PRACTICE GUIDELINES

I. Disclosure requirements.
A midwife shall provide written disclosures to any client seeking midwifery care. The midwife shall review each disclosure item and obtain the client's signature as evidence that the disclosures have been received and explained. Such disclosures shall include:

A. A description of the midwife's qualifications, experience, and training;
B. A written protocol for medical emergencies, including hospital transport, particular to each client;
C. A statement as to whether the midwife has hospital privileges;
D. A statement that a midwife is prohibited from prescribing, possessing or administering controlled substances;
E. A description of the midwives' model of care;
F. A copy of the regulations governing the practice of midwifery;
G. A statement as to whether the midwife carries malpractice or liability insurance coverage, and if so, the extent of that coverage;
H. An explanation of the Virginia Birth-Related Neurological Injury Compensation Fund and a statement that licensed midwives are currently not covered by the Fund; and
I. A description of the right to file a complaint with the Board of Medicine and with NARM and the procedures and contact information for filing such complaint.

II. Confidentiality.
A midwife shall not willfully or negligently breach the confidentiality between a practitioner and a client. A breach of confidentiality that is required or permitted by applicable law or beyond the control of the practitioner shall not be considered negligent or willful.

III. Client records.

A. Practitioners shall maintain the confidentiality and disclosure of client records.
B. Practitioners shall provide client records to another practitioner or to the client or his personal representative in a timely manner.
C. Practitioners shall properly manage client records and shall maintain timely, accurate, legible and complete client records. Practitioners shall clearly document objective findings, decisions and professional actions based on continuous assessment for on-going midwifery care.
D. A midwife shall document a client's decisions regarding choices for care, including informed consent or refusal of care. Practitioners shall clearly document when a client's decisions or choices are in conflict with the professional judgment and legal scope of practice of the midwife.

IV. Practitioner-client communication; termination of relationship.

A. Communication with clients.
    1. Midwife shall accurately inform a client or her legally authorized representative of the client's assessment and prescribed plan of care. A midwife shall not

deliberately make a false or misleading statement regarding the practitioner's skill or the value of a treatment or procedure directed by the practitioner.

2. A midwife shall present information relating to the client's care to a client or her legally authorized representative in understandable terms and encourage participation in the decisions regarding the client's care.

B. Termination of the midwife/client relationship.

1. The midwife or the client may terminate the relationship. In either case, the practitioner shall make a copy of the client record available, except in situations where denial of access is allowed by law.
2. A midwife shall not terminate the relationship or make her services unavailable without documented notice to the client that allows for a reasonable time to obtain the services of another practitioner.

V. Midwife's responsibility

A. A midwife shall

1. Transfer care immediately in critical situations that are deemed to be unsafe to a client or infant and remain with the client until the transfer is complete
2. Work collaboratively with other health professionals and refer a client or an infant to appropriate health care professionals when either needs care outside the midwife's scope of practice or expertise; and
3. Base choices of interventions on empirical and/or research evidence that would indicate the probable benefits outweigh the risks.

B. A midwife shall not:

1. Perform procedures or techniques that are outside the scope of his practice or for which he is not trained and individually competent.

VI. Vitamins, minerals and food supplements.

A. The recommendation or direction for the use of vitamins, minerals or food supplements and the rationale for that recommendation shall be documented by the practitioner. The recommendation or direction shall be based upon a reasonable expectation that such use will result in a favorable client outcome, including preventive practices, and that a greater benefit will be achieved than that which can be expected without such use.

B. Vitamins, minerals, or food supplements, or a combination of the three, shall not be sold, dispensed, recommended, prescribed, or suggested in doses that would be contraindicated based on the individual client's overall medical condition and medications.

VII. Prenatal Care

Upon mutual agreement, client will have regular visits of once a month until 32 weeks, bi-weekly from 32-38 weeks, weekly from 38-41 weeks, and more often as indicated till 42 weeks. The responsibilities of the Midwife shall include but not be 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: height; weight; blood pressure and pulse; temperature; breasts, to include teaching on self exam (may be deferred); abdomen, to include fundal height, fetal heart tones, fetal lie and presentation; estimation of gestational age by physical findings; 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) Prenatal Profile to include: CBC with Differentials, Blood Grouping & Rh Typing; Antibody Screen; Hepatitis B, Syphillis, and Rubella Screenings.
    b) Genetic screening tests, including an Maternal Serum & Tetra Screen, NIPT, if indicated
    c) Gonorrhea and Chlamydia Screening
    d) HIV
    e) Hepatitis C
    f) Hemoglobin A1C
    g) Vitamin D25 Hydroxy
    h) Semi-Quantitative SARS-CoV-2 Antibody Testing

B. On-going Prenatal Care
1. Assessment of general health, including social and emotional well-being
2. Exercise/Activity and Optimal Nutritional counseling.
3. Review of supplementation, OTC, and prescribed medications.
4. Physical Exam to include, but not limited to: blood pressure; pulse; temperature; weight; urinalysis of protein & glucose; abdomen, to include fundal height, fetal heart tones, fetal lie and presentation; estimation of gestational age by physical findings; assessment of varicosities, edema and reflexes.
5. Laboratory Tests and Procedures; The client will be offered access to the following laboratory tests to include but not limited to:
    a) Glucose Tolerance Test (GTT) between 24-28 weeks;
    b) Hemoglobin, repeated at 24-28 weeks and 36 weeks, and as clinically suggested/recommended;
    c) Group Beta Strep (GBS) culture(s), informed consent given at 32 weeks, testing performed at 36 weeks with consent;
    d) Prophylactic RhoGam informed consent given to all Rh- clients after initial lab results received and reviewed. Plan for RhoGam administration reviewed and charted with client by 28 weeks.

VIII. Intrapartum Care

During 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. Upon labor admission. While in attendance, assess fetal heart tones.
    1. 1st Stage of labor: While in attendance during active labor once every hour, or as indicated.
    2. 2nd Stage of labor: every 10-15 minutes, or as indicated;
B. Assess & monitor maternal well-being. Upon labor admission. While in attendance, assess vital signs 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. 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;
    1. Assess cervical dilatation, effacement, station, and position during each vaginal exam
H. Documentation of all stages of labor and birth of baby charted in client's EHR.

lX. 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: Bleeding/lochia and EBL; Vital signs; Abdomen, including fundal height and firmness; Bowel/bladder function; Perineal exam and assessment and repair if indicated and with consent;
    2. Facilitation of maternal-infant bonding and family adjustment.
    3. Overall infant well-being: APGARs at 1-5-10 minute marks; vital signs; extended newborn examination; bowel/bladder function; nursing support and evaluation.
    4. Review of all postpartum care instructions for mother and baby.
    5. Breastfeeding/other concerns of the mother.
B. 24-48 hour In-Home Postpartum Care
    1. Overall maternal well-being: Bleeding/lochia and EBL; Vital signs; Abdomen, including fundal height and firmness; Bowel/bladder function; assess perineal/vaginal area for concerns/healing; review supplementation and nutrition.
    2. Overall infant well-being: vital signs; extended newborn examination; bowel/bladder function; nursing support and evaluation;
    3. Newborn Metabolic Screen performed with consent
    4. Critical Congenital Heart Defect Screen performed with consent
    5. Nursing/other concerns of the mother.
    6. Review of all birth certificate and state forms from VISITS
    7. Labor/Birth/Immediate Postpartum charting and documentation reviewed

C. In-Home Postpartum Care from 48 hours to 2 weeks
   1. Visits scheduled for 3-5 days and 7-14 days postpartum
   2. Overall maternal well-being: Bleeding/lochia and EBL; Vital signs; Abdomen, including fundal height and firmness; Bowel/bladder function; assess perineal/ vaginal area for concerns/healing; review supplementation and nutrition.
   3. Overall infant well-being: vital signs; extended newborn examination; bowel/ bladder function; nursing support and evaluation;
   4. Nursing/other concerns of the mother.
   5. Complete birth certificate filing or review status of paperwork
   6. Newborn Hearing Screen

D. Ongoing Postpartum Care from 2-6 weeks
   1. Additional on-going postpartum care available as needed may be scheduled at the home or office.
   2. Weekly text or phone check-ins to assess overall well-being of mother and baby.
   3. 6 week office postpartum appointment scheduled

X. 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. APGARs at the 1-5-10 minute marks
   2. Overall newborn well-being: vital signs; color; tone/reflexes; temperature;
   3. Feeding;
   4. Bowel/bladder function;
   5. Delayed clamping/cutting of umbilical cord;
   6. SPO2%
   7. Extended newborn physical exam, including weight and measurements;
   8. Review postpartum care instructions for baby and address concerns of the family.

B. Ongoing Newborn Care
   1. Overall newborn well-being: vital signs; color; tone/reflexes; temperature;
   2. Feeding;
   3. Bowel/bladder function;
   4. Newborn Metabolic Screen performed with consent
   5. Critical Congenital Heart Defect Screen performed with consent
   6. Newborn Hearing Screen;
   7. Nursing/other concerns of the mother.

XI. Physician consultation and Referral

The Midwife may consult with a physician whenever there are significant deviations (including abnormal laboratory results), during a client's pregnancy and birth, and/or with the newborn. If a referral to a physician is needed, the Midwife may 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. Type 1 or 2 diabetes mellitus;
    12. previous Cesarean section with classical incision;
    13. three or more previous Cesarean sections;
    14. current alcoholism or abuse;
    15. current drug addiction or abuse;
    16. current severe psychiatric illness;
    17. positive for HIV antibody.

B. Prenatal Conditions include but are not limited to:
    1. labor before the completion of 36 weeks (after reevaluation of dates)
    2. significant vaginal bleeding;
    3. Gestational Diabetes Mellitus, uncontrolled by diet & lifestyle;
    4. severe anemia, not responsive to treatment;
    5. evidence of pre-eclampsia;
    6. consistent size/dates discrepancy;
    7. deep vein thrombosis (DVT);
    8. known fetal anomalies or conditions affected by site of birth, with an infant compatible with life;
    9. spontaneous abortion or stillbirth after 12 weeks;
    10. abnormal ultrasound findings;
    11. Fetal malpresentations;
    12. Multiples;
    13. isoimmunization;
    14. documented placental anomaly or previa;
    15. documented low-lying placenta in woman with history of Cesarean section;
    16. post-maturity pregnancy after reevaluation of dates (>42 completed weeks)

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 and/or transport to medical facility. 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. Breech or transverse lie;
7. primary genital herpes outbreak;
8. prolapsed cord;
9. client's desire to transport

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 and/or transport to medical facility. 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) greater than 2nd degree;
   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 5 at five minutes of age, without significant improvement at 10 minutes or continued neonatal distress;
   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.

XII. 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 Neonatal Resuscitation of the newborn with a bag and mask;
B. Administration of oxygen; in states other than the Commonwealth of Virginia.

XIV. Prohibitions in the Practice of Midwifery

A. Medications. The Midwife shall not administer any prescribed medications or injections of any kind.
B. Surgical Procedures. The Midwife shall not perform any operative procedures or surgical repairs other than:
    1. artificial rupture of membranes (AROM);
    2. clamping and cutting of the newborn's umbilical cord.
    3. emergency episiotomy
    4. repair of laceration.
C. Instrumental Delivery. The Midwife shall not use forceps and/or vacuum extraction to assist the birth of the baby.