph. Our catchment area encompasses a radius of approximately a one-hour drive from the city of Cambridge. Pre and post-partum visits at home are provided within the entire catchment area. These boundaries have been defined in the interests of safety, and we encourage clients to discuss them with us. Parking is available on both sides of the street as well as the parking lot across the street. There is no parking behind our building.

Model of Care

At your first clinic visit you will be assigned a team of three midwives. A primary midwife, who will be responsible for most of your care and two back up midwives. It is our hope that your primary midwife and one back-up will be present at your birth. In some cases, one or more of your midwives may be unavailable due to weekend's off-call, sleep requirements or simultaneous birth. (The unpredictability of birth makes planning for such occurrences difficult.) Cambridge Midwives will provide you with the highest quality of obstetrical care and in the event that your midwife/midwives are unavailable, we ask for your understanding incorporating other midwives into your care team. Again, we stress that the majority of women under our care will have 2 members from their care team at their birth and when this is not possible, we will provide you with the highest quality of care, regardless of the midwives in attendance.

Second Attendant

We may need to use a qualified second attendant in case of simultaneous births, or to provide holiday coverage. Clients will be consulted should the need to use a second attendant arise.

Midwifery Students

Cambridge Midwives is a teaching practice incorporating a midwifery student from the Midwifery Education Programme during periods of three months. The student is involved in all aspects of midwifery care-prenatal, intrapartum and postpartum. We enjoy very much the presence of a student with fresh points of view, enthusiasm, energy, eagerness to learn and dedication to contributing to our client's experiences.

We hope that you will consider yourselves very vital in the teaching of a student. Your willingness to open your care and experiences creates opportunities for the future as we train the next midwives to serve Ontario women. You are contributing in a very real way to the possibility of other women having the chance to experience midwifery care for their pregnancies as well.

Scope of Practice

We follow the discussion, consultation and transfer of care protocols of the College of Midwives of Ontario, which outline situations in which we would discuss with another midwife, consult with a physician or transfer primary care. You will find the complete text of these indications on page 31.This will help you to understand the breadth of midwifery practice as well as its limits. It is in the scope of practice for Ontario Midwives to order blood work and ultra sounds. As well there are certain medications midwives can prescribe.

Client Records

We keep all your original records in a secure manner for 28 years following your baby's birth as required by law. These are available to you at any time. You will be given a copy of your records at your discharge visit. These records are confidential and are seen only by your Midwives and students involved in your care. We are required to maintain statistics of our

practice. They are collected for research purposes but do not reveal your identity. In the hospital, standard record forms are kept in the medical records department.

Practice Protocols and Emergency Protocols

We have written protocols for all conceivable situations in practice and in emergencies, which outline the roles of primary and second midwife at the birth. Through these, we are able to function more smoothly and clearly in decision-making and action.

Prenatal Care

Visits should begin as early as possible in pregnancy. We will see you on a regular basis, every 4 weeks until 28 weeks, then every 2 weeks until 36 weeks, then weekly until labour begins. We also plan one hour visits late in your pregnancy. During your visits, besides the physical monitoring of your pregnancy, we will have plenty of time for discussions about emotional adjustments, education on many issues, and getting to know and trust each other.

Your partner, children, friends and family members are welcome at any time you wish to include them in your care. Between visits, we are on call to you 24 hours a day for emergencies.

Any medical care you require beyond the scope of our practice will be provided by your family physician. We normally send a letter to her/him when you come into midwifery care and follow-up with another after your discharge visit, usually six weeks following the birth.

Labour and Birth

Midwifery care includes monitoring the clinical progress of labour, supporting the well-being of both mother and baby in the birth and third stage, screening for problems and addressing them, discussing options with you, suturing the perineum if necessary, performing the newborn exam and taking emergency action should that be necessary. Our role is to provide care in normal circumstances, to recognize developments outside the norm and to take appropriate measures. Two midwives will be present at your birth. One to care for the mother and one to care for the baby.

In emergencies, which are rare, we depend on the basis of trust we have developed over time to allow us to work together quickly, where lengthy informed choice discussions might be impossible and inappropriate.

Choice of Birthplace

Ontario midwives attend women in their choice of birthplace. It is important that women receive accurate information about the risks and benefits of birthplace for low-risk pregnancy and labour to assist in their decision-making.

Birth Setting

Cambridge Midwives attend births in home and hospital and have admitting privileges at Cambridge Memorial Hospital.

Home

It is well recognized that for healthy women with low risk pregnancies home can be a safe place for birth. Cambridge Midwives will bring equipment to your home to respond to unexpected emergencies. This includes oxygen for mother and baby, resuscitation equipment for the newborn, intravenous supplies and medications for the treatment of hemorrhage. The fetal heart rate is monitored frequently in active labour with a portable hand-held doptone. In the event a home birth has been planned, and complications arise, transport to a hospital takes place in a straightforward manner. The midwife will stay at your home for approximately 3 hours postpartum to ensure mother and baby are stable, and will return within 24 hours to check on you both. We will do home visits the first week after birth.

Hospital

If you choose to have a hospital birth, we can attend and monitor you at your home and move to the hospital when labour is well established. All birthing rooms at Cambridge Memorial Hospital have showers and 2 of the rooms also include a

Jacuzzi, tubs for labouring in (not for delivery). Women who deliver in hospital can choose to return home after 3 hours postpartum, or to stay in hospital for up to 60 hours (2 ½ days).

Postpartum Care

We will be with you in the immediate postpartum time for 3 hours until we are assured that all is well with you and your baby. You will then continue to be visited on the first day before 24 hours, 3rd day, and 5th day thereafter, then at 2 weeks and 4 weeks in clinic for the six weeks check-up and well baby exam. We continue to be on call to you 24 hours a day and extra visits are provided as needed.

The Responsibilities of the Parent(s)

Primary responsibility for your health and your baby's rests with the choices you make in diet, exercise, rest and healthy living. Take advantage of our lending library and video collection to inform you on all aspects of pregnancy, birth, baby care, breastfeeding, etc. We have a library of articles on many issues that will help you with your decision-making. As questions come to you, write them down and bring them to your next visit, or call to discuss concerns. We are interested in all aspects of your life that can affect your physical and emotional health. Remember that in midwifery care, you, the mother, are the central decision-maker in all things. We can provide you with information and expertise, but we as midwives do not wish to promote dependence on us for important choices you make. This is a time of personal growth and development and we wish to support you in this important transition, including realizing yourself as independent and in charge of your life's decisions.

Concerns and Disagreements

We encourage you to bring forward any feelings of disappointment or unhappiness with the care you are experiencing or have experienced in this practice. We all learn from this sharing process and we hope that we can provide an atmosphere of safety whereby you can feel comfortable raising issues of concern. At your final visit, we will give you a care evaluation form to complete and return by mail, anonymously if you wish. We participate in regular peer review with other midwives in our region.

In addition, if you feel that we cannot adequately resolve any issues ourselves, you are entitled to know that you can appeal to the College of Midwives if your concern is a very serious one. Certainly, we feel that all attempts should be made to address concerns directly first.

We look forward to working with you throughout this very special time of transition. Being midwives is the greatest privilege for us. We hope that this care can help you to grow and achieve your very best experience possible.

Pre-natal Information

Nutrition

It is vital to pay special attention to your diet during pregnancy so that you are eating well each meal, each day. It is better to eat small, frequent meals, avoiding refined foods such as sugar, white flour, etc. You and your baby need high quality food nutrients and refined foods spoil the appetite for whole foods.

Proteins are the most important way you can ensure the health or your baby and yourself. High quality protein is found in meat, fish, yogurt, cheese, soybeans, eggs and combinations of other foods (peanut butter, beans, nuts).

Iron is a particularly vital nutrient in pregnancy because of the increase in your own blood and growth of a whole blood system for your baby. The best sources are brewers yeast, wheat germ, blackstrap molasses, eggs, soybeans, dark, green leafy vegetables, and dried fruit. Iron is best derived from food sources since it is then balanced with other nutrients found in natural, whole foods. Remember that taking a supplement is not a substitute for good food. A woman should not need routine prenatal vitamins and minerals. A product called Floradix is an excellent natural supplement that we sometimes use in special situations to raise hemoglobin levels in women who have had poor iron and other nutrient intake. It assimilates quickly and remedies a crisis situation within the short limits of pregnancy.

Herbals

If you are a person who likes to use herbs in your life, then we recommend a book entitled The Wise Woman Herbal for the Childbearing Year, by Susan Weed. Here are some sample recipes to get you started.

Regular consumption of red raspberry leaf tea is a tradition among pregnant women for it's readily absorbed iron, calcium, and the beneficial effect on toning the uterine muscle. It helps with nausea, too.

Many women prepare an herbal bath to share with their babies right after birth. We'll give you a sample bag of the herbs later. This is the recipe for such a healing bath:

Herbal Bath

- 1/3 cup of squaw vine or uva ursi
- 1/3 cup comfrey
- 1/3 cup shepherd's purse
- 4-6 cloves of garlic
- 1/4 cup of sea salt

Simmer in 4-5 litres of water for at least 20 minutes. Strain the mixture and freeze it in two containers. May be added to two baths when ready.

Weight Gain

Please do not try to lose weight during pregnancy. Don't worry about the amount you are gaining unless it is excess stored fat from eating non-nutritious foods. If you are overweight at the beginning of pregnancy, by changing your eating habits you may actually lose weight while still building a strong, healthy baby. You can choose not to be weighed during your visits but keep in mind that the reason for doing so is to make sure that weight gain is taking place. During the last weeks of your pregnancy your baby lays down a lot of fat under the skin, gains 8 oz. per week and undergoes rapid brain development. Excellent protein at this time is vital. Weight gained on good food melts off quickly during lactation. The benefits for the whole family of good food preparation and eating habits that you can develop during the motivational time of pregnancy last a lifetime.

Smoking

Babies of smoking mothers tend to have growth restrictions and sometimes are premature. Please struggle with your habit. Fortunately, many women find cigarettes distasteful during pregnancy and nature takes care of it anyway. Any reduction is good. Apart from discussing the risks with you and supporting you to cut down or preferably stop smoking altogether, we are fully aware that this is truly a personal struggle and best motivated from within. However, should you choose to continue to smoke while pregnant. Please talk to your midwife, as we can make dietary and herbal supplement recommendations to help reduce the harmful effects.

Exercise

It is important to promote the well being of your cardiovascular system, and to nourish your cells with both nutrients and oxygen. Being in good physical shape will help you meet the demands of pregnancy and labour, not to mention the day-to-day care of a little child. Exercise is also an excellent way of reducing stress. However, special classes and aerobics are not necessary. Swimming, walking and bicycling are good exercise. Use your legs, not the car.

Emergency Childbirth

We recommend that everyone have the basic skills to handle a normal birth if necessary. This should be common knowledge so that childbirth is not a mysterious, fearful event. Rahima Baldwin's Special Delivery, and any book by Sheila Kitzinger or a basic midwifery text is good.

Postpartum Planning

These are guidelines primarily for the first two weeks following an uncomplicated birth. In the case of twins, prolonged or difficult labour, anemia, cesarean section, maternal hemorrhage or severe perineal lacerations, allow extra time for care and recovery.

1. Plan for physical help. Hire, bribe or barter the services of a strong, mentally positive person to do household chores. This person should be able to see what needs doing and do it without needing lots of direction. There is to be no guilt involved with having this person in your house.

2. Inform close friends and family when visiting privileges will begin after birth. Sometimes people assume that if you are strong enough to give birth at home; or to be returning home so soon after your hospital birth you will be ready for visitors that evening. Think about when you will want visitors, for what length of time, how many at a time, if there is any age cut-off, etc. Consider making a poster stating your rules.

3. Make a list of things your family likes to eat. Post this list on the fridge for all to see. This provides a quick answer for those asking to bring a meal. If you have some last trimester energy, you should freeze meals ahead of time and stock up on non-perishables. Use these after your support person has gone.

4. Make signs. A favourite is: “Mom and baby are blissfully slumbering. Please come another time.” Perhaps you would prefer: “ We are unavailable for visits now.” We are engaged in (check one): sleeping, bathing, trying to get some sleep, working out gastric difficulties, being just plain anti-social at the moment.

5. Simplify your life. Did you know that the less you have, the less there is to keep clean? 300 newborn outfits are fun, but alas, impractical. Tell friends to buy a variety of sizes or opt for a non-clothes gift such as a meal, cleaning, childcare, etc. Enjoy a walk in the fresh air every day. It is OK, even in the winter- just bundle up! It invigorates the mind and refreshes the soul. Eat simply. If it is financially feasible, designate one night to order in.

6. Listen to your body. If it says sleep, sleep. Be selfish it is perfectly acceptable. Don’t feel you have to do this or that. Love and take care of your baby and family. People are more important than things. Remember to eat properly. The milk supply and postpartum healing is number one on the agenda so eat well, drink lots of fluids and avoid constipation.

7. Consider your baby’s sibling(s). They go through adjustment too. Plan playtime for them at other homes. Wrap little goodies ahead of time for those “ I feel left out” moments. Take ten minutes a day to read books, play a game, etc. with other children. Have a list of simple activities prepared to ease rainy day doldrums.

8. Communicate. Postpartum can be emotionally high and low all at the same time. Hormones are bouncing around seeking a new level. Talk about the birth, the baby’s colic your disinterest\need concerning sex, body changes, and visitors. There are certain individuals in our surrounding friends who are better suited to listening than others. Talking to such people can be a release. Evaluate your needs and verbalize them.

Mother’s Special Care Postpartum

1. Vaginal bleeding (lochia) should be like a heavy period. It should smell like your period, not foul. Small blood clots are the normal result of blood pooling in the vagina, when you have been lying down for a while. The lochia will be bright red for the first few days, then pink, brown, etc. until it has stopped. Women will flow up to four weeks. Plan to have plenty of pads on hand.

2. Your uterus should feel firm like a grapefruit in the middle of your abdomen. Nursing helps the uterus to contract naturally and these contractions can be bothersome. It helps to press a pillow against your abdomen to support it when they occur. You may not have any uncomfortable afterpains with your first child. You can take pain medication, (e.g. Tylenol or Ibuprofen) if you need it or you can consider making a herbal ‘Afterpains Brew’ if you’ve had several babies and anticipate a problem. After about 10 days, the uterus has involuted to the point of having retreated back into the pelvic area. It takes six weeks for the organs to return to normal.

3. Let the baby tell you when and how long to nurse. It is by tuning into her/his needs that you learn successful nursing (and parenting). Your baby may want to nurse for hunger, loneliness, sucking satisfaction, to relax, to get to sleep, etc. The breast is nature’s pacifier. By using the breast in this natural way and by avoiding early introduction of solids, absences from baby

and the use of pacifiers, the menstrual cycle is often suppressed. This can be a side benefit, which promotes natural spacing of babies. For information, read Sheila Kipley's Breastfeeding and Natural Child Spacing or A Cooperative Method of Natural Family Planning by Margaret Nafziger. We highly recommend LaLeche League meetings for encouragement and support, as well as the regular contact with other nursing mothers. Plan to attend several meetings before the baby is born.

4. Urinating may sting. Try using a peri-bottle to pour some warm water or herbal bath solution over your genitals while you urinate to dilute the flow. Wipe or dab gently from front to back, especially if you have stitches. It is vitally important to keep this area scrupulously clean. Ice packs or comfrey leaf tea bags placed on the perineum will help alleviate swollen tissue and aid in healing. Air and sunshine are also great healers. All of these work for sore nipples, too.

5. Rest and fluids are essential. Try to sleep when the baby does. Take as much help from others, as they are willing to give, but leave the baby to you. Listen to your body's thirst demands while you are nursing.

6. Bathing is okay. Many women prepare an herbal bath to share with the baby right after the birth. Your midwife will give you a sample of such a healing bath.

7. Do your Kegel exercises (tightening of the pelvic floor muscles) whenever you think of them. They help in healing and restoring the muscle tone of the pelvic floor. Sit-ups (one in the morning to begin with - gradually do more) and single leg lifts (avoid lifting both legs at once) help in this area, too.

Baby's Special Care Postpartum

Cord Stump

The cord stump doesn't require any special care. Fasten the diaper below it. The midwife will remove the clamp in 24 hours. The cord will smell as though it is rotting, but it should not have pus oozing from it, and there should not be a red area on the belly at the base of the stump. Sometimes the cord will bleed slightly after it falls off.

Stools

The baby should pass meconium within the first 24 hours. The meconium diapers will last until the milk comes in (from 36 hours to 3 days). The colostrum in your breasts helps prepare the baby's system for breast milk as well as aids the baby to spit up any mucous.

Urination

The baby should urinate within the first 24 hours after birth. There will be little urine thereafter until the milk is in.

Temperature

Keep baby warm, especially her/his head.

Skin

It is normal for baby's skin to peel and flake during the first week. Babies enjoy being oiled and massaged if you wish to do so by lying her/him along your legs as you sit outstretched. You might enjoy Leboyer's book on this subject, Loving Hands.

Genitalia

Newborn genitals are normally enlarged. A baby girl may have blood-tinged discharge, like a small period. Babies, especially boys, may also have orange/pink spots on their diapers because of uric acid salts. The foreskin of a baby boys penis needs no special care and SHOULD NOT BE PUSHED BACK. It is usually quite loose by age three or so.

Newborn Testing/ Screening & Treatments

We usually do a PKU test at 3-5 days. Phenylketonuria is a rare metabolic disorder causing mental retardation. The test involves pricking the baby's heel to obtain a blood sample. The thyroid function test is done from the same blood sample. This test is not required by law but at the recommendation of the public health department as routine screening. Other issues you must consider soon after the baby's birth (i.e. during the first hour) include the use of erythromycin (antibiotic ointment) in the eyes for the prevention of infection from gonorrhea or chlamydia, which are sexually transmitted diseases. Although this is public health law, many parents in fact decline it, feeling that the existence of such conditions would be extremely unlikely if not impossible in their individual cases. The shot of Vitamin K in the baby's leg is to prevent rare neonatal haemorrhagic disease. This is also a parent's individual choice. We can discuss these issues further at your visits.

Jaundice

Jaundice (yellowing of the skin) between 3-7 days is normal unless it is very deep in colour and involves the baby's whole body and extremities and is affecting the baby's alertness to nurse. It should be investigated if it is present within the first 24 hours, as this is abnormal. Normal jaundice occurs because the immature liver is unable to excrete the byproducts of the breakdown of the excess red blood cells the baby needed in intrauterine life. Exposure to sunlight, (e.g. through a sunny window) will help to eliminate the yellow colour. Frequent feedings would also be helpful.

Please call if you have any questions or concerns between postpartum visits

When To Call Your Midwife

We are on call to you 24 hours a day. Please call us when you need us. Here are some situations in which you should page us immediately.

Prenatal Warning Signs

- you think your water has broken
- you have vaginal bleeding
- significant decrease in number of fetal movements

Labour

- if your water breaks, call your midwife.
- if your labour starts during the day, give your midwife an early warning notice.
- if your labour starts at night, call your midwife when you are having regular contractions that are increasing in strength, length and frequency, that is, lasting at least one minute and coming less than five minutes apart, timed from the beginning of one to the beginning of the next.

Postpartum Warning Signs For Mother

- you have vaginal bleeding that soaks more than one pad in an hour
- you pass a clot larger than your fist
- you have foul-smelling vaginal discharge (not smelling like your period)
- you have pain that is not relieved by over-the-counter Tylenol or Ibuprofen
- you feel feverish and/ or have a temperature over 38 degrees Celsius
- you have redness, swelling, oozing, or separation of a tear, episiotomy or C-section
- you have a red, tender or lumpy area in the breast that does not clear after nursing
- you feel like you have the flu
- you feel depressed and unable to cope
- you are worried about your own or your baby's physical safety
- painful,warm,or red spot in your leg

Postpartum Warning Signs For Baby

- temperature less than 36.0 or greater than 38.0 degrees Celsius (97.7and 99.5 F)
- blueness (cyanosis) around the lips or face or on the trunk
- pallor, i.e. lack of colour or greyness
- jaundice in the first 24 hours

- no urine in the first 24 hours
- excessive salivation
- labored, rapid breathing and/or a retracting breastbone
- lethargy, with no interest in breastfeeding
- distended abdomen
- high pitched or odd sounding cry

Preparation List for a Home Birth

Have these items ready about three weeks before your baby is expected to arrive:

- Clean birthing room
- Bed made up this way:
- Clean sheets, bottom and top
- waterproof covering
- clean fitted sheets over the waterproof covering
- When baby is born, the top coverings can be removed, and mother and baby can settle down in a clean bed. (Of course, this does not mean that you have to give birth on the bed; many women do not.)
- pillows (covered with plastic garbage bags under the cases)
- a pile of towels, soft is preferable 4-10
- baby blankets (4) to be warmed just before the baby comes
- a collection (10-15) washcloths for perineal compresses
- a crock-pot if you can get one for hot compresses
- sanitary pads (not dry weave, i.e. Always, etc.)
- household family thermometer
- a roll of paper towels
- light food for labour
- a mirror if you wish to watch the birth
- a bowl for the placenta (good size mixing bowl)
- newspaper for floor or a large plastic drop cloth
- a large waste basket lined with a garbage bag for waste
- another large waste basket, or box lined with a garbage bag for soiled laundry
- ice chips or cubes, juice, Popsicles or a fluid replacement drink
- flashlight
- a small unopened bottle of olive oil – to be used for perineal massage and baby's bottom at diaper changes
- hydrogen peroxide for removing blood stains 500 ml or larger
- space heater to warm room during winter months
- small table or surface so that we can lay out sterile supplies
- extension cord

For Baby

Babies don't need much. Expect the baby to want to sleep with you most of the time. Consider reading the Family Bed, Three in a Bed, or Nighttime parenting

- nightgowns or sleepers and undershirts
- a small cap for right after the birth
- receiving blankets
- diapers
- baby diaper liners or paper towels for those first meconium ones

Most of this will already be in your home. Put it all into a large basket and keep it in the closet where it can be retrieved quickly. Please don't' leave things until the labour to pull together. The quicker we can get supplies set up, the more attention we can give to your labour and how you're coping.

Preparation List For A Hospital Birth

Basic Hospital Bag

- Clothes: One outfit for baby to come home in, and one for you. You will not fit into regular clothes yet, so plan on maternity wear for going home.
- A small unopened bottle of Olive Oil for perineal massage and baby's bottom at diaper changes
- personal grooming items
- money and small change –for parking and payphone
- infant car seat
- hospital and health card
- prenatal records
- extra pillows
- food and drink for you and your partner
- watch with second hand
- vomit basin or plastic bags (for car)
- lip ointment
- antibacterial hand soap

Optional Supplies For Both Home Or Hospital Birth

- Homeopathic Arnica 30C
- Bach Flower Rescue Remedy
- 2 pocket-size combs
- rolling pin or tennis balls (for back labour)
- camera with fast film

Postpartum Supplies For Both Home Or Hospital Birth

- sanitary pads
- thermometer (digital)
- Ibuprofen (Advil) and Acetaminophen (Tylenol)
- ice pack
- sanitary pads soaked in water and kept in freezer to be used after the birth

The following is excerpted from the document provided by the College of Midwives of Ontario. What have been omitted are further explanations and instructions for midwives use.

COLLEGE OF MIDWIVES OF ONTARIO

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INDICATIONS FOR MANDATORY DISCUSSION CONSULTATION AND TRANSFER OF CARE

As a primary caregiver, the midwife together with the client, is fully responsible for decision-making. The midwife is responsible for writing orders and carrying them out or delegating them in accord with the standards of the College of Midwives.

The midwife discusses care of a client, consults, or transfers primary care responsibility according to the Indications for Mandatory Discussion, Consultation and Transfer of Care. The responsibility to consult with a family physician/general practitioner, obstetrician and/or specialist physician lies with the midwife. It is also the midwife's responsibility to initiate a consultation within an appropriate time after detection of an indication for consultation. The severity of the condition and the availability of a physician(s) will influence these decisions.

DEFINITIONS

Category 1: Discuss with another midwife or with a physician

Category 2: Consult with a physician
Category 3: Transfer to a physician for primary care

INDICATIONS: Initial History and Physical Examination

Category 1:
adverse socio-economic conditions
age less than 17 years or over 35 years
cigarette smoking
grand multipara (para 5)
history of infant over 4500g
history of one late miscarriage (after 14 completed weeks) or preterm birth
history of one low birth weight infant
history of serious psychological problems
less than 12 months from last delivery to present due date
obesity
poor nutrition
previous antepartum hemorrhage
previous postpartum hemorrhage
one documented previous low segment cesarean section
history of essential or gestational hypertension
known uterine malformations or fibroids

Category 2:
current medical conditions for example cardiovascular disease, pulmonary disease, endocrine disorders, hepatic disease, neurologic disorders
family history of genetic disorders
family history of significant congenital anomalies
history of cervical cerclage
history of repeated spontaneous abortions
history of more than one late miscarriage or preterm birth
history of more than one low birth weight infant
history of gestational hypertension with proteinuria and adverse sequelae
history of significant medical illness
previous myomectomy, hysterotomy or cesarean section other than one documented previous low segment cesarean section
previous neonatal mortality or stillbirth
rubella during first trimester of pregnancy
significant use of drugs or alcohol
age less than 14

Category 3:
any serious medical condition, for example: cardiac or renal disease with failure or insulin dependent diabetes mellitus

INDICATIONS: Prenatal Care

Category 1:
presentation other than cephalic at 36 completed weeks
no prenatal care before 28 completed weeks
uncertain expected date of delivery
uncomplicated spontaneous abortion less than 12 completed weeks

Category 2:
anemia (unresponsive to therapy)
documented post term pregnancy (42 completed weeks)
fetal amomaly
inappropriate uterine growth
medical conditions arising during prenatal care, for example:
endocrine disorders, hypertension, renal disease, suspected significant infection, hyperemesis
placenta previa without bleeding

polyhydramnios or oligohydramnios
gestational hypertension
isoimmunization
serious psychological problems
sexually transmitted disease
twins
vaginal bleeding other than transient spotting
presentation other than cephalic, unresponsive to therapy, at 38 completed weeks

Category 3:
cardiac or renal disease with failure
insulin dependent diabetes
multiple pregnancy (other than twins)
gestational hypertension with proteinuria and /or adverse sequelae
symptomatic placental abruption
vaginal bleeding, continuing or repeated
placenta previa after 28 completed weeks

INDICATIONS: During Labour and Birth

Category 1:
no prenatal care
non-particulate meconium

Category 2:
breech presentation
preterm labour (34-37 completed weeks)
prolonged active phase
prolonged rupture of membranes
prolonged second stage
retained placenta
suspected placenta abruption and/or previa
third or fourth degree tear
twins
unengaged head in active labour in primipara
preterm prelabour rupture of membranes (PPROM) between 34 and 37 completed weeks
particulate meconium
gestational hypertension

Category 3:
active genital herpes at time of labour
preterm labour (less than 34 completed weeks)
abnormal presentation (other than breech)
multiple pregnancy (other than twins)
gestational hypertension with proteinuria and/or adverse sequelae
prolapsed cord or cord presentation
placenta abruption and/or previa
severe hypertension
confirmed non-reassuring fetal heart patterns, unresponsive to therapy
uterine rupture
uterine inversion
hemorrhage unresponsive to therapy
obstetric shock
vasa previa

INDICATIONS: Post Partum (Maternal)

Category 2:
suspected maternal infection e.g. breast,abdomen,wound,uterine,urinary tract,perineum

temperature over 38 C (100.4 F) on more than one occasion
persistent hypertension
serious psychological problems

Category 3:
hemorrhage unresponsive to therapy
postpartum eclampsia
thrombophlebitis or thromboembolism
uterine prolapse

INDICATIONS: Post Partum (Infant)

Category 1:
feeding problems
failure to pass urine or meconium within 24 hours of birth

Category 2:
34 to 37 weeks gestational age
infant less than 2,500g
less than 3 vessels in umbilical cord
excessive moulding and cephalhematoma
abnormal findings on physical exam
excessive bruising,abrasion,unusual pigmentation and/or lesions
birth injury requiring investigation
congenital abnormalities, for example:cleft lip or palate, congential dislocation of hip,ambiguous gentitala
abnormal heart rate or pattern
abnormal cry
persistent abnormal respiratory rate and/or pattern
persistent cyanosis or pallor
jaundice in first 24 hours
suspected patholodical jaundice after 24 hours
temperature more than 37.4 C, unresponsive to non-pharmaceutical therapy
temperature less than 36 C unresponsive to therapy
vomiting or diarrhea
infection of umbilical stump site
significant weight loss (more than 10% of body weight)
failure to regain birth weight in three weeks
failure to thrive
failure to pass urine or meconium within 36 hours of birth
suspected clinical dehydration

Category 3:
APGAR lower than 7 at 5 minutes
suspected seizure activity
major congenital anomaly requiring immediate intervention, for example: omphalocele, myelomeningocele
temperature instability

Glossary of Words

Adverse Sequelae: Bad side effects

After pains: Postpartum contractions that work to reduce the size of the uterus and help to minimize blood loss. These pains tend to be worse during breastfeeding and are more common in women who have had more than one child.

Anemia: A condition in which the level of hemoglobin in the blood is below normal limits.

Anomaly: Any variation in the body from what is regarded to be normal. “Congenital” anomalies are those present at the time of birth.

Breech: Situation at birth in which the feet, knees, or buttocks of the infant appear first.

Cardiovascular System: The network of heart and blood vessels that work to pump blood throughout the body.

Cephalic: Pertaining to the head. In pregnancy, a cephalic presentation implies that the baby's head is at the cervix or opening to the uterus. (Head down)

Cephalhematoma: An accumulation of blood that collects in the newborn's scalp due to the pressure of labour and birth. This causes a localized swelling that may last a few weeks.

Cerclage: An obstetric procedure in which a stitch is used to hold the cervix closed to prevent a spontaneous miscarriage. Used for women who have had repeated miscarriages.

Colic: Recurrent episodes of crying in a newborn, usually accompanied by signs of abdominal discomfort. Normally goes away by 3 months old.

Colostrum: The protein rich yellow milk that can be expressed from the breast from the second trimester onward but is most evident in the first few days after the birth. It contains maternal antibodies that protect the newborn from infection.
Constipation: Difficulty, or inability to have a bowel movement, or pass hard stool. This is quite common in pregnancy due to the relaxing effect of progesterone on the digestive system.

Cyanosis: A blue, gray or dark purple color in the skin and mucous membranes occurring when the oxygen level in the blood is low. It is quite common for newborns, in the first few days to have cyanosis of their hands and feet.

Dehydration: Extreme loss of water from the body

Eclampsia: The serious condition of seizures and coma that may occur as a result of severe pregnancy induced hypertension.

Endocrine disorder: Abnormal function of any one of the many glands of the body that secrete hormones. E.g. thyroid gland-hypothyroidism.

Erythromycin Ointment: An antibiotic gel that is placed on the eyes of the newborn to prevent bacterial infection from gonorrhea and chlamydia. This is required by provincial law for all newborns.

Gestational Hypertension: Also known as Pregnancy Induced Hypertension (PIH). This complication of pregnancy is marked by a high blood pressure. This condition occurs most commonly in the last trimester and id left untreated may develop into eclampsia

Gravida: A women who is pregnant. A woman who is pregnant for the first time is a gravida. A woman in her second pregnancy is a gravida 2, and so on.

Hemoglobin: The component of blood that carries oxygen throughout the body.

Hemorrhage: A severe internal or external loss of blood in a short period of time.

Hepatic Disease: Disease that pertains to the liver. E.g. cirrhosis

Hypertension: High blood pressure

Hyperemesis: Severe vomiting

Hysterotomy: A surgical incision of the uterus.

Intrapartum: Pertaining to the period of labour and birth

Intrauterine: Pertaining to the inside of the uterus.

Involution: The process where by the uterus reduces to it's pre-pregnancy size after childbirth.

Isoimmunization: The development of antibodies to antigens from the same species. For example, a woman whose blood group is negative may develop antibodies if cells from her positive baby enter her circulation during pregnancy or the birth process.

Meconium: The first bowel movements of a newborn baby. It is greenish black, odorless and tarry. It should begin to be passed during the first 24 hours after birth and persist for about 3 days until the mother's milk replaces the colostrum in her breasts.

Membranes: A thin layer of tissues that covers the baby and holds the amniotic fluid.

Midwife: From the Middle English meaning "with woman"

Moulding: Refers to the shaping of the baby's head as it passes through the birth canal. The head often becomes elongated and the bones of the skull may slightly overlap. This resolves itself during the first few days of life.

Myelomeningocele: A condition resulting from a neural tube defect where part of the spinal cord, spinal meninges and cerebrospinal fluid are contained in an external sac or swelling in the lower spinal column, (lower back region)

Myomectomy: The surgical removal of uterine muscle tissue.

Neurologic Disorders: Abnormal function in the nervous system, which includes the brain, spinal cord, cranial and spinal nerves. E.g. epilepsy.

Oligohydramnios: An abnormally small volume of amniotic fluid in the uterus.

Omphalocele: A condition where the infant's organs protrude through the abdominal wall around the umbilicus. This would require corrective surgery soon after birth.

Pallor: Abnormal paleness of the skin

Para: The number of children a woman has given birth to.

Perineum: The area of the skin between the vagina and the anus.

Placenta: The fetal organ that forms during pregnancy that becomes the baby's source of oxygen and nutrition before birth. The mother expels this after the birth of the baby. (Also known as afterbirth)

Placental Abruption: The separation of part or the entire placenta from the uterine wall before delivery of the baby. This condition often results in severe hemorrhage and can pose a high risk to mother and baby.

Placenta Previa: A placenta that is implanted in the lower uterine segment so that it covers partially or fully the internal opening of the cervix.

Polyhdramnios: An abnormally large amount of amniotic fluid in the uterus.

Postpartum: Pertaining to the time after childbirth.

Prenatal/Antepartum: Pertaining to the care of the woman during pregnancy prior to childbirth.

Prolapsed Cord: An umbilical cord that protrudes beside or in front of the presenting part of the baby.

Prolonged Rupture of Membranes (PROM): When the amniotic sac has been broken for over 18 hours.

Proteinuria: The presence of protein in the urine.

Pulmonary Disease: A disorder of the respiratory system. E.g. emphysema

Renal Disease: Any disease affecting the kidneys.

Retained Placenta: A placenta that has not been delivered during the appropriate period following the birth of the baby.

Thromboembolism: A condition in which a blood vessel is blocked by a clot.

Thrombophlebitis: Inflammation of a vein, often accompanied by formation of a clot.

Trimester: A period during a pregnancy of a approximately 3 months. E.g. 1st trimester = up to 12 weeks 2nd trimester =12-28, 3rd trimester = 28-40weeks

Uterine Inversion: A condition in which the uterus is turned inside out and protrudes into the vagina.

Uterine Prolapse: Protrusion of the uterus into the vaginal canal.

Uterine Rupture: A rare but serious condition where the uterine wall tears endangering the life of both mother and baby.

Vasa Previa: A condition in which the fetal blood vessels pass across the cervical opening. This places the fetus at risk of hemorrhage once the membranes rupture.

Vitamin K: A naturally occurring substance found in the digestive tract that is important for blood clotting.

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