

Agenda

LICENSED DIRECT-ENTRY MIDWIFE BOARD ELECTRONIC MEETING

February 27, 2015 9:00 a.m.

Room 464 – 4th Floor
Heber M. Wells Building
160 E. 300 S. Salt Lake City, Utah

This agenda is subject to change up to 24 hours prior to the meeting.

ADMINISTRATIVE BUSINESS:

1. Call Meeting to Order
2. Sign Voucher
3. Introduction of Bureau Manager, Dr. Suzette Farmer
4. Administer Oath of Office to Tara Tulley
5. Review and approve the February 25, 2014 minutes

DISCUSSION ITEMS:

1. Discussion about management of 3rd stage labor
2. Legislative update
3. Determination of issues that need to be discussed at future Board meetings
4. Open and Public Meetings Act Training

NEXT SCHEDULED MEETING:

As determined by the Board

Note: In compliance with the Americans with Disabilities Act, individuals needing special accommodations (including auxiliary communicative aids and services) during this meeting should notify, Dave Taylor, ADA Coordinator, at least three working days prior to the meeting. Division of Occupational & Professional Licensing, 160 East 300 South, Salt Lake City, Utah 84115, 801-530-6628 or toll-free in Utah only 866-275-3675

ACTIVE MANAGEMENT OF THE THIRD STAGE OF LABOR

Definitions:

Traditional expectant management of the third stage: No uterotonic medication administered until after delivery of placenta; umbilical cord not cut or clamped until after cessation of pulsating; separation of the placenta without intervention; and placenta delivered by gravity or spontaneously by maternal expulsion.

Active management of the third stage: (1) Uterotonic medication administered within one minute after delivery of baby after ruling out presence of another fetus; (2) controlled umbilical cord traction and counter traction to support the uterus until separation and delivery of the placenta; (3) uterine massage after delivery of the placenta.

Past issues of concern:

Until the past two or three decades, administering a uterotonic medication prior to delivery of the placenta was thought to increase the incidence of trapped placenta requiring manual removal, and increase the chance of uterine inversion. This concern is not evidence based. Active management of the third stage of labor is now considered best-practice and is the worldwide standard of care.

Evidence:

A Cochrane systematic review identified five randomized controlled trials comparing active and expectant management that included more than 6,400 women. Compared with expectant management, active management was associated with: a shorter third stage (mean difference, -9.77 minutes); a reduced risk of postpartum hemorrhage (number needed to treat = 12) and severe postpartum hemorrhage (NNT=57); a reduced risk of anemia (NNT = 27); a decreased need for blood transfusion (NNT = 57); and a decreased need for additional uterotonic medications (NNT = 7). No increase in the risk of manual removal of the placenta with active management. No increase in uterine inversion or cord separation with active management. Oxytocin is the first choice for prevention of postpartum hemorrhage because it is as effective or more effective than ergot alkaloids or prostaglandins and has fewer side effects.

Cochrane review conclusion: “Routine ‘active management’ is superior to ‘expectant management’ in terms of blood loss, post partum haemorrhage and other serious complications of the third stage of labour. Active management should be the routine management of choice for women expecting to deliver a baby by vaginal delivery in a maternity hospital.”

Method of Active Management of the Third Stage

- 1) After delivery of the anterior shoulder, give oxytocin by rapid IV drip or 10 units IM.
- 2) After the cord is clamped and cut, delivery of the placenta by *controlled cord traction* (gentle constant pulling on the umbilical cord) with counter-traction on the fundus. Hold the clamped cord with one hand, and place the other hand just above the woman’s pubic bone and stabilize the uterus by applying counter traction during controlled cord traction. Keep slight tension on the cord and await a strong uterine contraction. When the uterus becomes rounded or the cord lengthens, very gently pull downward on the cord to deliver the placenta. Do not wait for a gush of blood before applying traction on the cord. Continue to apply counter traction to the uterus with the other hand. If the placenta does not descend during 30-40 seconds of controlled cord traction, do not continue to pull on the cord. Gently hold the cord and wait until the uterus is well contracted again. Do not massage the fundus until after delivery of the placenta.
- 3) Fundal massage after delivery of the placenta.

58-77-102. Definitions.

In addition to the definitions in Section 58-1-102, as used in this chapter:

(1) "Board" means the Licensed Direct-entry Midwife Board created in Section 58-77-201.

(2) "Certified nurse-midwife" means a person licensed under Title 58, Chapter 44a, Nurse Midwife Practice Act.

(3) "Client" means a woman under the care of a Direct-entry midwife and her fetus or newborn.

(4) "Direct-entry midwife" means an individual who is engaging in the practice of Direct-entry midwifery.

(5) "Licensed Direct-entry midwife" means a person licensed under this chapter.

(6) "Low risk" means a labor and delivery and postpartum, newborn and interconceptual care that does not include a condition that requires a mandatory transfer under administrative rules adopted by the division.

(7) "Physician" means an individual licensed as a physician and surgeon, osteopathic physician, or naturopathic physician.

(8) "Practice of Direct-entry midwifery" means practice of providing the necessary supervision, care, and advice to a client during essentially normal pregnancy, labor, delivery, postpartum, and newborn periods that is consistent with national professional midwifery standards and that is based upon the acquisition of clinical skills necessary for the care of pregnant women and newborns, including antepartum, intrapartum, postpartum, newborn, and limited interconceptual care and includes:

- (a) obtaining an informed consent to provide services;
 - (b) obtaining a health history, including a physical examination;
 - (c) developing a plan of care for a client;
 - (d) evaluating the results of client care;
 - (e) consulting and collaborating with and referring and transferring care to licensed health care professionals, as is appropriate, regarding the care of a client;
 - (f) obtaining medications, as specified in this Subsection (8)(f), to administer to clients, including:
 - (i) prescription vitamins;
 - (ii) Rho D immunoglobulin;
 - (iii) sterile water;
 - (iv) one dose of intramuscular oxytocin after the delivery of the ~~placenta~~ fetus to minimize blood loss;
 - (v) an additional single dose of oxytocin if a hemorrhage occurs, in which case the licensed Direct-entry midwife must initiate transfer if the client's condition does not immediately improve;
 - (vi) oxygen;
 - (vii) local anesthetics without epinephrine used in accordance with Subsection (8)(l);
 - (viii) vitamin K to prevent hemorrhagic disease of the newborn;
 - (ix) eye prophylaxis to prevent ~~ophthalmia~~ ophthalmia neonatorum as required by law;
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