

Home Birth Midwifery Service™

NARM Certified Professional Midwife
Commonwealth of Virginia Licensed Midwife

~ PRACTICE GUIDELINES ~
REVISED FOR 2009-2010

Adopted, January 2001 from the Tennessee Midwives Association's official document
Revised, September 2008 for practice in the Commonwealth of Virginia



“We Bring the Birth Center to YOU !!”™

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Introduction

Midwifery care is the autonomous practice of giving care to women during pregnancy, labor, birth, and the postpartum period, as well as care to the newborn infant. Midwifery care is provided in accordance with established standards, which promote safe and competent care. The Midwife implements these standards through adherence to these Practice Guidelines, the NARM Job Analysis, the NACPM Scope and Standard's of Practice and the MANA's Core Competencies.

Evaluation of the childbearing woman is an on-going process, including risk screening to assess and identify conditions which may indicate a deviation from normalcy. The identification of those conditions may require physician involvement. In making this assessment, a Midwife relies on her/his training, skill, and clinical judgment.

This document is representative and not an exhaustive list of the conditions that a Midwife may encounter. This document is not meant to replace the clinical judgment or experience of the Midwife. There may be variations based on agreements between individual midwives and other health care practitioners with whom they may collaborate.

I. Midwife and Client Responsibilities and Rights

The Informed Choice and Disclosure (ICD) Agreement

The Midwife is required to have on file a signed statement verifying that each client has read and understood the Midwife's Informed Choice and Disclosure (ICD) Agreement. The ICD should be written or translated in language understandable to the client. There must be a place on the form for the client to sign attesting that she understands the content by signing her full name. The ICD discloses, to a prospective client, information regarding the Midwife's practice. The ICD includes information regarding the Midwife's responsibilities and rights as well as the client's responsibilities and rights. Each Midwife may broaden the agreement to include additional information reflecting details of the Midwife's practice.

The ICD shares information regarding the responsibilities and rights of the Midwife and those of her client. It includes information including, but not limited to:

- A. philosophy of practice and care;
- B. benefits and risks of out-of-hospital birth;
- C. training and education;
- D. years of experience;
- E. participation in Peer Review;
- F. information regarding the emergency care plan and any collaborating or consulting physician(s) information;
- G. care/equipment/supplies provided;
- H. information regarding a client's right to give informed consent prior to any procedure to the mother or newborn, including risks, benefits, options, and alternatives;
- I. acceptance/refusal of the Midwife's recommended care. The client's decision to refuse/decline recommended care will be made in writing, signed by the client, and kept in the client's records;
- J. information regarding client conditions/concerns for which a Midwife may consult with a physician, refer a client to a physician, and/or transfer the client out of Midwife's care to a physician's care;
- K. Midwife's expectations of the client's responsibilities and the Midwife's right to discontinue care;
- L. state legal requirements;
- M. financial information;
- N. Midwife's current legal status;
- O. grievance process for client complaints regarding care;
- P. process to access copies of the client's Midwifery records/HIPAA.

The Midwife will give a copy of the ICD to the client and keep a copy of the ICD Agreement Statement in the client's records.

II. Midwifery Record Keeping

The Midwife shall:

- A. document completely and accurately the client's history, physical exam, laboratory test results, prenatal visits, consultation reports, referrals, labor and birth care, postpartum care/visits, and neonatal evaluations at the time Midwifery services are delivered and when reports are received;
 - B. facilitate clients' access to their own records;
 - C. maintain the confidentiality of client records;
 - D. retain records for a minimum of five years;
 - E. complete/file all state required reports/certificates in a timely manner.
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III. Practice Protocols

Practice protocols based on these Practice Guidelines will be available for each potential client to review.

IV. Safe Environment for Birth

The Midwife Shall:

- A. assess the birth setting for freedom from environmental hazards;
 - B. bring her own equipment to the birth setting;
 - C. promptly respond to the client's needs;
 - D. practice universal precautions regarding equipment, examinations, and procedures;
 - E. practice in accordance with the Midwives Model of Care.
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V. Prenatal Care.

During prenatal care, the client shall be seen by the Midwife or other appropriate health care provider at least once every four weeks until 28 weeks gestation, once every two weeks from 28 until 36 weeks gestation, and weekly after 36 weeks gestation, or as appropriate. The responsibilities of the Midwife shall include, but are not limited to:

A. Initial Prenatal Visit

1. History/assessment of general health.
2. History/assessment of obstetric status.
3. History/assessment of psychosocial status.
4. Physical Exam to include, but not limited to:
 - a. height;
 - b. weight;
 - c. blood pressure;
 - d. pulse;
 - e. breasts, to include teaching on self exam (may be deferred);
 - f. abdomen, to include fundal height, fetal heart tones, fetal lie, and presentation;
 - g. estimation of gestational age by physical findings;
 - h. assessment of varicosities, edema and reflexes.
5. Laboratory/Diagnostic Tests. The client will be offered, but she may decline, the following laboratory and diagnostic tests to include but not limited to:
 - a. CBC
 - b. hemoglobin and/or hematocrit;
 - c. gross urinalysis;
 - d. syphilis serology;
 - e. blood group, Rh type, and antibody screen;
 - f. hepatitis B surface antigen;
 - g. rubella screen;
 - h. genetic screening tests, as clinically appropriate;;
 - i. gonorrhea test;
 - j. chlamydia test;
 - k. HSV I & II;
 - l. HIV test;
 - m. obstetrical ultrasound (including AFI and BPP), as clinically indicated.

B. On-going Prenatal Care

1. Assessment of general health.
2. Assessment of psychosocial health.
3. Nutritional counseling.
4. Physical Exam to include, but not limited to:
 - a. blood pressure;
 - b. pulse, (optional);
 - c. weight;
 - d. abdomen, to include fundal height, fetal heart tones, fetal lie, and presentation;
 - e. estimation of gestational age by physical findings;
 - f. assessment of varicosities, edema and reflexes.

5. Laboratory/Diagnostic Tests. The client will be offered, but she may decline, the following laboratory and diagnostic tests to include but not limited to:
 - a. hemoglobin, hematocrit, or CBC by 28 and/or after 32 weeks;
 - b. gross urinalysis at each visit;
 - c. Glucose Tolerance Test (GTT), as clinically indicated;
 - d. Group Beta Strep (GBS) culture(s);
 - e. obstetrical ultrasound (including AFI and BPP), as clinically indicated;
 - f. non-stress test evaluation, as clinically indicated;
 6. Prophylactic Rhogam information/administration for Rh negative clients, as clinically indicated.
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VI. Intrapartum Care

During labor, the Midwife shall monitor and support the natural/normal process of labor and birth, assessing mother and baby throughout the birthing process. The responsibilities of the Midwife shall include, but are not limited to:

- A. assess & monitor fetal well-being. While in attendance, assess FHT:
 1. 1st Stage of labor:
 - a. Early Labor: at least once every hour, or as clinically indicated;
 - b. Active Labor: at least once every 30 minutes, or as clinically indicated;
 - c. Transition: at least every 15 minutes, or as clinically indicated.
 2. 2nd Stage of labor: at least every other contraction, or as clinically indicated.
 - B. assess & monitor maternal well-being. While in attendance, assess vital signs at least every 2 hours, or as clinically indicated;
 - C. monitor the progress of labor;
 - D. monitor membrane status for rupture, relative fluid volume, odor, and color of amniotic fluid;
 - E. assess cervical dilatation, effacement, station, and position during each clinically indicated exam;
 - F. keep vaginal exams performed to assess the progress of labor to a minimum to reduce the risk of infection. Attention will be directed toward aseptic/sterile technique and universal precautions;
 - G. assist in birth of baby;
 - H. assess and monitor newborn for normal transition to extra-uterine life;
 - I. inspection of placenta and membranes;
 - J. manage any problems in accordance with the guidelines cited elsewhere in this document;
 - K. document all interactions and clinical data in client's chart.
-

VII. Postpartum Care

After the birth of the baby, the Midwife shall assess, monitor, and support the mother during the immediate postpartum period until the mother is in stable condition and during the on-going postpartum period. The responsibilities of the Midwife shall include, but are not limited to:

- A. Immediate Postpartum Care**
 1. Overall maternal well-being;
 2. Bleeding;
 3. Vital signs;
 4. Abdomen, including fundal height and firmness;
 5. Bowel/bladder function;
 6. Perineal exam and assessment;
 7. Suture 1st or 2nd degree laceration(s)/episiotomy, as indicated;
 8. Facilitation of maternal-infant bonding and family adjustment;
 9. Concerns of the mother.
- B. On-going Postpartum Care**
 1. Overall maternal well-being;
 2. Bleeding;
 3. Abdomen, including fundal height and firmness;
 4. Bowel/bladder function;
 5. Perineal exam and assessment, as indicated;
 6. Facilitation of maternal-infant bonding and family adjustment
 7. Concerns of the mother.

VIII. Newborn Care

After the birth of the baby, the Midwife shall assess, monitor, and support the baby during the immediate postpartum period until the baby is in stable condition and during the on-going postpartum period.

A. Immediate Newborn Care

1. Overall newborn well-being;
2. Vital signs;
3. Color;
4. Tone/Reflexes;
5. APGAR scores at 1 and 5 minutes, and at 10 minutes when clinically indicated;
6. Temperature;
7. Feeding;
8. Bowel/bladder function;
9. Clamping/cutting of umbilical cord;
10. Newborn physical exam, including weight and measurements;
11. Eye prophylaxis;
12. Administration of Vitamin K, orally or intramuscularly;
13. Concerns of the family.

B. Ongoing Newborn Care

1. Vital signs, including color and temperature;
 2. Tone/Reflexes;
 3. Feeding;
 4. Bowel/bladder function;
 5. Weight gain;
 6. Metabolic Screening);
 7. Concerns of the family.
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IX. Physician Consultation, Collaboration, Referral and Transfer of Care

As an autonomous maternity health care practitioner, the Midwife may consult with a physician, as clinically indicated, or whenever there are significant deviations (including abnormal laboratory/diagnostic results), during a client's pregnancy and birth, and/or with the newborn. If a referral to a physician is needed, the Midwife will remain in consultation with the physician until resolution of the concern. It is appropriate for the Midwife to maintain care of her client to the greatest degree possible, in accordance with the client's wishes, remaining present through the birth. Physician-Midwife collaboration is encouraged whenever a client's health is compromised by pathology or whose pregnancy risk status changes, or when a condition(s) or situation arises that is beyond the Midwife's scope of practice or level of expertise.

The following conditions are clinical indications for physician consultation. Based on specific client care needs, these clinical indications may necessitate physician consultation and collaboration, and/or may require physician referral and/or transfer of care; nevertheless the client, may opt out of such consultation, collaborative care, referral or transfer of care with proper, written informed consent/declination. It is further understood that the midwife always has the right to discontinue care of any client whom she determines to be non-compliant, confrontational, or who, in her professional opinion, demonstrates poor judgment with regard to responsible decision making. In such an event as the discontinuation of care by the midwife, it is her responsibility to inform her client of her decision, in writing, and to provide a reasonable timeframe in which the client can seek out and find alternative care. Nevertheless and in no circumstances shall midwives be required to abandon their client(s) due to non-compliance or informed consent/declination decisions.

A. Pre-existing Conditions include but are not limited to:

1. cardiac disease;
2. active tuberculosis;
3. asthma, if severe or uncontrolled by medication;
4. renal disease;
5. hepatic disorders;
6. endocrine disorders;
7. significant hematological disorders;
8. neurologic disorders;

9. essential hypertension;
10. active cancer;
11. diabetes mellitus;
12. history of newborn with positive Group Beta Strep (GBS) sepsis;
13. previous Cesarean section with classical incision;
14. three or more previous Cesarean sections;
15. previous Cesarean section within 18 months of current EDD;
16. current alcoholism or abuse;
17. current drug addiction or abuse;
18. current significant psychiatric illness;
19. isoimmunization;
20. positive for HIV antibody;
21. significant deviation in weight for height or morbid obesity

B. Prenatal Conditions include but are not limited to:

1. labor before the completion of the 36th week of gestation;
2. lie other than vertex after 34 weeks;;
3. multiple gestations;
4. significant vaginal bleeding;
5. gestational Diabetes Mellitus, uncontrolled by diet;
6. severe anemia, not responsive to treatment;
7. evidence of pre-eclampsia or HELLP syndrome;
8. consistent size for dates discrepancy;
9. deep vein thrombosis (DVT);
10. known fetal anomalies or conditions affected by site of birth, with an infant compatible with life;
11. threatened or spontaneous abortion after 12 weeks;
12. abnormal ultrasound findings;
13. isoimmunization;
14. documented placental anomaly or previa;
15. documented low-lying placenta with history of Cesarean section;
16. post-maturity pregnancy (>42 completed weeks);
17. positive HIV antibody test;
18. recurrent urinary tract infection, unresponsive to treatment;

C. Intrapartum Conditions. It should be noted that because of time urgency during certain intrapartum situations, it may be necessary to institute emergency interventions while waiting physician consultation. These conditions include but are not limited to:

1. non-reassuring fetal heart tones, persistent or worsening fetal stress, or fetal distress;
2. abnormal bleeding;
3. thick meconium-stained fluid with birth not imminent;
4. significant rise in blood pressure above woman's baseline with or without proteinuria;
5. maternal fever >100.4 degrees Fahrenheit, unresponsive to treatment;
6. lie other than vertex;
7. Multiple gestation;
8. primary genital herpes outbreak;
9. prolapsed cord;
10. client's desire for pain medication.

D. Postpartum Conditions. It should be noted that because of time urgency during certain postpartum situations, it may be necessary to institute emergency interventions while waiting for physician consultation. These conditions include but are not limited to:

1. seizure;
2. significant hemorrhage, not responsive to treatment;
3. adherent or retained placenta;
4. sustained maternal vital sign instability;
5. uterine prolapse;
6. uterine inversion;
7. repair of laceration(s)/episiotomy, which is beyond Midwife's level of expertise;
8. anaphylaxis;
9. maternal fever > 100.4 degree Fahrenheit, unresponsive to treatment;
10. mastitis/breast infection which is unresponsive to treatment;
11. postpartum depression, unresponsive to treatment.

E. Neonatal Conditions. It should be noted that because of time urgency during certain postpartum situations, it may be necessary to institute emergency interventions while waiting for physician consultation. These conditions include but are not limited to:

1. APGAR score less than 7 at five minutes of age, without significant improvement at 10 minutes;
2. persistent respiratory distress;
3. persistent cardiac irregularities;
4. central cyanosis or pallor;
5. prolonged temperature instability or fever >100.4 degrees Fahrenheit, unresponsive to treatment;
6. significant clinical evidence of glycemic instability;
7. evidence of seizure;
8. birth weight <2300 grams;
9. significant clinical evidence of prematurity;
10. significant jaundice or jaundice prior to 24 hours;
11. loss of >10% of birth weight/failure to thrive;
12. major apparent congenital anomalies;
13. significant birth injury.

X. Administration of Prescribed Medications

*** Not permitted by VA law at this time. This section is maintained herein as a reference for future use.**

Upon the administration of any prescribed medication(s), the Midwife shall document in the client's chart the type of prescribed medication(s) administered, name of prescribed medication, expiration date, lot number, dosage, method of administration, site of administration, date, time, and the prescribed medication's effect.

Administration of Physician Prescribed Medications, where permitted by law by a Midwife shall include:

- A. Rh Immune Globulin, both antenatum & postpartum;
- B. Oxygen, for both mother and/or baby;
- C. Pitocin[®] (oxytocin) and Methergine[®], orally or intramuscularly, postpartally (as described under section **XI. Emergency Care**, below);
- D. I.V. solutions, antenatally to treat dehydration, and postpartally, for vitals support resulting from excessive blood loss and/or shock;
- E. I.M. injection of Rocephin[®] (Ceftriaxone), as intrapartum treatment of positive GBS status in the mother (as an alternative to I.V. antibiotic treatment);
- F. Local injectible anesthetics (lidocaine, xylocaine) for perineal repair;
- G. Prophylactic ophthalmic medication for newborn;
- H. Vitamin K, orally or intramuscularly, for newborn;
- I. Intramuscular injection of Epinephrine for anaphylaxis
- J. Other medications, as prescribed by a physician.

XI. Emergency Care

The following procedures may be performed by the Midwife, only in emergency situations in which the health and safety of the mother and/or newborn are determined to be at risk.

- A. Cardiopulmonary resuscitation of the mother or newborn with a bag and mask;
- B. * Administration of oxygen to mother and/or baby;
- C. Episiotomy;
- E. * Administration of Pitocin[®] (oxytocin), Methergine[®], and/or Cytotec[®] (misoprostol) to control postpartum bleeding;
- F. * Administration of I.V. solutions to re-hydrate and/or stabilize vital signs due to excessive bleeding;
- G. Manual exploration of the uterus and removal of retained placenta to control excessive bleeding.

*** Not permitted by VA law at this time, however is maintained herein as a reference for future use.**

XII. Prohibitions in the Practice of Midwifery

A. Medications. The Midwife **shall not** administer any prescribed medications or injections of any kind, except as indicated in section **X. Administration of Prescribed Medications.**

1. The use of synthetic prostaglandin compounds (Cervidil[®], Prepidil[®], or Cytotec[®] [misoprostol]) is not sanctioned for out-of-hospital use. Except that, Cytotec[®] [misoprostol]), when prescribed by a physician for postpartum hemorrhage, is excluded from this section;
2. Intrapartum use of oxytocics, such as Pitocin[®] and/or Methergine[®], is prohibited through all routes of administration.

B. Surgical Procedures. The Midwife shall not perform any operative procedures or surgical repairs **other than:**

1. artificial rupture of membranes (AROM);
2. perform and repair episiotomy;
3. perineal/vaginal laceration repair;
4. clamping and cutting of the newborn's umbilical cord.

C. Instrumental Delivery. The Midwife shall not use forceps and/or vacuum extraction to assist the birth of the baby.