



**CERTIFIED NURSE MIDWIFERY (CNM)
PRACTICE GUIDELINES**



CNM PRACTICE GUIDELINES

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SECTION 1. INTRODUCTION

- **The Practice of Nurse-Midwifery**

- 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 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 an 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..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.

- **Legal Basis for CNM Practice in Colorado**

- 1..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) (1) “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)

- **Definitions**

- 1..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..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. **Nurse-midwifery Management:** The responsibility for decisions and orders concerning care of the patient meeting low risk criteria is 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. Seeks obstetrical consultation when deviations from normal develop which are not covered by practice guidelines.
- c. Obtains mutual agreement with the obstetrician/gynecologist to collaboratively manage the care of the woman who has developed medical or obstetric complications
- d. Refers 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..4. **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..5. **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.

- **Prescriptive Authority**

- 1..6. 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.

- **Scope of Practice**

- 1..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..2. Nurse midwives are members of a collaborative team comprised of physicians, nurses, pharmacists, social workers, nutritionists, lactation specialists, support staff, and administrators from BCH. Together, care is provided for women of childbearing age, as well as for adolescents and women across the life span. Care is rendered in both the ambulatory and inpatient settings.

- **Quality/Peer Review**

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

Section 2: TYPES OF MANAGEMENT

CNMs engage in the independent management of women's health care, focusing particularly on pregnancy, childbirth, the postpartum period, and well-woman health needs with emphasis on gynecologic and common health problems. Women that enter into care from certified nurse midwife practices are healthy and are generally considered low to low-moderate risk.

- **Consultation**

2.1 Consultation is a process whereby the CNM seeks the advice or opinion of the attending provider. With consultation, the CNM maintains primary management responsibility for the woman's care. Consultation may be informal, single-visit, continuing collaborative care with consultation, continuing care with management, or transfer of primary clinical responsibility.

Formal Consultation involves examination of the patient or the patient's record and performance of diagnostic tests or therapeutic procedures (eg. Medical complications, preeclampsia, etc.). The finding, procedures, and recommendations of the consultant are recorded in the patient's medical report or letter. The care of the patient after the consultation continues to be provided by the referring nurse-midwife. Following the consultation, the consultant and referring CNM will communicate and jointly decide whether the single consultation is sufficient or continued ongoing collaborative care or transfer of care are indicated. Recommendation for transfer of care may be made by the consulting provider.

Collaborative Management
Collaborative management involves jointly managing the patients care. The goal of collaboration is to share authority while providing quality care within each individual's professional scope of practice. During the course of providing care, the CNM consults with the physician (or other appropriate health care professional), when problems that require collaboration arise. Collaborative management occurs in one of two ways: collaborative care with consultation or collaborative care with management.

- **Collaborative Care with Consultation**

2.2 Collaborative Care with consultation occurs if a health condition requires frequent and/or continuing management by a physician or other health professional, but certain aspects of care remain within the scope of CNM management. Under collaborative management, a patient may be followed by both the physician and the CNM, however the CNM retains primary management responsibility for the woman's care. When continuing collaborative care with consultation, the referring CNM is responsible for writing orders and managing care of the patient. The consultant provides ongoing consultation in conjunction with the managing CNM. The consultant periodically assesses the patient and communicates with the CNM. This level of consultation may occur at the time of admission and initial consultation or may result from transfer of the patient from continuing collaborative care with management. During the course of care, the two services may decide that continuing collaborative care is no longer necessary.

- **Continuing Collaborative Care with Management**

2.3 Continuing collaborative care with management involves consultation with the physician when primary management by the physician is needed (e.g. Preterm labor .34 0/7 weeks, Cesarean birth, etc.). The physician consultant assumes primary responsibility to write all orders and manage the patient, as indicated. The referring CNM is expected to be involved in daily management and to participate in the delivery and assume care, as appropriate. The extent of participation of the referring

CNM in the delivery is determined by the consulting physician, the degree of difficulty of the delivery, and the education and experience of the CNM. The physician consultant actively communicates with the referring CNM regarding the management plan.

- **Referral for Physician Management**

2.4 When a patient in the care of a CNM develops a condition that requires complete management by the physician, care is transferred to the physician. The CNM completely transfers all medical aspects of health care of the patient to the physician. The CNM retains the right to refer the patient to the physician and is responsible for doing so if the status of the woman becomes complicated as outlined in the practice guidelines. Such transfer of responsibility should be noted in the patient's health care record and formal communication completed.

When a referral is initiated the CNM continues rounds as a way of providing continuity of care for patients who will usually be transferred back to the CNM once the medical situation is resolved.

Emergency Management

The CNM utilized emergency procedures for women and newborns requiring immediate assistance. Practice guidelines for nurse midwifery care are utilized while medical assistance and/or consultation is sought.

Section 3 GENERAL GUIDELINES AND RISKING CRITERIA

CNMs are encouraged to seek provider consultation for the following risk factors which may prompt consideration for referral.

3.1 Antepartum:

- Anatomic uterine abnormalities/surgery to correct abnormality
- Anemia unresponsive to treatment
- Autoimmune disease (lupus, rheumatoid arthritis, sjogrens)
- Bariatric surgery
- Cerclage in current or previous pregnancy
- Chronic hypertension
- Congenital fetal anomaly
- Diabetes (poorly controlled, A2GDM, insulin dependent)
- Female genital mutilation (impending vaginal delivery)
- History of cancer
- History of IUFD
- History of IUGR
- History of preterm birth
- History of severe preeclampsia/HELLP
- Hyperemesis gravidarum-unresponsive to first line treatment
- Hyperthyroidism
- Infectious disease (hepatitis, syphilis, HIV)
- In vitro fertilization

Iso immunization/maternal alloantibodies
Intrauterine growth restriction
Maternal chronic conditions (multiple sclerosis, diabetes, cardiac disease, hypertension, seizures)
Maternal genetic disease
Mood disorder (unstable)
Multiple gestation
Prior cesarean section x 2 desiring trial of labor
Recurrent pregnancy loss
Selective reduction in current pregnancy
Spinal cord injury
Thromboembolic phenomenon (history of DVT, RE, antiphospholipid antibody syndrome)
Thrombophilia
Unresolved size/date discrepancy
Women opposed to or refusing CNM/OB collaborative practice model
Refusal of required antenatal testing

3.2 Intrapartum

Active vaginal bleeding
Congenital fetal anomaly
Fetal intolerance of labor
Fever unresponsive to treatment
Diabetes (poorly controlled A2DM and insulin dependent)
Infectious disease (hepatitis, syphilis, HIV infection, herpes outbreak at term)
Intrauterine growth restriction
Malpresentation at term (other than posterior)
Unstable mood disorder
Multiple gestation
Maternal cardia, gastrointestinal, pulmonary, endocrine, dermatologic, or renal disease (significant)
Placenta previa
Placental abruption
PPROM < 36 weeks
Preeclampsia
Preterm labor (documented cervical change prior to 36 weeks gestation)
Prolonged labor and/or significant abnormal descent patterns requiring surgical intervention
Refusal of blood products
Refusal for IV access if indicated
Shoulder dystocia unresolved with standard intervention
Trial of labor after cesarean section
Thromboembolic phenomenon (Including history of DVT, PE, antiphospholipid antibody syndrome)
Uterine rupture
History of uterine surgery (including previous Cesarean for recurrent condition or unknown scar).

3.3 Postpartum

Mastitis (unresolved in 48 hours)
Unstable mood disorder
Postpartum hemorrhage unresponsive to 1st line treatment
Retained placenta

3.4 Gynecologic

Abnormal cytology requiring colposcopy
Breast pathology
Cervicitis or vaginitis, unresponsive to treatment
Dysmenorrhea unresponsive to treatment in 4 – 6 cycles
Pelvic inflammatory infection requiring hospitalization
Pelvic mass
Unexplained vaginal bleeding unresponsive to treatment.

Section 4: GUIDELINES FOR MANAGEMENT OF TRIAGE AND INTRAPARTUM PATIENTS

4.1 Screening - The CNM or Labor & Delivery nursing staff screen triage patients. Screening includes history, vital signs, fetal well-being, and physical exam as indicated. CNM is notified of patient status and a plan of care is determined. CNM consults, collaborates/co-manages, or refers patient to physician care when indicated. Any transfer of patients to other facilities is done according to BCH policies to ensure compliance with EMTALA guidelines.

4.2 Intrapartal Management to include admission, management and discharge of patients as outlined in CNM Core & Special Privilege delineation.

4.3 Amniotomy

Membranes may be ruptured at the discretion of the CNM when the following criteria are met:

Active labor

Vertex presentation with head at 0/-1 station or lower, well applied to cervix

Absence of bleeding, except bloody show

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.

Approved: OB/GYN Committee: 2/99
Women & Family Services Committee: 11/02, 7/13, 11/2017 (rewrite)
Credentials Committee: 11/02, 7/13, 11/2017
Medical Executive Committee: 2/99, 11/02, 1/12, 7/13, 11/2017 (rewrite)
Board: 2/99, 11/02, 2/12, 11/2017 (rewrite)

Revised: 5/99, 11/02, 10/05, 06/07, 10/08, 5/09, 5/12, 7/13, 11/2017 (rewrite)

Reference

University of Colorado Denver, College of Nursing (2016), Nurse Midwifery Faculty Practice Guidelines