INFORMATION BOOKLET

3357 Walker Rd. Unit 3

Windsor ON. N8W 3R9

Telephone: 519-252-4784

Fax: 519-252-4034

Pager: 519-790-7777

Web Site: www.midwivesofwindsor.com

Revised March 2017

WELCOME TO MIDWIVES OF WINDSOR

We hope that you will find this package helpful. It was prepared with your needs in mind and includes important information that is relevant to your care. If you are interested in other resources, please visit the Midwives of Windsor library or talk to your midwife. It is not necessary to bring this booklet to appointments, but keep it handy for reference throughout your pregnancy.

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. Midwifery care embraces the diversity of women's needs. Midwifery also supports the variety of personal and cultural meanings attributed to the pregnancy, birth, and early parenting experience by women, families, and communities.

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

Care is continuous, personalized, and non-authoritarian. It responds to a woman's social, emotional, cultural, and physical needs. Midwives encourage each woman to actively participate in her care throughout pregnancy, birth, and postpartum, and to make choices about the manner in which her care is provided.

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

Midwifery promotes 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. Midwifery care includes education and counselling, enabling a woman to make informed choices.

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

MIDWIVES OF WINDSOR PRIVACY STATEMENT

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

This includes:

- Collecting only the information that may be necessary for your care
- Keeping accurate and up-to-date records
- Safeguarding the medical records in our possession
- Sharing information with other health care providers and organizations on a "need-to-know" basis when required for your health care
- Disclosing information to third parties only with your expressed consent, or as permitted or required by law
- Retaining and/or destroying records in accordance with the law
- Where required by the College of Midwives of Ontario standards, specific details of your care may be presented during peer review without divulging your name

You will be asked to sign a consent form that gives your consent for our collection, use and disclosure of your personal information for purposes related to your care.

You have the right to see and obtain copies of your records.

If you would like to discuss our privacy policy in more detail or have specific questions or complaints about how your information is handled, please speak to your midwife.

Midwives of Windsor is also required to report certain statistics regarding your pregnancy, birth and postpartum to BORN – Better Outcomes Registry and Network. BORN was created in 2009 in order to help promote better care for mothers and babies through the collection of accurate and timely data in Ontario. For more information about BORN, please visit their website at www.bornontario.ca or speak with your midwife.

STATEMENT OF INFORMATION PRACTICES

Collection of Personal Health Information

We collect personal health information about your 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 Midwives of Windsor 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:

- Provide appropriate care and treatment
- Receive compensation for care & treatment provided
- Plan, administer, and manage internal operations
- Conduct risk management and quality improvement activities
- Teach
- Compile statistics & conduct research
- 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).

How to Contact us

Our privacy contact person is Crystal Hall.
For more information about our privacy protection practices, or to raise a concern you have with our practices, contact us at:
3357 Walker Road Unit 3 Windsor ON N8W 3R9

Important Information	Phone: 519-252-4784 Fax: 519-252-4034
• We take steps to protect your personal information from theft, loss, 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 protects your privacy and only uses your personal health information for the purposes you have consented to.	You have the right to complain to the Information and Privacy Commissioner of 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, ON M4W 1A8 Toronto Area (416/local 905): (416)326-3333 Long Distance: 1-800-387-0073 Fax: (416) 325-9195

INFORMED CHOICE AGREEMENT

Responsibility for wellbeing rests with both those who offer health care and each individual seeking health care. Better care is attained when individuals make informed decisions regarding their care. This information is being provided to assist you in your choice of care model.

THE ROLE OF A MIDWIFE:

Midwives see most pregnancies and births as normal states for healthy women. Midwives believe that unnecessary intervention is an interruption of a healthy process. Midwives are skilled practitioners who provide primary care to low risk women and their newborns. They provide care for the full duration of pregnancy, birth, and six weeks postpartum. Midwives consult with (and refer to) specialists when necessary. Midwives use emergency measures within our scope of practice if the need arises.

All midwives are registered with the College of Midwives of Ontario. Please visit our website: www.midwivesofwindsor.com to read the biographies of our midwives.

PHILOSOPHY OF CARE:

Midwives of Windsor philosophy of care is based on a respect for the birth process and for a woman's ability to give birth. We are guided by the principles of continuity of care, choice of birthplace, informed choice, clients as the primary decision-makers, non-authoritarian relationships, and the appropriate use of technology.

CHOICE OF BIRTHPLACE:

The evidence is overwhelming that for low-risk, healthy women, a planned home birth with a midwife in attendance is a safe option. Homebirth outcomes are just as good as hospital birth outcomes, and women who give birth at home see a significant reduction in interventions, less infection, and higher satisfaction outcomes.

There are risks and benefits to any birth setting. Birth is essentially a normal process that can sometimes become a medical process. While birth is – for most women – uncomplicated, complications or emergencies can arise. Although approximately 80% of complications can be detected prenatally, some will arise spontaneously and unpredictably during labour and delivery. Should complications arise during a planned homebirth, transport to a hospital takes place in either the client's car or an ambulance, and is usually straightforward. It is important to remember that there are rare and serious emergencies that can arise in any birth setting; in these situations, sometimes the technology available only in a hospital setting will be required, and could make a difference in the well-being of the newborn or mother. It is also true that even with assistance of technology, a good outcome cannot be guaranteed when these rare emergencies arise in any birth setting.

SERVICES:

During your pregnancy, you will be seen every four to six weeks until the twenty-eighth week, every two to three weeks until the thirty-sixth week and then weekly until the birth of your baby. We will be present during your active labour and birth, and will stay with you until both you and your baby are stable and breastfeeding is established, which is usually about 2 – 3 hours postpartum. During the first week after your birth, all of your postpartum visits are done in the hospital or at your home. We routinely see you for 5-6 postpartum visits, and more appointments can be arranged as needed. These appointments are usually on day 1, day 3, day 5-7, day 10-14, and at 4 weeks. The final visit is at approximately 6 weeks, and is a follow-up visit for well woman/well baby care. Midwives are on-call 24 hours a day, 7 days a week for clients with urgent concerns or emergencies. Midwives are primary caregivers who are able to order pregnancy-related laboratory work and tests (including ultrasounds) and provide safe care during normal pregnancies. Midwives consult and/or refer to appropriate medical specialists when risk factors arise during the pregnancy, labour, birth, or the postpartum period.

As registered midwives, we follow the College of Midwives of Ontario protocols for Consultation and Transfer of Care – a copy of this document is included in this booklet. If your care should need to be transferred to an obstetrician, we would remain available to you in a supportive care role (for example, providing labour support, answering your questions, or acting as an advocate on your behalf) until care is transferred back to your midwife.

PATIENT'S RESPONSIBILITIES:

You are responsible for your health and childbirth experience. This includes eating a healthy diet and getting adequate physical activity and rest. It is beneficial to educate yourself about the processes of labour and birth.

We need to be informed of any relevant information or event that might affect you pregnancy or birth, including any pertinent medical information.

Your active participation in decision-making with your caregivers is expected throughout your care. We request that you refrain from the use of restricted substances for the benefit of you and your baby. Please tell us about any substances that you may be taking including prescription, herbal, homeopathic, over-the-counter, illicit/recreational drugs, cigarettes, caffeine and alcohol.

We ask that those planning a home birth have an adequately clean place for the birth. All pets need to be secured and away from the midwives, birth equipment, and birthing area. You will be provided with a list of a few items you will need to provide for the home birth. Possible reasons to transfer into the hospital will be discussed with you during a prenatal visit. We will discuss the need to transfer to the hospital if complications or emergencies arise during your labour or birth. You are asked to be responsible about accepting transport at such time.

If you are planning sibling participation at your birth, you will need someone that you and your child (or children) trust to be present and in charge of caring for the child (or children) for the duration of your labour and birth. This person should feel comfortable being present at the birth, but should also be ok with not seeing the birth, so that your child (or children)'s needs can be met.

TEACHING PRACTICE:

Midwives of Windsor is a preceptor site for student midwives. Students always work under the supervision of a midwife. You may be asked if a student can be involved in your care. You play an important role in teaching future midwives sensitive, woman-centered care. Your feedback to them, and to us, is an essential part of their experience.

CLINIC APPOINTMENTS:

We make every effort not to rearrange prescheduled appointments. However, at times, because the process of labour and birth is unpredictable (especially regarding when it happens), we may need to rearrange clinic appointments. This will happen when a client goes into labour and needs us during clinic days. Should this be the case, we try to notify you as soon as possible. Thank you for your patience and understanding regarding this situation and remember your turn may come. Please always check your phone for messages before heading to your appointment, in case we have left you a message about rescheduling.

OTHER CONCERNS AND CONFLICT RESOLUTION:

If at any time you have concerns regarding your care, please share them with us. We want to provide midwifery care that is responsive to each individual. If further steps are needed, please contact Crystal Hall at the clinic.

CONSULTATION AND TRANSFER OF CARE

According to the midwifery model of care, the midwife works in partnership with the client. As a provider of primary healthcare, the midwife is fully responsible for the clinical assessment, planning, and delivery of care for each client. The client remains the primary decision-maker regarding her own care, and that of her newborn. [1]

Throughout the antepartum, intrapartum, and postpartum periods, clinical situations may arise in which the midwife will need to involve other health care providers in the care of a client or her newborn. According to the requirements of this Standard, she will:

1. **Consult** with a physician, or the most appropriate available health care provider, OR
2. **Transfer responsibility for primary care** to a physician

Definitions

Consultation with a Physician, or other appropriate health care provider

- Consultation is an explicit request from a midwife of a physician, or other appropriate health care provider, to give advice on a plan of care and participate in the care as appropriate.
- It is the midwife's responsibility to decide when and with whom to consult and to initiate consultations.

- Consultation may result in the physician, or other health care provider, giving advice, information and/or therapy to the woman/newborn directly or recommending a plan of care and/or therapy to be carried out by the midwife.
- After consultation with a physician, the role of most responsible provider either remains with the midwife or is transferred to the consulting physician.
- Consultation may be initiated at the client's request.

Transfer of Care to a Physician

- Transfer of care occurs when the primary care responsibilities required for the appropriate care of the client fall outside of the midwife's scope of practice.
- A transfer of care may be permanent or temporary.
- When primary care is transferred from the midwife to a physician, the physician assumes full responsibility for the subsequent planning and delivery of care to the client.
- The client remains the primary decision-maker regarding her care and the care of her newborn.

---

[1] CMO *Standard on Informed Choice*

- After a transfer of care has taken place the midwife shall remain involved as a member of the health care team and provide supportive care to the client within the scope of midwifery.[2]
- If the condition for which the transfer of care was initiated is resolved, the midwife may resume primary responsibility for the care of the mother and/or newborn.

Midwife's Responsibilities

In all instances where another health care provider is required in the care of a midwife's client or her newborn, the midwife shall:

- Review the Consultation and Transfer of Care Standard with the client as part of an informed choice discussion.
- Respect the principles of informed choice, and support the client decision making process.
- Ensure that a client's decision not to pursue a consultation with another health care provider is clearly documented in the client's health record, in accord with the standards of the College of Midwives.[3]
- Ensure that a client's decision not to follow a consultant's recommendation, once it is communicated to the midwife, is documented in the client's health record, in accord with the standards of the College of Midwives.
- Involve the other health care provider within an appropriate time frame.

- Ensure that the request for a consultation or transfer of care are both clearly articulated to the other health care provider and the client, and documented in the client's health record. [4]
- Ensure, where possible, that a consultation includes an in-person evaluation of the client or her newborn and that a consultation is initiated by phone where urgency, distance or climatic conditions make an in-person consultation impossible.
- Ensure that the subsequent plan of care, including the roles and responsibilities of the primary care providers involved, are communicated to the clinicians, and to the client and documented in the client's health record.
- Remain accountable for the care they have provided whether working collaboratively or independently.

---

[2] *Refer to the* CMO *Interprofessional Collaboration Standard for additional information*
[3] CMO *Standard When a Client Chooses Care Outside the Midwifery Standards of Practice*
[4] *See* CMO *Record Keeping Policy Suite*

Initial History and Physical Exam

Consultation

- Significant current medical conditions that may affect pregnancy or are exacerbated due to pregnancy
- Significant use of drugs, alcohol or other substances with known or suspected teratogenicity or risk of associated complications
- Previous uterine surgery other than one documented low-segment cesarean section
- History of cervical cerclage
- History of more than one second-trimester spontaneous abortion
- History of three or more consecutive first-trimester spontaneous abortions
- History of more than one preterm birth, or preterm birth less than 34+ 0 weeks in most recent pregnancy
- History of more than one small for gestational age infant
- History of severe hypertension or pre-eclampsia, eclampsia or HELLP syndrome
- Previous neonatal mortality or stillbirth which likely impacts current pregnancy

Transfer of Care

- Cardiac disease
- Renal disease
- Insulin-dependent diabetes mellitus

- HIV positive status

Prenatal Care

Consultation

- Significant mental health concerns presenting or worsening during pregnancy
- Persistent or severe anemia unresponsive to therapy
- Severe hyperemesis unresponsive to pharmacologic therapy
- Abnormal cervical cytology requiring further evaluation
- Significant non-obstetrical or obstetrical medical conditions arising during pregnancy
- Sexually transmitted infection requiring treatment
- Gestational diabetes unresponsive to dietary treatment
- Urinary tract infection unresponsive to pharmacologic therapy
- Persistent vaginal bleeding other than uncomplicated spontaneous abortion less than 14+0 weeks
- Fetal anomaly that may require immediate postpartum management
- Evidence of intrauterine growth restriction
- Oligohydramnios or polyhydramnios
- Twin pregnancy
- Isoimmunization
- Persistent thrombocytopenia
- Thrombophlebitis or suspected thromboembolism
- Gestational hypertension
- Vasa previa
- Asymptomatic placenta previa persistent into third trimester
- Presentation other than cephalic, unresponsive to therapy, at or near 38+0 weeks
- Intrauterine fetal demise
- Evidence of uteroplacental insufficiency
- Uterine malformation or significant fibroids with potential impact on pregnancy

Transfer of Care

- Molar pregnancy
- Multiple pregnancy (other than twins)
- Severe hypertension or pre-eclampsia, eclampsia or HELLP syndrome
- Placental abruption or symptomatic previa
- Cardiac or renal disease
- Gestational diabetes requiring pharmacologic treatment

Labour, Birth and Immediate Post-Partum

Consultation

- Preterm prelabour rupture of membranes (PPROM) between 34 +0 and 36 +6 weeks
- Twin pregnancy
- Breech or other malpresentation with potential to be delivered vaginally
- Hypertension presenting during the course of labor
- Abnormal fetal heart rate pattern
- Suspected intra-amniotic infection
- Labour dystocia unresponsive to therapy
- Intrauterine fetal demise
- Retained placenta
- Third or fourth degree laceration
- Periurethral laceration requiring repair

Transfer of Care

- Active genital herpes at time of labour or rupture of membranes
- HIV positive status
- Preterm labour or PPROM less than 34 +0 weeks
- Fetal presentation that cannot be delivered vaginally
- Multiple pregnancy (other than twins)
- Prolapsed or presenting cord
- Placental abruption, placenta Previa or vasa Previa
- Severe hypertension or pre-eclampsia, eclampsia or HELLP syndrome
- Suspected embolus
- Uterine rupture
- Uterine inversion
- Hemorrhage unresponsive to therapy

Post-Partum

Consultation

- Breast or urinary tract infection unresponsive to pharmacologic therapy
- Suspected endometritis
- Abdominal or perineal wound infection unresponsive to non-pharmacologic treatment

- Persistent or new onset hypertension
- Significant post-anesthesia complication
- Thrombophlebitis or suspected thromboembolism
- Significant mental health concerns including postpartum depression and signs or symptoms of postpartum psychosis
- Persistent bladder or rectal dysfunction
- Secondary postpartum hemorrhage
- Uterine prolapse
- Abnormal cervical cytology requiring treatment

Transfer of Care

- Postpartum eclampsia
- Postpartum psychosis [5]

---

[5] Transfer of care to a mental health care specialist. The midwife shall remain the primary obstetric care provider, within her scope of practice, given it is possible to do so

Infant

Consultation

- 34 +0 to 36 +6 weeks gestational age
- Suspected neonatal infection
- In utero exposure to significant drugs, alcohol, or other substances with known or suspected teratogenicity or other associated complications
- Findings on prenatal ultrasound that warrant postpartum follow up
- Prolonged PPV or significant resuscitation
- Failure to pass urine or meconium within 36 hours of birth
- Suspected clinical dehydration
- Feeding difficulties not resolved with usual midwifery care
- Significant weight loss unresponsive to interventions or adaptation in feeding plan
- Failure to regain birth weight by three weeks of age
- Infant at or less than 5th percentile in weight for gestational age
- Single umbilical artery not consulted for prenatally
- Congenital anomalies or suspected syndromes
- Worsening cephalhematoma
- Excessive bruising, abrasions, unusual pigmentation and/or lesions
- Significant birth trauma

- Abnormal heart rate, pattern or significant murmur
- Hypoglycemia unresponsive to initial treatment
- Hyperglycemia
- Suspected neurological abnormality
- Persistent respiratory distress
- Persistent cyanosis or pallor
- Fever, hypothermia or temperature instability
- Vomiting or diarrhea
- Evidence of localized or systemic infection
- Hyperbilirubinemia requiring medical treatment or any jaundice within the first 24 hours
- Suspected seizure activity

Transfer of Care

- Major congenital anomaly requiring immediate intervention

THE FIRST TRIMESTER

EXERCISE:

We strongly encourage an active lifestyle and exercise during pregnancy. Being in good physical shape will help you meet the demands of pregnancy and labour. It is also an excellent way to reduce stress. Swimming, walking, bicycling, and prenatal yoga are good ways to exercise during pregnancy. Use your legs, not the car! Some worry about overexertion – when exercising, you should be able to carry on a conversation (the "talk test"). We discourage you from lying flat on your back to do abdominal exercises after the first trimester, particularly if this makes you feel dizzy, light-headed, or nauseaus. If you have more specific questions, talk to your midwife.

NUTRITION:

Eating well when you are pregnant is crucial. We encourage you to eat when you are hungry. We suggest that you eat several small healthy meals throughout the day to ensure that the baby receives a steady supply of nutrients. Pregnancy requires an extra 300 calories in addition to your non-pregnant diet, which is only one extra snack per day. Trying to avoid refined sugars found in white bread, pasta, and sweets (including pop and juice) is recommended. Your baby will receive more nutrients from whole foods. Plenty of fluids are essential for hydration. Limit the amount

of coffee, tea, and juice you drink, and aim for 8 glasses of water a day. Do not exceed two measured cups of coffee per day. A prenatal vitamin is not necessary for all women. However, pregnant women need adequate calcium, iron, magnesium, and protein. If you have concerns that your diet is lacking in any of these, talk to your midwife for more detailed information.

IRON:

Iron is the most common nutrient deficiency in pregnancy. Iron is necessary for increasing the quantity of red blood cells, which carry oxygen. The amount of iron needed doubles during pregnancy to meet the needs of your placenta and growing baby. Signs of iron deficiency includes fatigue, shortness of breath, pale skin, increased susceptibility to infections, brittle nails, heart palpitations, and dizziness. Your midwife will check your iron levels in the first and third trimester. For some women, increasing their dietary iron is adequate to maintain their levels. Iron is available in meat and non-meat sources. Meat sources generally have the most iron and it is in a form that is easily absorbed. A supplement is likely more beneficial for women who eat minimal or no meat. The best sources of iron (because they are most easily absorbed) are found in meat such as beef, chicken, lamb, pork and veal. Other good sources included beans, eggs, tuna, lentils, pumpkin seeds, sunflower seeds, sesame seeds, nettle tea, quinoa grain, dried fruits, cooked oatmeal, pistachios, prune juice, cooked oysters, molasses, whole grain breads, leafy greens, iron-fortified cereals, and bran muffins.

After reviewing your blood work, your midwife may recommend that you take an iron supplement, usually Ferrous Gluconate 300 mg taken one to three times per day or Ferrous Fumarate 300 mg (Euro-Fer, Palafer, or Floradix) taken once per day (either one capsule or five millilitres of oral suspension). Another option is HVP (Hydrolyzed Vegetable Protein) chelated iron 30 mg one to three times per day. This is more easily absorbed than a non-chelated type. Ferrous Gluconate and Ferrous Fumarate can be purchased at most pharmacies. You may need to ask the pharmacist for it as it is typically kept behind the counter. The HVP chelated iron is found in health food and bulk food stores, which carry vitamins. Like all medications, they should be stored in a safe place as it is toxic if ingested in high doses, especially in young children.

Taking an iron supplement may cause nausea, bloating, constipation or diarrhea, and may make your stools turn black. These side effects will often decrease as your body adjusts to the iron. Increasing your fluids and fibre, and avoiding taking iron in the morning when your blood sugars are low, will help minimize these side effects. Iron is best absorbed on an empty stomach; however, if this causes nausea, try taking it with a meal. For best absorption, iron should be taken with a source of Vitamin C, like orange juice or a Vitamin C supplement of 250 to 500 mg. Tea, coffee, or caffeinated sodas should be avoided a few hours before taking the supplement. If you take a thyroid medication, it should be taken at a different time, as it will bind to the iron and inhibit absorption. Avoid taking calcium supplements, calcium-containing medications (such as

antacids like Tums or Rolaids, or your prenatal vitamin), or calcium-containing foods with your iron supplement, as these will also inhibit iron absorption.

CALCIUM:

Another important mineral during pregnancy is calcium. Calcium is necessary for healthy bones, teeth, and the development of your baby's skeletal system. Calcium also plays a role in regulating blood pressure. Adequate calcium levels decrease leg cramps, though excessive calcium can cause leg cramps. When women have insufficient calcium intake through their diet or supplements, calcium will be taken from maternal bones. Fortunately, during pregnancy the body is twice as efficient at absorbing calcium as when you are not pregnant.

Pregnant women need 1000 to 1200 milligrams of calcium per day. If dairy is a normal part of your diet, three dairy servings per day will meet your needs. Dairy sources include milk, cheese (especially Swiss) and plain yogurt. Non-dairy sources of calicum include tofu, soy milk, sesame seeds, sardines, canned salmon, broccoli, oranges, legumes, almonds, kale, oysters and bok choy. In general, vegetable sources have less calcium and are not as well absorbed, especially when cooked. Where possible, try to eat vegetables raw.

For women with lactose sensitivity or those who do not regularly eat dairy, a supplement may be necessary. We recommend a Calcium Citrate preparation with Vitamin D and Magnesium added to increase absorption. This preparation also causes less constipation and bloating. If you are also taking a prenatal vitamin with iron or an iron supplement, avoid taking it within two hours of taking your calcium supplement, which will improve absorption of both minerals. Also avoid taking more than 500 milligrams of calcium at one time, as absorption will be decreased. Finally, like any supplement, too much is not good. High doses of calcium (i.e. more than 2500 mg) can increase the risk of urinary tract infections and kidney stones.

THE SECOND TRIMESTER

PRETERM LABOUR:

Definition of Preterm Labour

Preterm labour is labour that starts before 37 weeks of pregnancy. It is rare, but can happen to anyone. The reasons it happens are not well understood, but you may be more at risk if you have had a preterm baby before, smoke, are underweight, are not getting enough healthy food, have lots of stress, or have had several miscarriages.

Effect on Baby

Preterm babies may:

- Have trouble breathing
- Have trouble feeding
- Have trouble keeping warm (temperature instability)
- Have an increased risk of getting an infection
- Need special care in the hospital NICU, including prolonged hospitalization

Some preterm babies are very small and may not be strong enough to live. Generally, the earlier in the pregnancy the baby is born, the more fragile the baby.

Warning Signs

- Cramps, contractions, or pains that come at regular intervals (i.e. that are getting longer, stronger and closer together)
- Lower back pain or dull aching that comes in waves
- Pressure as if the baby is pushing down
- Bleeding from the vagina
- A trickle or gush of fluid from the vagina
- A feeling that something is not right

Page your midwife if you are less than 37 weeks and think that you may be in preterm labour.

GESTATIONAL HYPERTENSION:

Definition of Gestational Hypertension

Gestational hypertension (GH), also known as Pregnancy Induced Hypertension (PIH), is a serious condition that happens in 1 out of every 10-20 pregnancies. It is more common in first time mothers and in women having a prengnacy with a new partner. It usually happens at the end of your pregnancy. Going to prenatal visits is important. We see you more frequently at the end of your pregnancy to check your blood pressure and to check if there is protein in your urine. Stress may play a role in hypertension. Know how to manage yours with exercise, support, and a healthy diet.

Effect on Baby

Gestational hypertension may lead to preterm birth, stillbirth, or growth restriction in the baby.

Warning Signs

Possible signs of gestational hypertension include:

- Elevated blood pressure
- Protein in your urine
- Rapid weight gain (four or more pounds in a week)
- Sudden, obvious swelling in your hands of face
- Severe abdominal pain under your right breast or ribs (liver pain)
- Severe headache (usually frontal) that doesn't resolve with the usual remedies
- Blurry vision
- Seeing shiny or black spots
- Severe, sudden nausea and vomiting

If you develop these symptoms, please page your midwife.

THE THIRD TRIMESTER

FETAL MOVEMENT COUNTING:

Over time you will become an expert on your baby's movements. Often babies have predictable times when they are more active (e.g. after you eat, or during a certain time every night). As you approach the end of pregnancy, the baby may change his/her movements as there becomes less room for big kicks. This change in the quality (type or strength) of movements is normal, but there should't be a change in the quantity (number) of movements.

If you become concerned that your baby has not been as active as usual, we suggest that you do a fetal movement count as detailed below. Please note that this criteria applies after 32 weeks gestation.

Have a drink and then lie on your left side with your hands on your abdomen. Avoid all other distractions such as the TV or a conversation. Count your baby's movements (i.e. kicks, jabs, punches, twists and turns.) You should feel at least six movements in two hours. Page your

midwife if you felt no movement in one hour or if you counted less than six movements in two hours.

NEWBORN MEDICATIONS:

In the first hours after birth, the following medications are routinely given to all newborns. Erythromycin is administered by law; however, some clients choose to decline erythromycin administration following an informed choice discussion. It is also your choice whether or not your baby will receive Vitamin K.

Erythromycin

This clear antibiotic ointment is administered into each eye. This ointment does not sting, but it may cloud the baby's vision for a brief period of time. Erythromycin effectively destroys gonorrhea and is somewhat effective against chlamydia and other types of bacteria. These bacteria may be present in your baby's eyes after passage through the birth canal and could lead to blindness if symptoms of an eye infection are ignored and the baby did not receive the eye ointment.

Vitamin K

In humans, Vitamin K is produced primarily by bacteria in the bowel. Babies are born naturally deficient in Vitamin K as only a small amount is transferred across the placenta in utero, and the bowel is sterile at birth.

There are only small amounts of Vitamin K in breast milk. Cow's milk is high in Vitamin K. Vitamin K is essential in blood clotting.

Vitamin K is administered by intramuscular injection (IM) to the thigh of newborns. It is effective in preventing a rare condition called Vitamin K deficiency bleeding (VKDB), formerly know as hemorrhagic disease of the newborn (HDN). The incidence of VKDB in breastfed babies who do not receive Vitamin K after birth is about 1 in 50 to 1 in 250. The benefit of administering Vitamin K after birth is that the occurrence of VKDB is virtually eliminated.

Risks of Vitamin K IM injection include pain, bleeding, and possible infection at the injection site. Skin-to-skin and/or breastfeeding during Vitamin K administration may help to reduce the pain of the injection. Over thirty years of experience in administering IM Vitamin K in the early hours of life has not identified adverse effects related to this medication

GBS (GROUP B STREPTOCOCCUS):

Here is some information on Group B Streptococcus (GBS) infections in pregnancy, and the relevance to your newborn. The information will help you decide if you would like to have a vaginal/rectal swab for GBS, usually done at thirty-five to thirty-seven weeks of pregnancy.

- GBS is a type of bacteria that normally lives in the bowels, and is found in the vagina in ten to thirty-five percent of pregnant women. In healthy adults, GBS does not typically cause problems.
- If a pregnant woman has GBS and is not treated, it may be transmitted to the baby during the birth, as bacteria can travel upward from the mother's vagina into the uterus. 40-50% of infants born to mothers who are GBS positive will be positive for GBS themselves (i.e. will be colonized with GBS) if the mother is not treated. Fortunately, most babies who acquire GBS from their mothers do not get sick; however, 1-2% of babies who become colonized with GBS will go on to develop GBS infection/disease, or about 1 in 200 babies. Infant GBS infection is treated with admission to the neonatal intensive care for seven to ten days (though it can be longer) where babies are given antibiotics through an IV. For babies thirty-seven weeks gestation or older (term babies), the prognosis is very good, with approximately ninety percent of infected babies responding to treatment.

Do I have GBS?

- During your pregnancy, we will offer you a vaginal/rectal swab at thirty-five to thirty-seven weeks gestation, to determine whether or not you carry GBS. It is your choice whether to have the swab or to decline it. Currently, family physicians, obstetricians, and recent research from the Centre for Disease Control and the Society of Obstetricians and Gynecologists, support routine swabbing of all pregnant women.

What happens if my swab is positive?

- Women who swab positive for GBS are offered treatment with antibiotics through an IV during labour (usually penicillin, unless the woman is allergic). As previously stated, if a woman is GBS positive, the chances of her baby developing GBS infection is approximately 1 in 200. This risk decreases to approximately 1 in 2000 if the woman receives IV antibiotics at least four hours prior to delivery. Taking antibiotics by mouth during or before labour does not prevent GBS infection in the newborn.
- It is recommended that newborns of GBS positive women who are untreated or partially-treated remain in the hospital for twenty-four hours after the birth to be monitored for signs of infection, and so the baby can receive a blood test to rule out any infection. If you choose to go home before twenty-four hours, your midwife will educate you on the signs and symptoms of an infection.

If I am positive for GBS, do I need to have antibiotics?

As midwives, we provide information and offer treatment options. It is your decision to accept or decline treatment.

If you have GBS and no antibiotic treatment, there is a 1 in 200 chance that your baby will develop an infection. If you have GBS and antibiotic treatment, there is a 1 in 2000 chance that your baby will develop the infection. The risk of GBS infection increases when other risk factors are present. These risk factors are:

- Preterm delivery (delivery at less than thirty-seven weeks)
- Fever during labour (greater than or equal to thirty-eight degrees Celsius)
- If your waters have been broken for eighteen hours or more before the birth
- Having had a previous baby with GBS disease/infection
- Having GBS bacteria found in your urine during the pregnancy

Some women choose to treat with antibitoics only if a risk factor comes up during their labour.

Possible Risks of Taking Antibiotics

Possible side effects of treating with antibiotics include:

- Allergic reaction in the mother (i.e. anaphylaxis) – very rare
- Yeast infections or thrush in mom and/or baby
- A potential for antibiotic resistance

What if I don't swab?

If we don't know whether or not you have GBS, antibiotics would be recommended and offered in labour if you develop a risk factor (as listed above).

Waters Breaking and GBS

Once the amniotic sac is broken, bacteria can ascend up the vagina and to the baby.

If you are GBS positive, the community standard is to induce labour soon after the waters are broken and to begin antibiotics at that time. However, other options are also possible – such as treating with antibiotics while waiting for labour to start on its own or declining antibiotics and waiting for labour to start on its own. Your midwife can discuss these options (and the associated risks and benefits) with you in more detail. Research shows it is safe to wait up to 18 hours before choosing to start antibiotics and/or an induction.

If you do not have GBS, you do not require antibiotics. You may choose to have labour induced or wait for labour to start on its own.

If your GBS status is unknown, usually you only receive antibiotics and an induction if a risk factor develops (i.e. if your waters have been broken for more than eighteen hours, if you develop a fever in labour, or if you are preterm). However, other options are also available, such as treating with antibiotics and undergoing induction of labour within 6-12 hours of your waters breaking (similar to if a woman were GBS positive). The community standard (in the obstetrics community) if you are GBS unknown is to induce labour and give IV antibiotics.

PRE-LABOUR AND EARLY LABOUR

In the textbooks, labour is described in three stages. During the first stage of labour, the cervix is effacing (softening and thinning) and dilating (opening). Second stage is the pushing stage and the third stage is the delivery of the placenta (afterbirth).

This information is going to discuss the more specific details of pre-labour and early labour. As you can see from the chart below, labour can be described in terms of pre-labour (also known as false labour), early labour, and active labour. These are all part of the first stage of labour.

Pre-labour

During bouts of pre-labour (and there may be more than one bout), contractions are usually IRREGULAR or have NO PATTERN. Sometimes pre-labour contractions will be regular (i.e. every five minutes) but they DO NOT PROGRESS. That is to say, they do not get longer, stronger, or closer together. They are uncomfortable enough to make you wonder if you are in labour, but not so uncomfortable that you have a lot of trouble coping with them. While they are preparing your uterus, they are not changing your cervix and they may lead to exhaustion. There are a number of remedies to help alleviate pre-labour:

- A hot bath – this is not just a warm and comforting thing to do; it has true physiological effects. A hot bath can decrease contractions and allow you to get the sleep you will need for true labour, when it happens.
- Increase your fluid intake. You need to stay hydrated and the increased fluids will also assist in the dilution of oxytocin (the hormone causing your contractions).
- A gentle walk outside if weather permits, as ambulation may help slow pre-labour and it will help to distract you.
- Sometimes pre-labour is working to get your baby lower in the pelvis or into a better position for labour. If the above suggestions don't help, try position changes to aid your baby's movement deeper into the pelvis. Often the most uncomfortable position is the one that works to shift the baby's position.

True Labour/ Early Labour

Early labour can take twenty-four hours or longer. Rest (or sleep) is essential to promote a normal process. During early labour, the contractions cause your cervix to get softer and thinner (effacement) and to dilate to four centimetres.

Early labour may begin with menstrual-like cramps and increase in intensity slowly. Contractions may begin with an irregular length or frequency. For some women, their early labour begins as intense labour and becomes stronger from there.

Early labour will continue at its own pace even if you attempt to speed it up. Walking often makes the contractions come more frequently, but they are often milder – so walk for comfort or pleasure, but don't exhaust yourself trying to speed things up.

Early labour may be preceded or start with the passing of your mucous plug. It may be clear, or blood tinged. The mucous plug has been providing extra protection to your cervix, much like a seal. The mucous plug may be passed hours or days prior to the onset of labour.

As early labour can last many hours, it is very important to focus as much as possible on getting enough rest. Women who are unable to get enough rest in the days and nights preceding true labour risk being exhausted before active labour begins. We recommend in early labour to live your life as normally as possible. This means that if it is the middle of the night, try to go back to sleep. If contractions wake you, take Gravol (50-100mg) and Tylenol (500-1000mg) and a warm bath, then go back to bed. Remember that the better rested you are, the better you will cope and work with your labour once it becomes active.

If it is daytime, try to distract yourself. Go for a walk, watch some television or a movie, listen to music – anything that will keep you feeling relaxed and positive. If you are tired, have a nap. Make sure to eat lightly and to drink adequate fluids. We suggest 1-2 cups of fluid (alternate between water and juice if you wish) each hour. If you want to time contractions, time a few every hour, but if they are more than 5 minutes apart and not lasting at least 50-60 seconds consistently, then stop. This will only increase the focus on contractions and will drain you.

WHEN TO CALL YOUR MIDWIFE:

When contractions are 5 minutes apart or less, lasting 60 seconds, and this has gone on for more than 1 hour, you may wish to page your midwife (the 5-1-1 rule). If you are coping well, it is not necessary to call your midwife. 5 minutes apart contractions can last for many hours and the contractions typically become closer together (i.e. 3 minutes apart, lasting 60 secs) and stronger as the labour gets more active. Be sure you are timing contractions correctly – they are timed from the beginning of one contraction to the beginning of the next. It is important to pay attention to the intensity of the contractions as well as the timing.

IF THIS IS YOUR FRIST BABY: Contractions that are 5 minutes apart and are not getting closer, not getting stronger, and not getting longer are likely still early labour. If you are coping well with 5 minute apart contractions, it is not necessary to page your midwife - wait for the contractions to get stronger and closer together. You can page your midwife if you are having a hard time coping with contractions, regardless of the pattern.

IF YOU HAVE HAD A BABY BEFORE: You may cope well, even with very intense 5 minute apart contractions. You should page your midwife after 1 hour of regular, intense contractions that are 5 minutes apart and last 50-60 seconds. Page right away if contractions are consistently

intense and less than 5 minutes apart. You should page your midwife if you are having a hard time coping with contractions, regardless of the pattern.

PRE-LABOUR, EARLY LABOUR AND ACTIVE LABOUR:

Findings	**Pre-labour/ False Labour**	**True/Early Labour**	**Active Labour**
Emotions	Excited, eager	Apprehensive, may be anxious	Focused, very intense
Uterine Contractions	Irregular, usually no pattern If pattern is present, it does not progress (see notes below)	Regular PATTERN begins to develop ↑ frequency (every 5 – 60 min) ↑ duration (x 20 – 60 sec) AND ↑ intensity (mild then moderate)	Regular PATTERN ↑↑ frequency (every 3 – 5 min) ↑↑ duration (x 50 –60+ sec) ↑↑ intensity (strong)
Bath/ Sleep	Both will usually stop or decrease the contractions	Will NOT stop the contractions, but may help relax you, allowing you to rest before active labour, or change the pattern of contractions	Will NOT stop or change the pattern of contractions. Cannot sleep or rest
Suggestions	-Time contractions only for ½ hour; if in early labour, stop timing contractions until you feel a significant change in pattern /strength -Hot bath x 45 min -Drink lots of water, as dehydration can increase symptoms and discomfort -Try to sleep or rest if it is nighttime or you are tired (do not exhaust yourself)	-Time contractions only for ½ hour; if in early labour then stop timing! -it is time for REST & DISTRACTION -Go about your normal activities (rest at night, usual events in day); -Tylenol and Gravol can help you get much needed rest for the upcoming hard work of active labour -Eat if you are hungry and drink lots of water; if not eating, have occasional sweet drinks or snacks -Walking or position changes -Start timing contraction again when you feel a significant change in pattern and/or strength -See pre-labour and early labour narrative for information on when to call your midwife	-Your midwife will be in attendance and will give you suggestions -Soaking in the tub or a shower can significantly increase your ability to cope with the pain -Dink 1-2 cups of fluid every hour -Empty your bladder at least once every 1-2 hours - Have something sweet to eat or drink every hour or so
Notes	Some women have several bouts of pre-labour and contractions may be regular but they DO NOT PROGRESS (they do not get longer, stronger, or closer together over time). In this	Early labour can be difficult to distinguish from pre-labour, but you will know it is early labour if the contractions get longer, stronger, and closer together. Early labour can take 24 hours or	Dilation from 4cm to 10 cm can take approximately 12 hours for a first baby or 6 hours if you've had a baby before, but timing varies for each woman.

	situation, you may have some cervical change, which will mean there is less work to do in early labour. Pre-labour may promote descent or help baby get into a better position for labour.	longer, we cannot stress enough the IMPORTANCE OF GETTING REST.	Some women have a very fast labour even with a first baby; typically in these situations there is no early labour and contractions are frequent and very intense right from the beginning.

SUPPLIES FOR A HOSPITAL BIRTH:

Regardless of where you plan to have your baby, it is a good idea to have a hospital bag packed. Your hospital bag should contain:

- Your photocopied chart with your prenatal records (we give you this around 36-37wks)
- Health card
- Money and small change for parking and vending machines
- Food and drink for yourself and your partner (during labour and postpartum)
- Extra pillow, slippers, and pajamas,
- Toiletries – toothbrush, toothpaste, shampoo, soap, body lotion, chapstick
- Clothes: and outfit for baby to come home in and one for you
- Infant car seat
- Optional – olive oil or coconut oil for baby's skin; depends diapers for you

SUPPLIES FOR HOMEBIRTH:

Please have the following supplies gathered together in one place by 37 weeks gestation. This ensures that if labour is active when we arrive, you will not have to spend time gathering supplies

- Your envelope with your prenatal records
- Baby's first clothes for after the birth, freshly laundered: diaper, undershirt, sleeper, socks, two hats (that you don't mind getting soiled or stained) and 2+ receiving blankets
- 4+ towels (for first receiving baby) and at least 4-5 face cloths (for perineal compresses – you can make these by cutting up an old towel) which you don't not mind soiling and staining
- Multiple clean towels for mom – especially if it is a water birth or if mom is labouring in the tub (need 6-8+ extra towels if planning a water birth) Two large receptacles (lined with garbage bags) where the birth will take place – one for laundry, one for garbage (e.g. large laundry tubs)
- 2-4 Plastic shower curtains or fleece-lined table cloths (or other suitable floor & bed coverings)
- One fitted sheet and one blanket for bed that you don't mind soiling and staining
- Garbage bags for pillow protection (optional)
- Bowl for water and compresses
- One litre disposable container (or ziplock) for storage of the placenta

- Snacks and drinks available for nourishment during labour and after birth – juice, fruit, honey, granola bars, etc.
- Depends diapers or large pads for mom (for after the water has broken)
- Telephone in room where birth will take place (if possible)

When labour starts, have the bed made up double sheeted with older sheets (that you don't mind soiling) on top and a vinyl mattress protector/plastic sheet between the two sets of sheets, with good sheets on the very bottom

Of note, prior to labour starting, you may want to clean the tub if needed.

POSTPARTUM SUPPLIES FOR HOME AND HOSPITAL BIRTH:

It is useful to have the below supplies available prior to the birth to avoid having to go out to buy them in the early postpartum period:

- Empty clean squeeze bottle for perineal care (i.e. empty dish detergent bottle)
- Large sanitary pads or Depends adult diapers
- Digital under-arm thermometer for the baby
- Ibuprofen (Advil or Motrin) and acetaminophen (Tylenol)
- Diaper cream, ointment, or petroleum jelly
- Olive oil or coconut oil (for baby's skin)
- Disposable diapers (at least for the first few days of meconium stools)
- Epsom Salts and the HERBAL BATH kit (from West Grand Pharmacy) -for postpartum baths that help with healing
- Tucks pads, Preparation H, Anusol or Witch Hazel (for haemorrhoids)
- You can make 'padsicle' ice packs by soaking a few sanitary pads with ¼- ½ cups of water (and a few drops of witch hazel if desired) and placing them in the freezer - make sure you place them with the pad open, not folded; alternatively you can make an ice pack by folding an adult washcloth in half and rolling it. Soak in water and cover it in Saran Wrap. (these can be used to reduce perineal swelling and pain)

POSTPARTUM

MOTHER'S CARE FOR POSTPARTUM:

Postpartum Planning

DISCUSS RULES ABOUT VISITING PRENATALLY: Sometimes people assume that they are invited to visit immediately after you have the baby, either in the hospital or at home. Think about when you will want visitors, for what length of time, how many at a time, etcetera. Remember this is the most important time for you to get to know your baby, establish breastfeeding and heal from giving birth. We strongly suggest that you do not invite visitors for the first few hours postpartum so that you and baby can stay skin-to-skin, and that you limit visitors during the first week.

PLAN FOR HELP: Whether it is family or friends, you will get more rest if you have help with household chores. People should be able to see what needs doing and do it without a lot of direction. Consider hiring a cleaning service or postpartum doula if you are able.

ORGANIZE MEALS: Make a list of things your family likes to eat and post it on the refrigerator for all to see. This provides a quick answer for those asking to bring a meal. If you have some last trimester energy, freeze meals ahead of time and stock up on non-perishables.

LISTEN TO YOUR BODY: If it says sleep, then sleep. The best way to take care of your baby is to take care of yourself. We will spend time talking about realistic expectations for new mothers and newborns.

CONSIDER SIBLINGS: They go through adjustment, too. Plan playtime for them at other homes. Wrap little goodies ahead of time for "I feel left out" moments. Consider taking ten minutes three times a day to read a book or play games (i.e. have designated time for older children).

REST AND FLUIDS: Spend the first twenty-four to forty-eight hours after the birth in bed with you baby, only getting up to use the bathroom. Take as much help from others as they will give, but you keep the baby with you. Keep visitors to a minimum in the first one to two weeks. Your partner can entertain while you and the baby get rest. Consider wearing pajamas during visits to remind people that you are recovering from giving birth. Short visits work well, or asking all visitors to come over the same short period on a certain day. Baby is here for good, let friends and relatives get to know him/her when you are all well-rested.

THE FACTS ABOUT HOME BIRTH IN ONTARIO

Midwives are primary care health professionals who provide women with clinical care and support throughout their pregnancy, the option of a home or hospital birth, and home visits up to six weeks postpartum.

The Model of Midwifery and the Role in Support of Home Birth

MODEL

- Midwives believe that each woman should be able to decide where she wants to give birth. They are required to offer a woman informed choice. This means they will take time to listen to her questions and concerns, to provide her with clear evidence-based information about the benefits and disadvantages of each choice she is considering, and to support her in her decision-making.
- All midwives in Ontario offer a woman the choice of giving birth in the hospital or at home.
- Every midwife is trained to provide all the necessary care and support needed at a home birth.
- Midwives are required to attend a minimum number of home births to maintain registration and to demonstrate that they have the skills needed to provide safe care at home. Of all the regulated care providers in Ontario (e.g. doctors, nurses) only midwives routinely attend home births.
- For births in Ontario where the woman has chosen midwifery, the model is that two midwives (or a midwife and a qualified second attendant) will attend every birth.

The Benefits of Home Birth

BENEFITS

Recent research conducted in Ontario and British Columbia comparing women experiencing an uncomplicated pregnancy attended by midwives has shown:

- Women who chose to deliver at home were significantly less likely to experience unnecessary interventions in their labour (for example, induction, augmentation, pharmacological pain relief, episiotomy, assisted delivery, etc.).[1,2]
- Women who chose a home birth moved to hospital for a cesarean delivery 5.2% of the time compared to a cesarean delivery rate of 8.1% in the planned hospital group.[1]
- Women planning to give birth at home reported that they felt competent, responsible, secure, adequate, relaxed, victorious...and open and receptive to the experience.[3]
- Women who give birth at home are more likely to breastfeed and to breastfeed longer than women who give birth in the hospital.[1,2]
- The Ontario Ministry of Health and Long-Term Care pays for midwifery services, whether the birth is in hospital or at home. The cost to the health care system for a midwife-attended home birth is less than a hospital birth with a family physician.

College of Midwives of Ontario >> **phone**. 416.327.0874 **email**. admin@cmo.on.ca **web**. www.cmo.on.ca

THE NUMBERS

As of 2010, midwives have attended more than 25,000 home births since the regulation of the profession in Ontario.
Ontario midwives attend approximately 3,000 home births annually.
The number of births attended by midwives in Ontario has been increasing each year since regulation.
Last year approximately 10% of all births in the province were attended by midwives.
Approximately 20% of midwife-attended births take place at home.

The Safety of Home Birth

The literature demonstrates that there is no difference in the safety of births that take place in the home versus those planned to take place in the hospital.[1,2]

- There was no difference in the safety or results when home births were planned with a well-screened population of women, within a supportive health care system, and attended by professionally trained midwives carrying emergency equipment.
- All midwives in Ontario are required to carry emergency equipment and are trained in its use.
- Midwives are experts who continually assess their clients through pregnancy and labour to ensure that they are good candidates for home birth.
- Midwives communicate with doctors regarding a client's care whenever necessary.
- Midwives communicate with ambulance personnel and hospital staff regarding the details of home births, in case they are required.
- Similar safety outcomes have been shown in other jurisdictions with comparable models of midwifery care.
- Two skilled attendants at every home birth means that there is a primary care provider present for both mother and infant.

SAFETY

References

1. Hutton EK, Reitsma AH, Kaufman K. Outcomes associated with planned home and planned hospital births in low-risk women attended by midwives in Ontario, Canada, 2003-2006: a retrospective cohort study. Birth 2009;36(3):180-9.
2. Janssen PA, Saxell L, Page LA, et al. Outcomes of planned home birth with registered midwife versus planned hospital birth with midwife or physician. CMAJ 2009;181:377–83.
3. Janssen PA, Carty E, Reime B. Satisfaction with planned place of birth among midwifery clients in British Columbia. J Midwifery and Women's Health 2006;51:91–7.

COLLEGE OF MIDWIVES OF ONTARIO
ORDRE DES SAGES-FEMMES DE L'ONTARIO

Home birth with a midwife might be right for you.
For more information, contact the **College of Midwives of Ontario** at 416-327-0874.

College of Midwives of Ontario
55 St. Clair Avenue West
8th Floor, Box 27
Toronto, ON M4V 2Y7

phone. 416.327.0874
fax. 416.327.8219
email. admin@cmo.on.ca
web. www.cmo.on.ca

Midwives of Windsor

3357 Walker Road – Unit #3
Windsor ON N8W 3R9

KEEP THIS INFORMATION ON HOW TO REACH US

OUR OFFICE NUMBER: 519-252-4784

Please leave us a message if you have any non-urgent questions, or to cancel or change appointments; your call will be returned within 1 - 2 business days. Our office hours are currently on Tuesdays, Wednesdays, and Thursdays in our office space located at:

3357 Walker Road – Unite # 3
Windsor ON N8W 3R9

Emergency Service Number (Pager): 519-790-7777

The service number is for midwifery client emergencies. When you call the pager number you will talk to an operator who will ask you very specific questions about the nature of the concern. Ask for your midwife by name. The operator will then page the midwife. PLEASE STAY OFF THE PHONE. Your midwife will call you back within 15-20 minutes; if your midwife has not called you back, then call the paging service again. For non-pregnancy related concerns please contact your doctor or nurse practitioner.

If it seems you have a problem which must be dealt with immediately, page your midwife, regardless of the time of day. Below is a list of examples of when to page us, but use your own judgement, and page with any urgent concerns or emergencies.

CONTACT US IMMEDIATELY IF YOU EXPERIENCE THE FOLLOWING:

- Any vaginal bleeding which is bright red or dark
- Severe abdominal or upper gastric pain
- Severe, unusual headaches and blurred vision
- Illness with vomiting, or fever for over 24 hours
- Any leaking of amniotic fluid, weather a gush or trickle, unless otherwise discussed with your midwife
- A noticeable decrease in fetal movement
- Regular contractions prior to 37 weeks
- Active labour at term (contractions 5 mins apart or less, lasting 50-60 secs for at least 1hour)
- If you have a car accident please inform us as soon as possible

☺ FRIENDLY REMINDER / REQUEST ☺

As you all know, the staff of the Midwives of Windsor work toward making your visits here as pleasant as possible and try to maintain a friendly family atmosphere where you and your family can learn and receive our care. But, like most families, we occasionally need to remind everyone of a few things:

WET SHOES AND BOOTS:

The children just seem to love our little play area and they play on the floor we all walk on. To make their visits happier, please remove your wet boots and shoes when you come in. We suggest you bring slippers for you and your children to keep everyone's feet warm and dry.

TOYS:

Since the little ones enjoy the toys so much, sometimes they forget to put them away when they leave. Would you please remind them to keep the toys neat for the next children who come in after them. Especially please try to keep the path to the office toy-free to prevent tripping and falling.

THANK YOU IN ADVANCE FOR MAKING THE MIDWIVES OF WINDSOR OFFICE A PLEASANT MEETING PLACE.

The Herbal Bath

The herbal bath is highly recommended for every woman following childbirth, to help prevent infection and aid in healing. Below is a list of the ingredients if you would like to make your own. You can also buy a premade postpartum herbal-bath kit from West Grand Pharmacy if you prefer.

1 ounce uva ursi
1 ounce comfrey
1 ounce shepherd's purse
2 large bulbs fresh garlic
2 cup fine sea salt

Place herbs (uva ursi, shepherd's purse, comfrey) in an old sock or nylon (this will aid in straining after cooking), then place the sock and water in a medium stock pot. Fill the pot to the top with water and bring to almost a boil. Allow the herbs to steep for at least two hours and keep the liquid solution. Place the liquid in a container and store in the freezer if you are not planning on using it immediately. Repeat the above process using the same herbs. You will now have enough for 2 baths. The remaining ingredients (garlic and sea salt) are put fresh into the bath the day you intend to use it. Use half the garlic and sea salt for each bath.

The garlic and sea salt help prevent infection. Uva ursi is helps heal and sooth reproductive organs. Shepherd's purse is excellent for preventing and controlling excessive bleeding. Comfrey helps heal and sooth raw tissue.

The baby should be put in the bath with you. The herbal bath will start the healing process of the cord stump and encourage it to fall off sooner. In the bath, your baby will likely become mellow, and may even smile. The infant will enjoy the weightlessness and warmth of the water. It's wonderful to watch the baby's joy at finding something so familiar and enjoyable in this new world. Caress and speak softly to the baby. The infant will love this communication and will respond by total eye contact and facial expressions. When the infant is taken out of the bath, they should be patted dry, not rubbed. Dress them in soft, warm clothes.

Normal Newborn Behaviour

Newborns look and act differently than older babies and children, as they are adjusting to life outside the womb. This handout is to help you figure out what is normal and what to do if signs arise that may indicate illness.

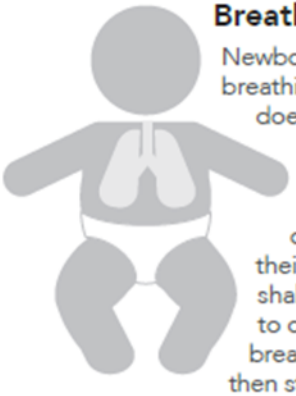
What to expect in the first few days	
Breathing	• Your baby may breathe in clusters—there may be times when your baby's breathing seems shallow and rapid. At other times your baby's breathing may seem deep or slow. • Your baby's breathing may be irregular.
Colour	Your baby may get: • blue/purple feet and hands in the first 24 hours. • blotchy and red when cold or crying. • mild jaundice (yellow face) after 24 hours.
Temperature	Normal temperature range: Armpit 36.5°C to 37.5°C (97.7°F to 99.5°F)
Feeding	• After the first 24 hours, your baby should eat every two to four hours, eight to 12 times per day. • Your baby will usually feed for a minimum of 20 minutes, though longer is very common. A satisfied baby will detach from the breast after finishing a feed. • Your baby may cluster feed (feed many times in a row) and then have a longer stretch without feeding.
Diapers	• Day 1 = 1 wet diaper • Day 2 = 2 wet diapers • Day 3 = 3 wet diapers • Your baby's stool will appear black-greenish (meconium) for the first couple of days, until your colostrum (thick, sticky and yellowish first milk) transitions to mature milk. • Once mature milk comes in (between third and fifth day), expect six to eight wet diapers a day and two or more stools that are liquid yellow, green or brown. Stools that look 'seedy' are normal.

It is important to watch your newborn for any unusual behaviour during the first hours and days of his or her life. In very rare circumstances, babies can develop an infection from bacteria such as Group B Streptococcus (also called GBS), which can cause serious illness. The signs of illness from GBS are most likely to occur within the first 24 hours, but sometimes occur later. It is important for all parents to know what is within the range of normal newborn behavior and when you should contact your midwife or 911.

This document provides client-friendly information based on the Association of Ontario Midwives' *Clinical Practice Guideline No. 16: Group B Streptococcus: Postpartum Management of the Neonate*. It is designed to help you better understand some of the considerations and choices you may face while receiving care from your midwife. It is not intended to replace the informed choice discussions that you and your midwife will have. If you have any questions, concerns or ideas after reading over this document, please share them with your midwife.

Behaviour

Your baby will spend his or her early days and weeks in different states: deep sleep, light sleep, drowsy, quiet alert, active alert, crying. While newborns sleep about 16 hours out of every day, their sleep patterns are unpredictable; they may sleep for a few minutes or a few hours at a time. Babies should always be put to sleep on their backs. Because your baby's stomach is so tiny at this age, he or she needs to wake to feed often. In the first days and weeks, your baby should sleep for stretches no longer than four to six hours in a 24-hour period without waking to feed. If your baby is sleeping for a long period, wake your baby up and try to feed him or her. Some babies are difficult to wake; if they don't wake up with your first attempt, try again in half an hour. An effective way to wake your baby is to undress him or her, change their diaper and talk to them. It is normal for it to take a while for babies to latch to the breast. Be patient! If your baby seems unusually sleepy and uninterested in feeding upon waking, try again in 30 minutes or wipe a cool cloth on their face to help wake them up.



Breathing

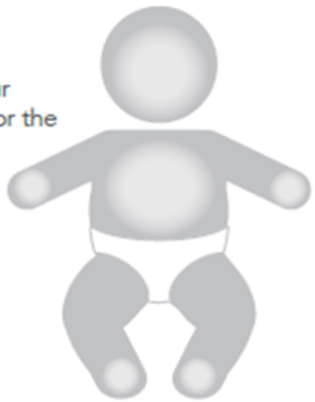
Newborns often have irregular breathing patterns. Their breathing does not look or sound like an adult's. At times, newborn babies will breathe progressively faster and deeper, and at other times their breathing is more slow and shallow. It is normal for babies to occasionally pause their breathing for 10 seconds and then start up with a deep breath. It is not normal for a baby to gasp for breaths or pant (quickly breathe) for 10 minutes or more. Babies make lots of different strange sounds and faces, and it can be difficult to know what is charming and normal and what should be concerning. It is normal for newborns to sound like a cat coughing up a hairball as they try to bring up mucous; they may also have bubbles at their mouths.

Contact your midwife if you notice any of these signs that your baby is having difficulty breathing:

- *Your baby's nostrils widen as he or she breathes (nasal flaring) for longer than a few minutes.*
- *Your baby makes grunting sounds with each breath; this lasts longer than a few minutes.*
- *The skin around your baby's ribs or at the base of the throat pulls in sharply with each breath.*
- *Your baby's breathing stops for more than 10 seconds.*

Colour

A pink chest and face shows that your baby is getting enough oxygen. Your baby's hands and feet may be blue, purple or grey and cool to the touch for the first few days – this is normal. Your baby's skin may get blotchy and red after crying or when cold.



If the skin on your baby's face or chest becomes blue or grey please call 911 and contact your midwife immediately.

Normal temperature in °C

Temperature

A newborn should be dressed in one layer more than you are comfortable wearing. Placing your baby skin-to-skin (holding your bare baby against your bare chest or stomach), covered by a light blanket, will help them to regulate their temperature. If you want to know if your baby is too hot or too cold, feeling their chest or the back of their neck will give you a more accurate idea of their temperature than their hands or feet. It is normal for a baby's hands and feet to be cool for the first few days. The best way to take your baby's temperature is under the armpit (this is also known as an axillary temperature). Ear thermometers are not accurate for newborns and are not recommended. Normal armpit temperature is 36.5°C to 37.5°C (97.7°F to 99.5°F).

- If your baby's temperature is over 38.0°C (100.4°F), please page your midwife.
- If your baby's temperature is over 37.5°C (99.5°F), remove a layer of clothing and take his or her temperature again after 30 minutes have passed.
- If your baby's temperature is over 37.5°C (99.5°F), and you have taken the above actions, please page your midwife.
- If your baby seems cold or his or her temperature is less than 36.5°C (97.7°F), place your baby skin-to-skin and cover you and your baby with a blanket. Take his or her temperature again after 30 minutes have passed.

Feeding

If you are breastfeeding, putting your baby to the breast often gives your baby valuable nutrient-rich colostrum (thick, sticky and yellowish first milk), helps establish your milk supply, and helps both you and your baby learn how breastfeeding works. Your baby will need to eat at least every two to four hours (sometimes much more often), usually for a minimum of 20 minutes at a time. It can sometimes take time for you and your baby to learn how to breastfeed. Spending time together skin-to-skin will help encourage your baby to latch and feed. Your baby may spit up after eating, usually small amounts of milk come out and dribble down his or her chin.

A good online resource for breastfeeding is: http://www.breastfeedinginc.ca

Diapers

Your midwife may ask you to keep track of the number of wet and soiled diapers your baby produces. A disposable diaper feels heavier if it's wet. Many diaper brands today have a urine indicator that turns blue in the presence of a certain amount of urine. Not all diapers do, and some pees in the first few days may be too small to make this happen. If you have trouble telling when the diaper is wet, put a tissue in the bottom of the clean diaper. Sometimes babies will have what looks like "brick dust" in their diapers in the first few days, a pinkish or orange coloured spot. These are called urate crystals, and they are normal. A baby girl may have a small amount of bloody discharge from her vagina, this is a response to mother's hormones and it is normal.

Muscle Tone

A newborn needs to be supported when held, but newborn babies should not feel completely limp in your arms. A newborn should display strong, well-flexed movements of his or her arms and legs.

Umbilical Cord

As your baby's cord begins to fall off (anytime in the first 14 days) it may begin to look "goopy" and a small amount of blood or discharge may come off on your baby's diaper or clothing. Your baby's cord may also have a strong smell; this is normal. It is not normal for the skin around the base of the umbilical cord (on your baby's stomach) to become red and infected-looking. If it does, contact your midwife.

Contact your midwife if:

- Your baby is not feeding and seems lethargic (having trouble waking up) and you can't wake your baby to feed. One long sleep (4-6 hours) in every 24 hour period is ok.
- Your baby's armpit temperature is above 37.5°C (99.5°F) or below 36.5°C (97.7°F) and your baby is not wearing too much or too little clothing.
- Your baby breathes rapidly (more than 60 breaths every minute) for longer than 10 minutes (and your baby is not crying, being active or overdressed).
- Your baby has difficulty breathing, which may look like this:
  - » nasal flaring and grunting that lasts longer than a few minutes;
  - » your baby's skin seems to be pulling in sharply around the ribs or base of the throat when he or she breathes.
- Your baby is very irritable.
- Your baby is crying almost all the time and the crying is high-pitched.
- Your baby is limp and not interacting when awake.
- Your baby has repeated, projectile vomiting (more forceful than spitting up).
- You see a brick dust colour in your baby's diaper beyond the third day of life.
- Your baby has not had a wet diaper in a 24 hour period.
- You are worried about your baby for any other reason.

Call 911 and your midwife if:

- Your baby's skin colour changes to blue, grey or pale (blue hands and/or feet are normal in the initial days).
- Your baby's breathing stops for more than 10 seconds.

The development of this document was generously supported by the Ministry of Health and Long-Term Care

Association of Ontario Midwives
Delivering what matters.

Ontario