



CERTIFIED NURSE MIDWIFERY (CNM)
PRACTICE GUIDELINES



CNM PRACTICE GUIDELINES

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SECTION 1. INTRODUCTION

1.1. The Practice of Nurse-Midwifery

- 1.1.1. The practice of nurse-midwifery at Boulder Community Health is performed by certified nurse-midwives (CNMs) who are credentialed as allied health professionals and must maintain appropriate practice privileges at BCH. They provide nurse-midwifery services to women within a health care system that provides for consultation, collaboration and referral with their sponsoring Obstetrician. This is in agreement with the joint practice statement between the American College of Obstetricians and Gynecologists (ACOG) and the American College of Nurse Midwives (ACNM). The following practice guidelines also correspond with the ACNM Philosophy, Code of Ethics and Standards for the Practice of Nurse-Midwifery, the policies of Boulder Community Health and the Women & Family Services Department, and Colorado state legislation governing nurse-midwifery practice. Nurse-midwives are encouraged to participate in OB section meetings. There will be a CNM representative serving on the Women and Family Services Department Committee;
- 1.1.2. Certified nurse-midwives are responsible for the obstetric and gynecologic care of women whose medical obstetrical history and present condition indicate an essentially normal course. These Guidelines provide provisions for management of common deviations from normal, and for consultation, collaborative management, and referral to physician management when deviation from normal occurs.

1.2. Legal Basis for CNM Practice in Colorado

- 1.2.1. Certified nurse midwives practice under 12-38 C.R.S., Colorado Nurse Practice Act 1999. Section 12-38-111.5 C.R.S., “Requirements for advanced practice nurse registration – legislative declaration – definition – advanced practice registry,” specifically addresses nurse-midwifery. In addition, the Colorado State Medical Practice Act Section 2, 12-36-106 C.R.S. reads:

*Practice of medicine defined-exemptions from licensing requirements.
(f) (I) “The practice of midwifery except services rendered by certified nurse-midwives properly licensed and practicing in accordance with the provisions of article 38 of this title” (Nurse Practice Act)*

1.3. Definitions

- 1.3.1. **Certified Nurse Midwife (CNM):** A certified nurse-midwife is an individual educated in the two disciplines of nursing and midwifery, who possesses evidence of certification according to the requirements of the ACNM and who meets the additional, established credentialing criteria for practice privileges at BCH.
- 1.3.2. **Nurse-midwifery Practice:** Midwifery practice as conducted by CNMs, is the independent management of women’s health care, focusing particularly on pregnancy, childbirth, the postpartum period, care of the newborn, and the family planning and gynecological needs of women. The Certified Nurse-Midwife practices within a health care system that provides for consultation, collaborative management or referral as indicated by the health status of the patient.
- 1.3.3. **Nurse-midwifery Management:** The responsibility for decisions and orders concerning care of the patient meeting low risk criteria will be assumed by the CNM, according to approved practice guidelines. Management of deviations from normal may occur

when the diagnosis is clear with an expected predictable outcome, or when consultation with the physician results in a mutual decision for continued CNM management of the patient's care. Nurse-midwifery management includes observation, assessment, examination and treatment according to current standards of care and clinical practice guidelines. When deviations from normal occur the nurse-midwife:

- a. May implement guidelines to establish a diagnosis and treatment plan when deviations from normal are identified which are covered in practice guidelines.
 - b. will seek obstetrical consultation when deviations from normal develop which are not covered by practice guidelines.
 - c. may, with mutual agreement with the obstetrician/gynecologist, collaboratively manage the care of the woman who has developed medical or obstetric complications
 - d. may refer care of the woman to physician or other health care professional for management of particular aspect of patient's care or for assumption of total management of patient's care.
- 1.3.4. **Consultation:** Process whereby a CNM maintains primary management responsibility for the woman's care, seeks the advice/opinion of a BCH physician or another member of the health care team. The consultation will be documented in the medical record by the CNM. CNM may request or consultant may provide written consultation note by physician or health team member.
- 1.3.5. **Collaboration:** Process whereby a CNM and BCH physician jointly manage the care of a woman or newborn that has become medically, gynecologically or obstetrically complicated. The scope of collaboration may encompass the physical care of the patient, including delivery, by the CNM, according to a mutually agreed-upon plan of care. When the physician must assume a dominant role in the care of the patient due to increased risk status, the CNM may continue to participate in physical care, counseling, guidance, teaching and support. Effective communication between the CNM and physician is essential for ongoing collaborative management. The physician will document the assessment and plan of care in the medical record in a timely manner.
- 1.3.6. **Referral:** Process by which the CNM directs the patient to a BCH physician or another health care professional for management of a particular problem or aspect of the patient's care. Responsibility for decisions and orders concerning the care of a woman who is referred to physician management is assumed by the physician. CNM will document in medical record that care has been transferred to physician management. A patient who has been referred to a physician may be referred back to the CNM once the condition requiring referral has been resolved, as determined by the physician and CNM.
- 1.3.7. **Consulting physician:** Physician member of the Medical Staff, with appropriate clinical privileges, who consults, collaborates, and who assumes care for patients of medium or high risk status as outlined in practice guidelines.
- 1.3.8. **Proctoring Practitioner:** Physician/CNM member of the Medical/AHP Staff with appropriate privileges. If required, the proctoring function will not negate the role and responsibilities of the sponsoring physician.

1.4. Prescriptive Authority

- 1.4.1. CNMs, with prescriptive authority granted by the State of Colorado, will practice within state guidelines as delineated in Colorado Nurse Practice Act 12-38-111.6 CRS. CNMs who do not have prescriptive authority may prescribe medications according to the “Medically-Approved Orders for CNMs” section of these Guidelines. CNMs wishing to prescribe narcotics must obtain prescriptive authority by the State of Colorado and a Federal DEA.

1.5. Scope of Practice

- 1.5.1. The CNM is responsible for the management of patients during the antepartum, intrapartum, and postpartum periods. In addition, collaboration with the consultant physician in the co-management of selected medium risk patients may occur, if in the judgment of the physician and/or nurse-midwife this is deemed appropriate.

1.6. Quality/Peer Review

- 1.6.1. Evaluation of care provided by CNMs will be assessed through the established medical staff process.

SECTION 2. GENERAL GUIDELINES AND RISKING CRITERIA

- 2.1. The following Guidelines are meant as a framework to identify patients appropriate for nurse-midwifery care at Boulder Community Health, and not as an exhaustive and restrictive set of rules. They are intended to be amended from time to time as befits the ever-changing nature of health care. It is understood that a patient’s status may change during the antepartum, intrapartum or postpartum, and with the change of status, the care plan may also revised.

2.1.1. Low Risk Status

- a. Patient meeting generally accepted definition of “low risk” status, including but not limited to, term pregnancies, singleton, vertex presentations with uncomplicated antenatal and intrapartum courses, will be managed independently by the CNM.

2.1.2. Medium Risk Status/Consultation or Collaboration

- a. Patients with a history of more complicated antenatal courses due to medical, surgical, or obstetrical reasons may require consultation and/or collaboration. Intrapartum risk factors will necessitate consultation or collaboration, and a plan of care will be implemented that may or may not necessitate physician evaluation and/or co-management. These include, but are not limited to:

i Antepartum/Intrapartum

- i.25. PIH – mild with or without chronic hypertension
- i.26. Current history of maternal drug or alcohol addiction (excluding tobacco)
- i.27. Heart disease, without functional disabilities
- i.28. Post-term pregnancy beyond 42 weeks
- i.29. Prolonged ROM at term
- i.30. Maternal fever greater than 100.4F (38C)
- i.31. Anemia, Hct less than 27%
- i.32. Hemoglobinopathy
- i.33. Abdominal pain of unknown etiology or unresolving
- i.34. Small for gestational age (less than 10% estimated fetal weight)
- i.35. Gestational diabetes, diet controlled

- i.36. Preterm contractions without cervical change
- i.37. Abnormal ultrasound findings
- i.38. Mental impairment that interferes with patient compliance
- i.39. Current medical, surgical, or psychiatric condition
- i.40. Cholestasis pregnancy
- i.41. Fetal demise
- i.42. Renal disease without renal failure
- i.43. Induction or augmentation of labor
- i.44. Labor deviating from normal rate of progress
- i.45. 3rd stage labor lasting longer than 30 minutes, CNM to call physician
- i.46. Premature labor and/or PROM \geq 35 weeks
- i.47. Second stage > 2 hours with not epidural or > 3 hours with an epidural

ii Postpartum

- ii.1. Maternal fever > 100.4F (38C)
- ii.2. Severe anemia defined by Hct < 22 or a symptomatic patient
- ii.3. Persistent urinary retention
- ii.4. Abdominal pain unresponsive to analgesic relief
- ii.5. Mastitis

2.1.3. High Risk Status

- a. Patients in this category will require referral to physician management.

i Antepartum/Intrapartum

- i.1. Insulin-dependent diabetic
- i.2. PROM in pre-term infant < 35 weeks
- i.3. Severe pre-eclampsia/eclampsia
- i.4. Any patient requiring magnesium sulfate
- i.5. Severe IUGR (less than 3% estimated fetal weight)
- i.6. Persistent non-reassuring fetal heart rate tracing
- i.7. Biophysical profile < 6
- i.8. Unstable Placenta previa or unexplained third trimester bleeding
- i.9. Suspected abruptio placentae
- i.10. Hyperemesis gravidarum with electrolyte imbalance
- i.11. Unstable medical, surgical or psychiatric condition
- i.12. Trauma with vaginal bleeding or severe abdominal pain
- i.13. Complications resulting from isoimmunization
- i.14. DVT/thromboembolic disease
- i.15. Fetal anomalies requiring surgery (e.g. gastroschisis, NTD, cardiac defects, diaphragmatic hernia)
- i.16. Severe thrombocytopenia (platelets < 50,000)
- i.17. Premature labor < 35 weeks
- i.18. Suspected maternal sepsis
- i.19. Use of illegal drugs, other than marijuana, immediately preceding or during labor
- i.20. Multiple gestation antepartum

ii Postpartum

- ii.1. Hematoma increasing in size
- ii.2. Endometritis
- ii.3. DVT
- ii.4. Episiotomy or laceration complications

- ii.5. Suspected maternal sepsis
- ii.6. Complicated medical, surgical, or psychiatric condition
- 2.1.4. **Physician Immediately Available**
 - a. Physician will be immediately available for the following patients:
 - i Previous C-sections or Uterine Surgery
 - ii Anticipated shoulder dystocia
- 2.1.5. **Physician Notification Required**
 - a. Physicians will be notified immediately for infants with Apgars <6 at five minutes.

SECTION 3. GUIDELINES FOR MANAGEMENT OF TRIAGE AND INTRAPARTUM PATIENTS

- 3.1. **Screening** - The CNM or Labor & Delivery staff will screen triage patients. Screening will include history, vital signs, and fetal monitor tracing and physical exam as indicated. CNM will be notified of patient status and a plan of care is determined. CNM will consult, collaborate/co-manage, or refer patient to physician care when indicated. Any transfer of patients to other facilities will be according to BCH policies to ensure compliance with EMTALA guidelines.
- 3.2. **Intrapartal Management** to include admission, management and discharge of patients as outlined in CNM Core & Special Privilege delineation.
 - 3.2.1. Amniotomy
 - a. Membranes may be ruptured at the discretion of the CNM when the following criteria are met:
 - i Active labor
 - ii Vertex presentation with head at 0/-1 station or lower, well applied to cervix
 - iii Absence of bleeding, except bloody show
 - b. If the above criteria are not met, the CNM may perform amniotomy in selected circumstances, after consultation with physician. If head is not well applied to cervix, physician should be immediately available. Amniotomy may be utilized as a method of induction, after consultation with physician.
 - 3.2.2. Vacuum extraction
 - a. If credentialed, CNM may perform vacuum extraction for indication of second stage fetal non-reassuring heart rate/tones at greater than or equal to +2 station. Physician will be consulted and en-route prior to CNM proceeding with the vacuum assisted birth.

SECTION 4. MEDICALLY APPROVED MEDICATION ORDERS

THIS LIST OF MEDICATIONS IS NOT INTENDED TO BE ALL INCLUSIVE, AND SHOULD NOT BE INTERPRETED AS EXCLUDING OTHER APPROPRIATE MEDICATIONS, OR MEDICATIONS WHICH MAY BECOME AVAILABLE AFTER THE EFFECTIVE DATE OF THESE GUIDELINES.

4.1. INTRAPARTUM

- 4.1.1. Analgesics
 - a. Tylenol 325-500 mg tab 1-2 po or pr q 4-6 hours prn
 - b. Narcotics
 - ii Morphine sulfate 10-15 mg IM q 4h x 2 doses for sedation prn (C), 2-4 mg IV q 2-4 hours prn
 - iii Sublimaze (Fentanyl) per BCH Fentanyl administration protocol for L&D

- b. Narcotic agonist-antagonists
 - ii Butorphanol tartrate (Stadol) 1-2mg IV q 1-2h prn (C)
 - iii Nalbuphine (Nubain) 5-10 mg IV q 1 h prn
 - c. Naloxone
 - ii Neonatal
 - iii Maternal
 - d. ***If maternal respiratory rate is 6-8/min. after narcotics and/or oxygen saturation is <92%, give Nubain 5-10 mg slow IV push. If respiratory rate is <5/min., give Naloxone 0.2mg (1/2 ampule) IV push, administer oxygen, arouse patient, and call MD.***
- 4.1.2. Sedatives
- a. Ambien 5-10 mg for sleep or prodromal labor (B)
 - b. Promethazine (Phenergan) 25mg IM or IV q 3-4h prn (C)
 - c. Hydroxyzine (Vistaril) 25-100 mg IM q 3-4 h prn (C)
- 4.1.3. ANTACIDS/H2 blockers/Proton Pump Inhibitors as indicated
- a. Aluminum and magnesium hydroxide (Maalox, Mylanta, Gelusil) 10-45 ml or 1-4 tab po prn
 - b. Calcium carbonate (Tums)
 - c. Cimetidine (Tagamet) 400 mg po bid or 400-800mg po q hs
 - d. Zantac 150mg po daily-bid, or 300mg po q hs
 - e. Pepcid 20mg q daily
- 4.1.4. Antibiotics as indicated
- 4.1.5. Antiemetics as indicated
- 4.1.6. Enema as indicated
- 4.1.7. Rhogam if indicated
- 4.1.8. IV fluids as indicated
- 4.1.9. Oxytocin
- a. per protocol for induction of labor - 3rd stage 10 units IM or 20-30 units in IV fluids
- 4.1.10. Methyergonovine 0.2mg **IM**; Methyergonovine 0.2mg **PO**
- 4.1.11. Carboprost (Hemabate) -250mcg IM
- 4.1.12. Misoprostol
- a. per protocol for induction of labor - for postpartum hemorrhage 600-800mcg po or up to 1000mcg pr
- 4.1.13. Lidocaine 1% for local or pudendal anesthesia
- 4.1.14. Lidocaine 2% jelly
- 4.1.15. Prostaglandin induction agents
- a. per protocol (prostaglandin gel, Cytotec “Misoprostol”, Cervidil)
- 4.1.16. Terbutaline 0.25mg IV or sq
- 4.1.17.
- 4.2. **POSTPARTUM**
- 4.2.1. Analgesics
- a. Anaprox 275mg po q 6-8h prn
 - b. Ibuprofen 200mg po q 4h prn
 - c. Ibuprofen 600-800mg po q 6-8h prn
 - d. Toradol 60mg IM x1, then 30mg IM q 8h or 30mg IV x 1
 - e. Tylenol 325-500mg 1-2 tabs po q 4-6 h prn
 - f. Narcotics

- ii Darvocet (propoxyphene and acetaminophen) 100mg po q 4h prn
 - iii Meperidine hydrochloride 25-100mg IM q 3-4h prn
 - iv Hydrocodone 1-2 tabs q 3-4h prn
 - v Percocet (oxycodone 5mg and acetaminophen 325mg) 1-2 tab po q 6h prn
 - vi Tylenol #2 (codeine 15mg) 1-2 tab po q 4h prn
 - vii Tylenol #3 (codeine 30mg) 1-2 tab po q 4h prn
 - viii Tylox (oxycodone 5mg and acetaminophen 500mg) 1 tab po q 6h prn
 - ix Vicodin (hydrocodone 5mg and acetaminophen 500mg) 1-2 tabs po q 4-6h prn
 - x Fentanyl per protocol
- g. SAMS Kits 1, 2, 3, or 4
- a. ***If respiratory rate is 6-8 per minute after narcotics and/or oxygen saturation is <92%, give Nubain 5-10mg slow IV push. If respiratory rate is less than 5/min., give Naloxone 0.2mg (1/2 ampule) IV push, administer oxygen, arouse patient, and call Obstetrician.***
- 4.2.2. Oxytocin 10 units IM or 20-30 units in IV fluids
 - 4.2.3. Methergine 0.2mg po q4h x 6 doses, 0.2mg IM
 - 4.2.4. Antibiotics as indicated
 - 4.2.5. Antiemetics as indicated
 - 4.2.6. Anhydrous lanolin to nipples
 - 4.2.7. Rubella vaccine
 - 4.2.8. Calcium 500mg po bid for nursing mother
 - 4.2.9. Prenatal vitamins
 - 4.2.10. Irons supplements
 - 4.2.11. Rhogam as indicated
 - 4.2.12. Mylicon 80mg ac & hs or Mylicon SAMS
 - 4.2.13. Depoprovera 150mg IM
 - 4.2.14. Sedatives
 - a. Ambien 5-10 mg po hs (B)
 - b. Temazepam (Restoril) 15-30mg po hs (X)
 - 4.2.15. Stool softener of choice
 - 4.2.16. Antacids
 - 4.2.17. Perineal care preparations
 - a. Tucks, magnesium sulfate soaks
 - b. Anusol HC
 - c. Corticaine crème, or
 - d. other antihemorrhoidal agents
 - 4.2.18. Topical anesthetic spray or cream
 - 4.2.19. Antitussives/expectorants including those with codein or Phenergan
 - 4.2.20. Sudafed 30-60mg po q 4-6h prn
 - a. Actifed 1 po q 4-6h prn
 - b. Chlortrimeton 4mg po q 4-6h prn
 - 4.2.21. Sudafed 30-60mg po q 4-6h prn
 - 4.2.22. Benadryl 25-50mg IV, IM, po q 4-6h prn

4.3. **OTHER**

- 4.3.1. Topical treatments for lice and scabies
- 4.3.2. Topical treatments for vaginitis

SECTION 5. REFERENCES

- 5.1. American College of Nurse Midwives (ACNM) Philosophy and Code of Ethics (2004)
- 5.2. ACNM Standards for the Practice of Midwifery (August 1997)
- 5.3. Joint Statement of Practice Relations Between Obstetrician-Gynecologists and Certified Nurse-Midwives/Certified Midwives (2002)
- 5.4. Medical Staff – Allied Health Professional’s Manual

Approved: OB/GYN Committee: 2/99
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