CA

75075 Birth Services-General Requirements

(a)

Primary care clinics providing a birth service shall provide: (1) Care for patients during pregnancy, labor, delivery and the immediate postpartum period, and refer patients in need for specialized or tertiary care at any stage of pregnancy. (2) A continuing assessment of all factors which would indicate whether labor and delivery may post high-risk or life threatening problems to a maternal patient or infant. (A) Upon a determination that high-risk, abnormal or life threatening factors exist or are likely to occur, a birth service shall not proceed with plans to provide childbirth services during labor and delivery beyond the extent necessary to provide emergency care and stabilization. (3) Emergency care for mothers who have delivered in the clinic and infants born in the clinic who require immediate life support measures to sustain life pending transfer to a general acute care hospital. (4) Written policies and procedures for medical backup, consultation and emergency transfer and transportation of an infant to a newborn nursery or an intensive care nursery or of the mother and infant to a general acute care hospital with the capacity for management of obstetrical and neonatal emergencies. Written policies shall address the assignment of duties and responsibilities of all parties in resuscitation and stabilization in an emergency transfer. (5) An educational program designed for patients and their families to include but not limited to benefits and risks involved, information about genetic

counseling, health behavior screening services available, proper prenatal care, nutrition, preparation for labor and delivery and routine care for the newborn. (6) A maternal health record including: (A) Past medical, social and psychological history of significant risk factors for pregnancy which shall include but not be limited to:1. Cardiovascular, pulmonary, renal, endocrine, metabolic and hematologic disease. 2. Venereal and infectious disease. 3. Substance abuse. 4. Infertility. (B) Past obstetrical history which shall include but not be limited to:1. Pregnancy history. 2. Maternal and newborn complications of previous deliveries, if any. 3. Iso-immunization. (C) Prenatal physical examination which includes but is not limited to: 1. Last menstrual period. 2. Estimated date of confinement. 3. Hemoglobin and hematocrit tests. (D) Prenatal monitoring record which shall include but not be limited to: 1. Blood pressure. 2. Weight. 3. Urine protein and glucose tests. 4. Edema. 5. Estimated weeks of gestation. 6. Fundal height. (E) Onset of labor record which includes but is not limited to:1. Physical examination. 2. Fetal evaluation. (F) Labor progress record which includes but is not limited to: 1. Time of onset of labor. 2. Time of rupture of membranes. 3. Length of each stage of labor. (G) Delivery record including complications, if any. (H) Postpartum observations which shall include but not be limited to: 1. Vital signs. 2. Examination of fundus. 3. Ability of mother to ambulate, void and care for her infant. (I) Medication and anesthesia administration records. (J) Discharge note which includes but is not limited to:1. Summary of intrapartum and postpartum course. 2. Activity limitations. 3. Instructions for follow-up care. (7) Infant health record including: (A) Physical examination. (B) Weight. (C) APGAR scores. (D) Results of newborn heritable disease screening. (E) Prophylaxis for ophthalmia neonatorum. (F) Evidence of vital statistics registration. (G) Discharge note.

(1)

Care for patients during pregnancy, labor, delivery and the immediate postpartum period, and refer patients in need for specialized or tertiary care at any stage of pregnancy.

(2)

A continuing assessment of all factors which would indicate whether labor and delivery may post high-risk or life threatening problems to a maternal patient or infant. (A) Upon a determination that high-risk, abnormal or life threatening factors exist or are likely to occur, a birth service shall not proceed with plans to provide childbirth services during labor and delivery beyond the extent necessary to provide emergency care and stabilization.

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(3)

Emergency care for mothers who have delivered in the clinic and infants born in the clinic who require immediate life support measures to sustain life pending transfer to a general acute care hospital.

(4)

Written policies and procedures for medical backup, consultation and emergency transfer and transportation of an infant to a newborn nursery or an intensive care nursery or of the mother and infant to a general acute care hospital with the capacity for management of obstetrical and neonatal emergencies. Written policies shall address the assignment of duties and responsibilities of all parties in resuscitation and stabilization in an emergency transfer.

(5)

An educational program designed for patients and their families to include but not limited to benefits and risks involved, information about genetic counseling, health behavior screening services available, proper prenatal care, nutrition, preparation for labor and delivery and routine care for the newborn.

(6)

A maternal health record including: (A) Past medical, social and psychological history of significant risk factors for pregnancy which shall include but not be limited to:1. Cardiovascular, pulmonary, renal, endocrine, metabolic and hematologic disease. 2. Venereal and infectious disease. 3. Substance abuse. 4. Infertility. (B) Past obstetrical history which shall include but not be limited to:1. Pregnancy history. 2. Maternal and newborn complications of previous deliveries, if any. 3. Iso-immunization. (C) Prenatal physical examination which includes but is not limited to: 1. Last menstrual period. 2. Estimated date of confinement. 3. Hemoglobin and hematocrit tests. (D) Prenatal monitoring record which shall include but not be limited to: 1. Blood pressure. 2. Weight. 3. Urine protein and glucose tests. 4. Edema. 5. Estimated weeks of gestation. 6. Fundal height. (E) Onset of labor record which includes but is not limited to:1. Physical examination. 2. Fetal evaluation. (F) Labor progress record which includes but is not limited to: 1. Time of onset of labor. 2. Time of rupture of membranes. 3. Length of each stage of labor. (G) Delivery record including complications, if any. (H) Postpartum observations which shall include but not be limited to: 1. Vital signs. 2. Examination of fundus. 3. Ability of mother to ambulate, void and care for her infant. (I) Medication and anesthesia administration records. (J) Discharge note which includes but is not limited to:1. Summary of intrapartum and postpartum course. 2. Activity limitations. 3. Instructions for follow-up care.

(A)

Past medical, social and psychological history of significant risk factors for pregnancy which

shall include but not be limited to:1. Cardiovascular, pulmonary, renal, endocrine, metabolic and hematologic disease. 2. Venereal and infectious disease. 3. Substance abuse. 4. Infertility.

1.

Cardiovascular, pulmonary, renal, endocrine, metabolic and hematologic disease.

2.

Venereal and infectious disease.

3.

Substance abuse.

4.

Infertility.

(B)

Past obstetrical history which shall include but not be limited to:1. Pregnancy history. 2. Maternal and newborn complications of previous deliveries, if any. 3. Iso-immunization.

1.

Pregnancy history.

2.

Maternal and newborn complications of previous deliveries, if any.

3.

Iso-immunization.

(C)

Prenatal physical examination which includes but is not limited to: 1. Last menstrual period. 2. Estimated date of confinement. 3. Hemoglobin and hematocrit tests.

1.

Last menstrual period.

2.

Estimated date of confinement.

3.

Hemoglobin and hematocrit tests.

(D)

Prenatal monitoring record which shall include but not be limited to: 1. Blood pressure. 2. Weight. 3. Urine protein and glucose tests. 4. Edema. 5. Estimated weeks of gestation. 6. Fundal height.

1.

Blood pressure.

2.

Weight.

3.

Urine protein and glucose tests.

4.

Edema.

5.

Estimated weeks of gestation.

6.

Fundal height.

(E)

Onset of labor record which includes but is not limited to:1. Physical examination. 2. Fetal evaluation.

1.

Physical examination.

2.

Fetal evaluation.

(F)

Labor progress record which includes but is not limited to: 1. Time of onset of labor. 2. Time of rupture of membranes. 3. Length of each stage of labor.

1.

Time of onset of labor.

2.

Time of rupture of membranes.

3.

Length of each stage of labor.

(G)

Delivery record including complications, if any.

(H)

Postpartum observations which shall include but not be limited to: 1. Vital signs. 2. Examination of fundus. 3. Ability of mother to ambulate, void and care for her infant.

1.

Vital signs.

2.

Examination of fundus.

3.

Ability of mother to ambulate, void and care for her infant.

(I)

Medication and anesthesia administration records.

(J)

Discharge note which includes but is not limited to:1. Summary of intrapartum and postpartum course. 2. Activity limitations. 3. Instructions for follow-up care.

1.

Summary of intrapartum and postpartum course.

2.

Activity limitations.

3.

Instructions for follow-up care.

(7)

Infant health record including: (A) Physical examination. (B) Weight. (C) APGAR scores. (D) Results of newborn heritable disease screening. (E) Prophylaxis for ophthalmia neonatorum. (F) Evidence of vital statistics registration. (G) Discharge note.

(A)

Physical examination.

(B)

Weight.

(C)

APGAR scores.

(D)

Results of newborn heritable disease screening.

(E)

Prophylaxis for ophthalmia neonatorum.

(F)

Evidence of vital statistics registration.

(G)

Discharge note.

(b)

The professional director with assistance from a perinatal committee shall be responsible for ensuring that there is at least a quarterly evaluation of the services and procedures performed, including patient health record audits and

quality assurance activities. Such evaluation shall include, but not be limited to: (1) Extent of prenatal care. (2) Appropriateness of performing the deliveries on an outpatient basis. (3) Tabulation of infant APGAR scores. (4) Identification of needed services not being provided. (5) Tabulation of outcome of mothers and infants, including complications of pregnancy, labor and delivery, morbidity and mortality.

(1)

Extent of prenatal care.

(2)

Appropriateness of performing the deliveries on an outpatient basis.

(3)

Tabulation of infant APGAR scores.

(4)

Identification of needed services not being provided.

(5)

Tabulation of outcome of mothers and infants, including complications of pregnancy, labor and delivery, morbidity and mortality.