POLICY STATEMENT
The transition from fetus to newborn is a normal physiologic and developmental process—one that has occurred since the beginning of the human race. Many hospital routines that are used to assess and manage newborns immediately after birth developed because of convenience, expediency, or habit, and have never been validated. Some practices are so ingrained that older, traditional practices, such as providing skin-to-skin care or delaying cord clamping, must be considered “experimental” in current studies. However, recent research is beginning to identify some older practices that should not have been abandoned and some current practices that should be stopped. In order to achieve a gentle, physiologic birth and family-centered care of the newborn, practices that might interfere with maternal and newborn bonding need to be closely scrutinized.

BLOOD BORNE PATHOGEN
EXPOSURE CATEGORY: I (Involves exposure to blood, body fluids, or tissues)

FUNCTION: Care of Clients

EQUIPMENT:
1. Comfort Measures
2. Birth Equipment & Resuscitation Equipment for Neonate

POINTS OF EMPHASIS:
Currently, no formal guidelines about the best timing for umbilical cord clamping exist. Clamping the cord immediately after birth results in a 20% reduction in blood volume for the neonate and up to a 50% reduction in red cell volume. Several RCTs have indicated that more infants who experience immediate clamping have anemia of infancy compared to infants who have delayed clamping. While no studies exist beyond six months of age regarding immediate or delayed cord clamping, several studies have demonstrated improved hemoglobin and iron levels up to six months of age. As well, while these infants have higher hematocrit levels, no reports of symptomatic polycythemia or jaundice were found.

PROCEDURE:
1. Most analgesic agents commonly used to alleviate labor pain readily transfer to the fetus via the placenta and therefore are not offered by the nurse-midwives of Believe Midwifery Services, LLC. This one intervention is likely a large reason why our clientele demonstrate a lower level of respiratory depression, fewer neonatal sepsis and NICU evaluation cases, increased APGAR scores and breastfeeding successes.
2. Nurse-midwives of Believe Midwifery Services, LLC are strongly encouraged to delay cord clamping in effort to assist in the transition from fetal life to newborn. It is our position that early cord clamping is synonymous with newborn hemorrhage and the only benefit would be if it were necessary to achieve a successful resuscitation of baby or to intervene in the event of a third stage hemorrhage.
3. Keeping infants warm at birth is an essential part of immediate newborn management. Newborns are at risk for heat loss at birth because of their large surface area to mass ration, minimal subcutaneous tissue, and skin permeability to water. Skin-to-skin care is an absolute necessity in the management of a baby born at home.
   a. Blankets should be warmed prior to birth in either the dryer or oven.
   b. Following birth, baby should be placed on the maternal abdomen if born on land, so skin-to-skin can be initiated immediately and her heat can provide immediate warmth via conduction. If the infant is born in warm water, s/he should remain under water with exception of the face until both mother and baby are removed from the water. The newborn and mother should be dried completely when removed from the water, and a warm blanket should be placed over both mother and infant to prevent heat loss through convection or evaporation.
c. In the event mother and baby require separation for either of their needs for stabilization that can not be accomplished together, the newborn should be placed on blanket warmed by an electric heating pad or a chemical warming agent specific for transporting neonates should be utilized.

4. Routine suctioning the newborn’s nose and mouth at birth with a bulb syringe lacks supporting evidence. It is not recommended by Believe Midwifery Services, LLC.

5. Treatments to prevent meconium aspiration syndrome have included amnioinfusion during labor, intrapartum suctioning, and endotracheal intubation and suctioning of vigorous infants with meconium-stained fluid. The most recent evidence suggests that these practices are not helpful and do not prevent meconium syndrome. These practices should not be used to prevent meconium aspiration syndrome. See the clinical practice guideline specific to meconium-stained fluid for further management direction.

6. It has been suggested that gastric suctioning of the newborn might prevent regurgitation and aspiration of meconium or other stomach contents. The one available study found harm and no benefit from gastric suctioning, indicating that it should not be used in the routine care of the neonate (Widstrom, 1987).

7. Room air should be utilized for immediate resuscitation efforts of the newborn, and oxygen only for long-term support such as during transport. The administration of oxygen had known adverse effects and resuscitation with room air demonstrates no difference in APGAR scores, time to first cry, time to onset of regular respirations, hypoxic ischemic encephalopathy, or neurologic follow-up examination results.
   a. The American Academy of Pediatrics/American Heart Association Neonatal Resuscitation Program provides an authoritative set of recommendations. Please see the clinical practice guideline specific to newborn resuscitation for further management suggestions.

REFERENCES: