

Tennessee Midwives Association Practice Guidelines

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 the **Tennessee Midwives Association (TMA) Practice Guidelines** and **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 their consulting physicians.

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. It includes information including, but not limited to:

- A. a description of the Midwife's education, training, and experience level in midwifery, continuing education, participation in peer review, and grievance process;
- B. the Midwife's philosophy of practice;
- C. antepartum, intrapartum, and postpartum conditions requiring consult, transfer of care and transport to a hospital;
- D. a plan for a physician consult/collaboration plan;
- E. the services provided to the client by the Midwife;
- F. the Midwife's current legal status;
- G. treatments and procedures, possible alternative procedures and treatments, risks and expected benefits of home birth;
- H. documentation of any refusal by the client of any procedure required by law;
- I. the client's and Midwife's signatures and date of signing.

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.

III. Practice Protocols

Practice protocols based on *TMA 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/his own equipment to birth setting;
- C. promptly respond to the client's needs;

V. Prenatal Care

During prenatal care, the client may be seen by the Midwife or other appropriate health care provider monthly until 32 weeks, every 2-3 weeks from 32 weeks to 37 weeks, and weekly after 37 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 Tests. The client will be offered the following laboratory tests to include but not limited to:
 - a. hemoglobin and/or hematocrit or CBC;
 - b. gross urinalysis for protein and glucose;
 - c. blood group, Rh type, and antibody screen;
 - d. syphilis serology, pursuant to TCA 68-5-602;
 - e. hepatitis B surface antigen, pursuant to TCA 68-5-602;
 - f. rubella screen, pursuant to TCA 68-5-602;
 - g. genetic screening tests;
 - h. gonorrhea test, if at risk;
 - i. chlamydia test, if at risk;
 - j. HIV test, pursuant to TCA 68-5-703.

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 Tests. The client will be offered the following laboratory tests to include but not limited to:
 - a. hemoglobin, hematocrit, or CBC between 28 and 32 weeks;
 - b. gross urinalysis for protein and glucose at each visit;
 - c. Glucose Tolerance Test (GTT), if indicated;
 - d. Group B strep (GBS) culture, pursuant to TCA 68-5-401;
 - e. Herpes (HSV 1 and/or HSV 2) cultures(s), if indicated;
 - f. HIV after 28 weeks, pursuant to TCA 68-5-703.
6. Prophylactic Rhogam information for Rh negative clients, as indicated.

VI. Intrapartum Care

During active labor, the Midwife shall monitor and support the natural 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: at least once every hour, or as indicated;
 2. 2nd Stage of labor: at least every 10 minutes, or as indicated;
- B. assess & monitor maternal well-being. While in attendance, assess vital signs at least every 4 hours, or as indicated;
- C. monitor the progress of labor;
- D. monitor membrane status for rupture, relative fluid volume, odor, and color of amniotic fluid;
- E. assist in birth of baby;
- F. inspection of placenta and membranes;
- G. manage any problems in accordance with the guidelines cited elsewhere in this document;
- H. 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 technique;
- I. assess cervical dilatation, effacement, station, and position during each exam and document in client's chart.

VII. Postpartal 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 Postpartal 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, or refer for repair, as indicated;
8. Facilitation of maternal-infant bonding and family adjustment;
9. Concerns of the mother.

B. On-going Postpartal 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 and initial assessment;
2. Respond to the need for newborn resuscitation;
3. APGAR scores at 1 and 5 minutes, and at 10 minutes when indicated.

B. Newborn Physical Exam

1. Weight and measurements;
2. Temperature;
3. Feeding;
4. Bowel/bladder function;
5. Reflexes;
6. Physical deviations from normal;
7. Clamping and cutting of umbilical cord;
8. Eye prophylaxis, pursuant to TCA 68-5-202;
9. Administration of vitamin K, orally or intramuscularly;
10. Concerns of the family.

C. Ongoing Newborn Care

1. Vital signs, as appropriate;
2. Tone/Reflexes;
3. Feeding;
4. Bowel/bladder function;
5. Color;
6. Weight gain;
7. Perform or refer for newborn metabolic screening pursuant to TCA 68-5-401;
8. Refer for newborn hearing screening, pursuant to TCA 68-5-904;
9. Concerns of the family.

IX. Physician Collaboration, Consultation, and Referral

A collaborative care plan is an agreement between the Midwife and a physician. Midwives collaborate with other care professionals to ensure their clients receive the best possible care when the needs of the client exceed the scope of practice of the midwife. Collaborative care involves the cooperation of various professionals in the provision of care. If care is transferred to a physician, the midwife is expected to continue providing supportive care after care transfer and will resume primary care if appropriate. Collaboration with other health care providers occurs with informed client choice.

Low risk refers to a pregnancy that is anticipated to be problem free. This assessment is based on a woman's past medical history, past gynecological/obstetrical history, and any other relevant issues as the pregnancy continues.

The Midwife shall consult with a physician whenever there are significant deviations from normal 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, if possible. The following conditions require physician consultation and **may** require physician referral and/or transfer of care.

- 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 group B strep disease;
 13. previous Cesarean section with classical incision;
 14. three or more previous Cesarean sections;
 15. previous Cesarean section within one year of current EDD;
 16. current alcoholism or abuse;
 17. current drug addiction or abuse;
 18. current severe psychiatric illness;
 19. isoimmunization;
 20. positive for HIV antibody.
- B. Prenatal Conditions include but are not limited to:
1. labor before the 37th week of gestation;
 2. lie other than vertex at term;
 3. multiple gestations;
 4. significant vaginal bleeding;
 5. gestational hypertension;
 6. gestational diabetes mellitus, uncontrolled by diet;
 7. severe anemia, not responsive to treatment;
 8. evidence of pre-eclampsia;
 9. consistent size/dates discrepancy;
 10. deep vein thrombosis (DVT);
 11. known fetal anomalies or conditions affected by site of birth, with an infant compatible with life;
 12. threatened or spontaneous abortion after 12 weeks;
 13. abnormal ultrasound findings;
 14. isoimmunization;
 15. documented placental anomaly or previa;
 16. documented low-lying placenta in woman with history of Cesarean section;
 17. postdates pregnancy (>42 weeks);
 18. positive HIV antibody test.
- C. Intrapartal Conditions ***It should be noted that because of time urgency during certain intrapartal situations, it may be necessary to institute emergency interventions while waiting for physician consultation.*** These conditions include but are not limited to:
1. persistent and/or severe 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. transverse lie;
 7. primary genital herpes outbreak;
 8. prolapsed cord;
 9. client's desire for pain medication.
- D. Postpartum Conditions ***It should be noted that because of time urgency during certain postpartal 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.

- E. Neonatal Conditions ***It should be noted that because of time urgency during certain postpartal 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 (5 pounds, 2 ounces);
 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

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 Medications by a Midwife shall include:

- A. Rh Immune Globulin;
- B. Oxygen;
- C. Pitocin_x, Methergine_x, and Cytotec, postpartally (as described under section **XI. Emergency Care**, below);
- D. Local anesthetic for perineal repair;
- E. Prophylactic ophthalmic medication for newborn;
- F. Vitamin K, orally or intramuscularly, for newborn;
- G. Other medications, as prescribed.

XI. Emergency Care

The following procedures may be performed by the Midwife ***only in an emergency situation in which the health and safety of the mother 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;
- C. Episiotomy;
- E. Administration of Pitocin_x, Methergine, and/or Cytotec to control postpartum bleeding;
- F. Manual exploration of the uterus for placenta to control severe bleeding.

XII. Prohibitions in the Practice of Midwifery

- A. The Midwife shall not administer Cytotec or oxytocics, such as Pitocin and Methergine, except for postpartum administration as indicated.
- B. The Midwife shall not use forceps and/or vacuum extraction to assist the birth of the baby.
- C. 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/labial repair;
 4. clamping and cutting of the newborn's umbilical cord.