

## **Department of Health Practice Guidelines for New Mexico Licensed Midwives**

### **PRACTICE GUIDELINES**

The New Mexico Department of Health (NMDOH) recognizes that each midwife is an individual with specific practice protocols that reflect the midwife's own style and philosophy, level of experience, and legal status, and that practice protocols may vary with each midwife. The NMDOH does not set protocols for all Licensed Midwives (LMs) to follow but requires that they adopt and formally abide by the guidelines set forth in this document and elaborate their own practice protocols in written form as a supplement to these guidelines.

Practice guidelines are the specific protocols of practice followed by a midwife, and they should reflect the Midwives Model of Care™ ((c)1996-2018, Midwifery Task Force, Inc., All Rights Reserved.) Standards, values, and ethics are more general than practice guidelines, and they reflect the philosophy of the midwife. Practice guidelines must align with the rules and regulations governing the practice of licensed midwifery in New Mexico (NMAC 16.11.3). The NMDOH recommends that the midwife base the practice guidelines on documents such as:

- The Midwives Alliance of North America (MANA) Standards and Qualifications for the Art and Practice of Midwifery;
- The MANA Statement of Values and Ethics;
- The MANA Core Competencies;
- Midwives Model of Care©;
- NACPM Essential Documents;
- American College of Nurse-Midwives (ACNM) Standards for the Practice of Nurse-Midwifery;
- ACNM Core Competencies for Basic Midwifery Practice; and
- ACNM Code of Ethics for Certified-Nurse Midwives.
- International Confederation of Midwives (ICM) Essential Competencies for Midwifery Practice

### **NEW MEXICO LICENSED MIDWIVES SCOPE OF PRACTICE**

Providers who are licensed by the state of New Mexico as LMs are independent practitioners who provide antepartum, intrapartum, postpartum, and newborn care, as well as reproductive healthcare. LMs practice both the art and science of midwifery in caring for families who want a midwifery model for their care. LMs offer holistic care that encompasses the needs of the client, including the specific needs of the adolescent, antepartum, intrapartum, postpartum, and peri- and post-menopausal people. LMs provide holistic client- and family-centered care and attend their clients in all community birth settings.

LMs perform skills and procedures necessary to provide safe care for clients. These skills and procedures are defined by the North American Registry of Midwives (NARM), MANA, ICM, and the NMDOH.

LMs follow evidence-based standards of care that are rooted in a midwifery model of normal physiologic pregnancy, birth, and postpartum. Standards of care evolve based on changing community standards, national and international principles, new research, and recommendations

by experts in the field. As independent practitioners, LMs work in collaboration with the entire health care network to provide care for clients, including, but not limited to, ordering lab work, ultrasounds, non-stress tests, biophysical profiles, newborn screenings, obtaining consultation for medication and follow-up care for clients and their infants, and insurance billing. LMs use appropriate resources for referrals to meet psychosocial, medical, economic, cultural, or family needs.

More specifically, the midwife's care includes:

#### A. ANTEPARTUM, INTRAPARTUM, AND POSTPARTUM CARE

1. Elicit an accurate medical history, identifying risk factors
2. Perform appropriate physical examinations
3. Perform complete pelvic examinations, including bimanual and speculum examination, collection of laboratory, specimens, and clinical pelvimetry as indicated
4. Diagnose minor conditions, such as uncomplicated upper respiratory infection, asymptomatic bacteriuria, or cystitis, and refer for treatment and/or consult
5. Identify abnormal conditions and consult with physician, CNM, or APRN (as appropriate)
6. Provide individual and group counseling and teaching
7. Provide education for clients on topics such as nutrition, childbirth, informed consent, newborn feeding, parenting skills, and child development
8. Provide confirmation of pregnancy
9. Perform routine antepartum laboratory work and order ultrasound as needed
10. Manage intrapartum and postpartum course
  - a. Evaluate labor
  - b. Confirm rupture of membranes
  - c. Perform pelvic and cervical examinations
  - d. Assess the status of the pregnant person and the fetus during labor
  - e. Perform amniotomy as needed
  - f. Catheterize as needed
  - g. Initiate intravenous therapy as needed
  - h. Administer local anesthesia as needed
  - i. Perform and repair laceration and/or episiotomy as needed
  - j. Facilitate birth of infant and placenta
  - k. Administer anti-hemorrhagic medications as needed
  - l. Utilize natural therapies as needed
  - m. Facilitate family participation and bonding
  - n. Give the client and family postpartum instructions
  - o. Provide routine follow up of client and newborn during the postpartum period
  - p. Manage common problems of the immediate postpartum period
11. Manage any complications of childbirth and transfer as needed
12. Support breastfeeding and its common problems
13. Perform final examination at completion of postpartum period
14. Provide family planning and sexual counseling
15. Provide community resources and referrals

16. In special situations, the midwife may manage, in collaboration with the appropriate care providers, care of a client who develops complications in cases that are appropriate to the skills and knowledge of the particular midwife
17. Consult and refer as appropriate to other health care professionals

## B. PEDIATRIC CARE

1. Manage care of the normal newborn up to 6 weeks
  - a. Provide routine follow-up for the newborn
  - b. Obtain an accurate history of the labor and birth
  - c. Perform physical assessment, including gestational age assessment, of the healthy newborn
  - d. Identify deviations from normal in the newborn
  - e. Obtain labs as needed
  - f. Offer routine prophylaxis for the newborn's eyes
  - g. Offer anti-hemorrhagic prophylaxis for the newborn
  - h. Offer newborn metabolic and critical congenital heart defect (CCHD) screenings and perform or refer for hearing screening
    - (a) If client consents, the midwife must fax or otherwise securely submit CCHD results and hearing screen referral to the Department of Health point person (see NMDOH website for information and forms).
    - (b) If client declines the Newborn Screen (NBS), hearing screen, or CCHD screen, the midwife must fax or otherwise securely submit the signed "Newborn Screening Test Refusal" to the Department of Health point person (see NMDOH website for information and forms).
  - i. File a birth certificate and, as requested by parents, a social security number and paternity statement as needed with Vital Records
2. Manage emergency resuscitation
3. Provide guidance and counseling to parents regarding issues such as early childcare, feeding, safety, etc.
4. Midwives will recommend consultation with a family physician, pediatrician, or other health care provider as needed; after 6 weeks of life, will recommend transfer of care to appropriate provider

## C. REPRODUCTIVE HEALTH CARE

1. Provide periodic screening, preventative, and gynecologic care
  - a. Perform physical examinations, history, and obtain appropriate lab work
  - b. Perform breast examinations, including instructions for self-examination by the client
  - c. Perform pelvic examinations and collect appropriate laboratory specimens
  - d. Diagnose and treat common gynecological problems
  - e. Educate and counsel on family planning issues and unexpected pregnancy
  - f. Fit diaphragms as trained, per "Mechanism for Expansion of Practice"; note diaphragms are not part of the formulary, and a prescription is needed to obtain one
  - g. Consult or refer for abnormal conditions that arise

- h. Develop a comprehensive plan of care on issues such as nutrition, exercise, family violence, relaxation, emotional health, and spiritual health
  - i. Implement treatment for client and for other family members or sexual partners as appropriate
  - j. Provide needed counseling and/or teaching
2. Consult and refer as necessary to other health care professionals

## **MIDWIFE AND CLIENT RIGHTS AND RESPONSIBILITIES**

A birth at home or in a birth center setting requires a high level of self-awareness, respect, and responsibility on the part of the client, the client's family and/or support system, and the midwife. Clients and midwives also have rights in the hospital care system.

### **A. CLIENT RIGHTS**

An ethical midwife will respect the personal rights of the midwife's clients, including the right to:

- 1. Be treated with respect, dignity, and without prejudice;
- 2. Receive informed consent concerning care and access to relevant information upon which to base decisions;
- 3. Be free from coercion in decision-making;
- 4. Accept or decline treatment recommendations;
- 5. Receive full disclosure of the costs of care;
- 6. Know who will participate in the client's care and choose among resources for additional consultation as needed;
- 7. Not be abandoned, neglected, or discharged from care without an opportunity to find other care or have appropriate closure;
- 8. Maintain privacy as detailed by HIPAA, except where this right is preempted by law;
- 9. Receive timely access to midwifery records related to their own care.

### **B. MIDWIFE RIGHTS**

A midwife recognizes the importance of respect for the midwife's own rights as care provider, including the right to:

- 1. Refuse care to clients with whom no midwife/client relationship has been established;
- 2. Discharge clients from the midwife's care, provided adequate referral to other care is established;
- 3. Receive honest, relevant information from clients upon which to base care; and
- 4. Receive agreed upon (contracted) reasonable compensation for services rendered.

### **C. CLIENT RESPONSIBILITY**

A thorough commitment from the client and the client's family is necessary to ensure the safety and well-being of the client and infant. Most parents seeking to birth at home or in a birth center accept responsibility for their health and will share information with their provider(s) about changes and matters that may affect their pregnancy and birth. Maintaining communication is important to be able to respond appropriately to the particular needs a client may have. Midwives

should share the following expectations with their clients, and consider adding this wording to their client contracts:

A client will:

1. Disclose any medical history or current conditions that may influence whether or not they are an appropriate candidate for LM services;
2. Care for their physical, emotional, and spiritual health to the best of their ability;
3. Make a commitment to learn about their body, the antepartum changes that occur, the birth process, the postpartum period, and throughout the life cycle;
4. Work with the midwife to change or improve nutrition, health, and environment as needed;
5. Consider additional screening and tests or other health care provider visits as needed;
6. Communicate any concerns or changes that affect any aspect of care to provider(s);
7. Respect appointment schedule, changing times only when necessary and with suitable notification;
8. Discuss, sign, and abide by a financial agreement; and
9. Understand the boundaries and limitations of the care that can be provided by the LM in a community setting and that transport or transfer of care to another provider or facility may be necessary.

#### D. MIDWIFE RESPONSIBILITY

A midwife recognizes certain responsibilities, including:

1. Respecting the normal birth process;
2. Honoring confidentiality of information and details of the client's condition;
3. Providing complete, accurate, and relevant information to the client (and obtaining a signed consent) so the client can make informed choices regarding health care;
4. Remaining responsible for the client when referring to another health care provider, until the client is either discharged or formally transferred;
5. Developing and utilizing a safe and efficient mechanism for consultation, collaboration and referral;
6. Continuing professional development through ongoing evaluation of knowledge and skills and continuing education, including study of subjects relevant to midwifery practice;
7. Knowing and complying with all legal requirements related to midwifery practice within the state of New Mexico;
8. Maintaining accountability for all midwifery care delivered under the midwife's supervision (assignment and delegation of duties to other midwives or apprentices should be equal to their educational preparation and demonstrated proficiency);
9. Accurately documenting the client's history, condition, physical progress, and other vital information obtained during client care;
10. Filing annual reports with the Maternal Health Program of the Department of Health;
11. Participating in Peer Review as a reviewer and/or a reviewee;
12. Being informed about and implementing safety and infection control methods for the protection of the client, babies, and their families as well as of the midwife, the midwife's family, other clients, and staff; and

13. Obtaining a signed authorization (when necessary) to release midwifery and medical records for the purpose of insurance reimbursement, medical consultation or referral, or for the client's own records.

### **DETERMINING APPROPRIATE CLIENT CARE PROVIDER**

The following is a list of factors/conditions, which require primary care or consultation by a physician or nurse-midwife and factors/conditions which require transfer of care. Maternal (and fetal) factors and conditions are listed first, followed by newborn factors and conditions.

Consultation is the process whereby a LM who maintains primary management responsibility for the client's care seeks the advice or opinion of a physician, nurse-midwife, or another member of the health care team. Consultation may be in person, by phone, or electronically. When a consultation is done, a documented plan of care needs to be added to medical record; documentation can be made by the LM or the consulting provider.

Transfer is the process by which the LM directs the client to a physician, certified nurse-midwife, or another health care professional for management of a particular problem or aspect of the client's care, or for all aspects of a client's care. Documentation regarding the transfer, including the scope and specifics of what aspects of management are being transferred, should be clearly charted in the medical record.

#### **A. CONDITIONS THAT REQUIRE PRIMARY CARE BY A PHYSICIAN OR NURSE-MIDWIFE**

1. Chronic Medical Conditions
  - a. Cardiac disease (Class II or greater)
  - b. Diabetes Mellitus (DM) Type I
  - c. Diabetes Mellitus Type II not well controlled with diet
  - d. Hemoglobinopathies (carrier or disease, not trait)
  - e. Renal disease (chronic, diagnosed; not UTIs)
  - f. History of pulmonary embolism or deep vein thrombosis
  - g. Current chronic condition not well controlled: hyperthyroidism, seizures, lupus
  - h. Active tuberculosis
  - i. Active syphilis infection
  - j. Active gonorrhea infection at onset of labor
  - k. Positive HIV status or AIDS
  - l. Any other condition at midwife's discretion
2. Current Antepartum Conditions
  - a. Ectopic pregnancy or hydatidiform mole/molar pregnancy (suspected or confirmed)
  - b. Preeclampsia with or without severe features, HELLP syndrome, eclampsia
  - c. Placenta previa at onset of labor
  - d. Placental abruption
  - e. Primary genital/anal herpes simplex infection in the third trimester
  - f. Active genital/anal herpes simplex outbreak at onset of labor or at ROM
  - g. Positive Zika infection

- h. Gestational diabetes not controlled by diet
  - i. Preterm labor or preterm premature rupture of membranes (PPROM) defined as <37 weeks gestation per verified EDD by LMP date, ultrasound assessment, and/or physical exam
  - j. Fetus in any presentation other than vertex at onset of labor
  - k. Signs and symptoms of uterine rupture
  - l. Multiple gestation
  - m. Any other condition at midwife's discretion
3. Previous Obstetrical History
- a. Previous Rh sensitization
  - b. Previous cesarean with vertical uterine incision, inverted T uterine incision, or extension of the incision into the contractile portion of the uterus
  - c. Previous cesarean birth less than 18 months prior to EDD of current pregnancy
  - d. Two or more cesareans
  - e. Any other condition at midwife's discretion
4. Intrapartum
- a. Prolonged rupture of membranes (> 24 hours) with no progress of labor
  - b. Placental abruption, if birth is not imminent
  - c. Severe bleeding prior to or during birth
  - d. Signs and symptoms of maternal infection
  - e. Maternal fever of 100.4° F for over 4 hours
  - f. Severe headache, visual disturbances, epigastric pain
  - g. Maternal respiratory distress
  - h. Significant meconium stained fluid when birth is not imminent
  - i. Cord prolapse when birth is not imminent
  - j. Persistent or recurrent fetal heart tones below 100 or above 160 or late decelerations when birth is not imminent, or other non-reassuring fetal heart rate patterns
  - k. Signs and symptoms of uterine rupture
  - l. Client desires consult or transfer
  - m. Any other factor at midwife's discretion

## B. CONDITIONS THAT REQUIRE CONSULTATION

1. Antepartum Factors
- a. History of seizure disorder not on medication
  - b. Chronic hypertension
  - c. Gestational hypertension
  - d. Diabetes Mellitus Type II that is well controlled by diet
  - e. Gestational diabetes controlled by diet (transfer required otherwise)
  - f. Thrombophlebitis
  - g. Thrombocytopenia
  - h. Maternal anemia (Hgb <10, Hct <30%) unresponsive to treatment
  - i. Vomiting unresponsive to treatment
  - j. Persistent fever (unresponsive to treatment)
  - k. Serious maternal viral/bacterial infection at term unresponsive to treatment

- l. Maternal rubella infection contracted in first or second trimester
- m. Positive for Hepatitis B or C; severe symptoms of Hepatitis A
- n. Primary genital herpes simplex infection (except in third trimester which necessitates a transfer)
- o. UTI unresponsive to treatment
- p. Adnexal mass or uterine fibroid
- q. Positive and identifiable antibody screen
- r. Oligohydramnios (documented)
- s. Polyhydramnios (documented)
- t. Continued vaginal bleeding before onset of labor with or without pain
- u. Intrauterine growth restriction (IUGR), documented or suspected (size less than dates)
- v. Postdates >42 weeks gestation (verified EDD by dates, ultrasound assessment and/or physical exam)
- w. Signs of fetal distress or demise
- x. Teratogenic exposure
- y. Current severe psychiatric condition requiring medication within a 6-month period prior to pregnancy
- z. Current drug or alcohol substance use disorder
- aa. History of uterine surgery other than cesarean section
- bb. History of uterine inversion
- cc. Any other condition at midwife's discretion
- 2. Intrapartum Factors
  - a. Client desires consult or transfer
  - b. Any other factor at midwife's discretion
- 3. Fetal Factors
  - a. Two-vessel umbilical cord
  - b. Documented fetal anomaly
  - c. Any other factor at midwife's discretion

C. POSTPARTUM FACTORS THAT REQUIRE IMMEDIATE TRANSFER

- 1. Maternal hemorrhage not responsive to interventions
- 2. Third or fourth degree perineal laceration
- 3. Signs of infection not responsive to treatment
- 4. Retained placenta
- 5. Placenta accreta
- 6. Hematoma increasing in size or pain
- 7. Uterine inversion or prolapse
- 8. Any other factor at midwife's discretion

D. NEWBORN FACTORS THAT REQUIRE IMMEDIATE TRANSFER

- 1. Neonatal distress not responsive to interventions
- 2. Seizures
- 3. Any other factor at midwife's discretion

E. NEWBORN FACTORS THAT REQUIRE CONSULTATION

1. Fails to urinate or move bowels within 24 hours
2. Low birth weight (less than 2500 g)
3. Obvious anomaly or injury
4. Respiratory distress or abnormal respiratory patterns
5. Cardiac irregularities
6. Prolonged pale, cyanotic, or gray color
7. Abnormal cry
8. Jaundice within 24 hours of birth
9. Hyperbilirubinemia
10. Lethargy
11. Edema
12. Signs of hypoglycemia
13. Abnormal facial structure
14. Abnormal body temperature
15. Poor feeding
16. Maternal hepatitis B or C infection
17. Any other factor at midwife's discretion

### **EVENTS THAT REQUIRE REPORTING TO THE DEPARTMENT OF HEALTH**

Licensed midwives practicing in New Mexico are required to report and submit for review any cases that fall into the event categories listed within this section. The listed events trigger a required case review process by the NMDOH's Maternal Health Program. It is the midwife's responsibility to report and provide any required documentation for all reportable cases of any client for whom the midwife provided care for during the perinatal period, whether the client's care was transferred or not. Any report provided pursuant to this section is confidential to the extent of federal and state patient confidentiality laws.

#### **A. IMMEDIATE REPORTING REQUIRED FOR MORTALITY EVENTS**

1. Maternal death within 42 days of delivery (during 6-week postpartum period)
2. Neonatal death within 28 days of birth
3. IUFD or stillborn at 20 weeks gestation or more, or, if gestational age is unknown, when the fetus weighs greater than or equal to 350 grams
4. Immediate reporting is defined as within 48 hours of the event per the LM Rule

#### **B. REPORTABLE EVENT REPORTING PROCESS**

1. Per above requirements for reporting timeframe, LM should contact the NMDOH Maternal Health Program by email or phone call
2. LMs will be asked to provide:
  - a. Name and date of birth of the client, date of incident including delivery and/or death, and any hospitals or outside entities involved in the care of the client
  - b. Any and all client records for the case
3. NMDOH will be responsible for requesting records from hospitals or other applicable entities (i.e. Office of Medical Investigator).
4. All cases will be reviewed by the Maternal Health Program.

- a. The case will be brought to the LM Advisory Board to be heard by the Maternal Health Program and Board in a closed session format at a regularly scheduled or special meeting
  - i. The Maternal Health Program has the discretion to not bring a case to the Board if they will not be pursuing it further
- b. If warranted, disciplinary action and proceedings will be conducted according to the LM Rule, 16.11.3.9 NMAC "Disciplinary Action"
- c. If no disciplinary action is warranted, the case will be closed, and the LM will be notified via a USPS-posted letter

**LICENSED MIDWIFE FORMULARY**

As independent health care practitioners, licensed midwives may procure, carry, and administer the approved formulary medications as needed for safe practice. Licensed midwives (LMs) may also carry and administer additional medications as ordered by a provider with prescriptive authority or by the Department of Health Maternal Health Program in the case of an emergency community health initiative. For updated information regarding procurement and administrative authority, contact the Department of Health Maternal Health Program.

The table below shows the approved drugs—and their respective indications, doses, routes of administration, and durations of treatment—that it is best practice for LMs to carry and be prepared to administer if needed. LMs are advised to assess for client medication allergies prior to administration of drug(s).

<b>Drug</b>	<b>Indication</b>	<b>Dose</b>	<b>Route of Administration</b>	<b>Duration of Treatment</b>
Oxygen	Maternal/Fetal distress	0.5 L/min increased as needed to max	Mask or bag and mask	Until stabilization is achieved or transfer of care is complete; refer to “Oxygen in Labor” in Part VI
	Neonatal resuscitation	10-15L/min Amount as needed per NRP guidelines		
Oxytocin (Pitocin)		10 units	IM	

	Active management of third stage	20 units in 1 L NS or LR; Initial bolus rate (500-1000 ml/hour) for 30 minutes followed by a maintenance rate of 125 ml/hour for the next 3.5 hours	IV infusion	Immediately postpartum or with delivery of anterior shoulder
Oxytocin (Pitocin)	Postpartum hemorrhage	10 units	IM	Until stabilization is achieved or transfer of care is complete
		Add 20-40 units; not to exceed 40 units; to 1000 mL of NS or LR and infuse at necessary rate to control uterine atony	IV infusion	
Misoprostol <sup>1</sup>	Active management of third stage	600 mcg	Orally	Immediately postpartum or with delivery of anterior shoulder, if Pitocin is not available (2 <sup>nd</sup> line)
Misoprostol <sup>1</sup>	Postpartum hemorrhage	800 mcg	Sublingual	Until stabilization is achieved or transfer of care is complete

Methylergonovine (Methergine)	Postpartum hemorrhage	0.2 mg max 0.6 mg (3 doses)	IM(should be refrigerated)	Single dose; may be repeated every 6 hours up to a max of 3 doses; contraindicated in hypertension and before delivery of the placenta
Lidocaine HCl 1-2%	Local anesthetic for use during postpartum repair of lacerations or episiotomy	Maximum <25mL; Use as needed	Percutaneous infiltration only	Completion of repair
Lidocaine 2-4% gel	Local anesthetic for use during postpartum repair of lacerations or episiotomy	Maximum 600 mg in 12 hours; Use as needed	Topical	Completion of repair
Penicillin G <sup>2</sup>	Group B Strep Prophylaxis only	5 million units initial dose, then 2.5 million units q 4 hours until birth	IV in <sup>3</sup> 100 mL LR, NS or D5LR	Prophylactic treatment through end of delivery
Ampicillin Sodium <sup>3</sup>	Group B Strep Prophylaxis only	2g initial dose, then 1g q 4 hours until birth	IV in <sup>3</sup> 100 mL NS	Prophylactic treatment through end of delivery
Cefazolin Sodium <sup>4</sup>	Group B Strep Prophylaxis only	2g initial dose, then 1g q 8 hours until birth	IV in <sup>3</sup> 100 mL LR, NS or D5LR	Prophylactic treatment through end of delivery

Clindamycin Phosphate <sup>5</sup>	Group B Strep Prophylaxis only, if sensitive to clindamycin	900 mg q 8 hours	IV in <sup>3</sup> 100 mL LR or NS	Prophylactic treatment through end of delivery
Epinephrine	Maternal anaphylaxis	0.3-0.5 mg	IM x 1 Use filter to draw up solution (if ampule) and change needle to appropriate IM needle	May repeat dose x1 after 5-15 minutes; Administer first dose then immediately request EMS
Diphenhydramine	Treatment or post-exposure prevention of allergic reactions	25 mg- 50 mg	Orally	As needed; Not to be used in place of Epinephrine
Lactated Ringer (LR)	To achieve maternal stabilization or hydration	Appropriate volume to treat to client's condition	IV catheter	Until stabilization is achieved or transfer to a hospital is complete
5% Dextrose in Lactated Ringer's solution (D5LR)	To achieve maternal stabilization	Appropriate volume to treat to client's condition	IV catheter	Until stabilization is achieved or transfer to a hospital is complete
0.9% Sodium Chloride (NS)	To achieve maternal stabilization or hydration	Appropriate volume to treat to client's condition	IV catheter	Through end of delivery

Sterile H2O	Relief of back labor	0.1-0.5 cc at the 4 corners of the sacrum, should be administered rapidly, one after another, over a 30 to 90 second total period	Subdermal, using TB syringe and needle, into appropriate points in a client's back	Duration of pain relief is 2-4 hours
Inactive Influenza Vaccine	Prevent flu, make flu less severe if client is symptomatic or tests positive to flu, and to keep from spreading flu to family/others	0.5 mL	IM	Given as single dose to adult during influenza season (usually October-May); can be given every season; can be given in any trimester
Diphtheria, Tetanus, and Pertussis Vaccine (Tdap)	Administered to pregnant person to protect the newborn baby against pertussis	0.5 mL	IM	Pregnant people should receive a single dose of Tdap during every pregnancy, preferably at 27 through 36 weeks gestation. Tdap is recommended in the immediate postpartum period for those who have not received Tdap during the pregnancy or whose vaccination status is unknown.

Rh(D) Immune Globulin	Prevention of Rh(D) sensitization in Rh(D) negative people	300mcg	IM	Rh(D) negative, antibody negative pregnant people within 72 hours of spontaneous bleeding or abdominal trauma or prophylactically in the 2nd trimester or after birth (before 72 hours have passed) with Rh positive infant
Hepatitis B Immune Globulin (HBIG)	Post-exposure prophylaxis for infants exposed to hepatitis B (i.e. client is hepatitis B positive)	0.5 ml	IM	Should be administered to infant after physiologic stabilization of the infant and preferably within 12 hours of birth
Hepatitis B Vaccine	Prevention of hepatitis B infection in all infants; post-exposure prophylaxis for infants exposed to hepatitis B (i.e. client is hepatitis B positive)	0.5 ml of vaccine (10 ug) each	IM	The 1st dose should be given to infant within 1 day of birth and may be given concurrently with HBIG but at a separate site; the 2 <sup>nd</sup> and 3 <sup>rd</sup> doses should be given at 1 month and 6 months, respectively, after the 1st dose; these can be administered

				by pediatric care provider
Phytonadione (Vitamin K1)	Prophylaxis for Vitamin K deficiency bleeding	1 mg	IM	1 dose to infant postpartum
0.5% Erythromycin Ophthalmic Ointment	Prophylaxis of Neonatal Ophthalmia	1 cm ribbon in each eye	Topical	1 dose to infant postpartum
Various Sutures	Repair of lacerations or episiotomy			As needed

<sup>1</sup>Appropriate off label use

<sup>2</sup>Recommended antibiotic for prophylactic treatment of GBS as appropriate for client

<sup>3</sup>Alternative antibiotic for prophylactic treatment of GBS as appropriate for client

<sup>4</sup>Recommended antibiotic for prophylactic treatment of GBS for clients with penicillin allergy with low risk for anaphylaxis

<sup>5</sup>Recommended antibiotic for prophylactic treatment of GBS for clients with penicillin allergy with high risk for anaphylaxis

## **PROCESS FOR FORMULARY REVISIONS**

It is understood that a formulary will evolve over time given new research, drugs, and availability and shortages of listed medications. For this reason, formulary changes are expected and accepted for consideration through the following process.

1. Any proposed changes are formally requested through the Maternal Health Program and the LM Advisory board.
2. Upon recommendation from the LM Advisory Board, the proposed changes are forwarded to the Department of Health Maternal Health Program for review.
3. After final approval for the proposed change to the formulary by the Department, the approved changes will be integrated into these Department of Health Practice Guidelines for New Mexico Licensed Midwives without need for secondary approval by the LM Advisory Board.

## **SAFE STORAGE, TRANSPORTATION, AND DISPOSAL OF FORMULARY**

### **A. STORING FORMULARY DRUGS**

A licensed midwife must store all formulary drugs in secure areas suitable for preventing unauthorized access and for ensuring a proper environment for the preservation of the drugs.

1. Licensed midwives may carry formulary drugs to the home setting while providing care within the course and scope of the practice of midwifery.
2. The licensed midwife must promptly return the formulary drugs to the secure area when the licensed midwife has finished using them for patient care.

### **B. DISPOSING OF FORMULARY DRUGS**

A licensed midwife must dispose of formulary drugs using means that are reasonably calculated to guard against unauthorized access and harmful excretion of the drugs into the environment.

The means that may be used include, without limitation:

1. Transferring the drugs to an authorized collector for disposal; U.S. Drug Enforcement Agency (DEA) authorized collectors safely and securely collect and dispose of pharmaceuticals containing controlled substances and other medicines (see DEA website for disposal information);
2. Medicine take-back programs: The DEA periodically hosts National Prescription Drug Take-Back events where collection sites are set up in communities nationwide for safe disposal of prescription drugs;
3. Removing the drugs from their original containers, mixing them with an undesirable substance such as coffee grounds or kitty litter, putting them in impermeable, non-descript containers such as empty cans or sealable bags, and throwing the containers in the trash; or
4. Flushing the drugs down the toilet if the accompanying patient information instructs that it is safe to do so.

## **MIDWIFERY INSTRUCTOR/PRECEPTOR REGISTRATION**

In the state of New Mexico, LMs wishing to teach midwifery to an apprentice or student midwife are required to register with the Department of Health to become an Approved Preceptor pursuant to the LM Rule, 16.11.3.12 NMAC. Preceptor registration is achieved according to the requirements below. Forms may be found on the DOH website.

- A. Submit the following forms with the proof or documentation requested to the NMDOH Maternal Health Program
  - 1. “Application for Midwifery Instructor/Preceptor” form
  - 2. “Student/Instructor Relationship” form, signed and notarized
  
- B. Preceptors are encouraged to register as a NARM Registered Preceptor in addition to registering with the DOH with the rationale that registering as a NARM preceptor helps protect students who may not finish the New Mexico licensure process within the required timeframe.

**MECHANISM FOR EXPANSION OF PRACTICE**

The LM may expand their scope of practice beyond the Licensed Midwife Scope of Practice and Core Competencies to incorporate new procedures that improve care for clients and their families, consistent with the midwifery model of care and NMAC 16.11.3.12. The midwife’s practice should reflect knowledge of the new procedure including risks, benefits, screening criteria, and identification and management of potential complications. The following requirements must be followed for the new or expanded procedure to be incorporated in the New Mexico Licensed Midwife’s practice. This guideline is adapted from the Midwives Alliance of North America’s “Standards and Qualifications for the Art and Practice of Midwifery”.

**A. IDENTIFY THE NEED FOR A NEW PROCEDURE**

Take into consideration:

- 1. Consumer demand
  - 2. Standards for safe practice
  - 3. Availability of qualified professionals who provide the procedure
- 
- B. **LEGALITY:** Ensure that there are no institutional, state, or federal statutes, regulations, or bylaws that would constrain the midwife from incorporating the procedure into practice.
- 
- C. **TRAINING AND DOCUMENTATION:** Maintain documentation of the process used to achieve the necessary knowledge, skills, and ongoing competency of the expanded or new procedures, for example maintain documentation of supervised clinical and/or didactic training specific to the new skill/procedure.
- 
- D. **COMPETENCY:** Demonstrate knowledge and competency of the new procedure by writing and maintaining a practice protocol for the procedure including:
    - 1. Identification and management of complications
    - 2. Mechanism for obtaining medical consultation, collaboration, referral, and transport as related to this procedure
    - 3. Informed decision-making consent form for clients to sign which should include:
      - a. Risks
      - b. Benefits
      - c. Client selection criteria
    - 4. Outline how competency will be maintained
    - 5. Report any incurred complications to the NMDOH Maternal Health Program
    - 6. Process to evaluate outcomes (e.g., include in midwife’s peer review cases)

## **INTRAVENOUS THERAPY (IV) CERTIFICATION CLASS QUALIFICATIONS AND CURRICULUM CRITERIA**

Licensed midwives licensed by the state of New Mexico are required to certify in intravenous (IV) therapy with each license renewal. Class requirements are based on the North American Registry of Midwives (NARM) skills.

### **A. CERTIFICATION CAN BE ACHIEVED IN THE FOLLOWING WAYS**

1. Taking a course that includes a hands-on component approved by the NM DOH (including courses provided by national or state organizations and education programs);
2. Working in a health care role that requires performance of IV starts on a regular (every shift) basis for at least three months during the previous two years (e.g., RNs, EMTs);
3. Teaching an in-person IV Certification Course that includes the hands-on component at least two times per year.

### **B. COURSE REQUIREMENTS**

1. It is recommended that a class meet a continuing education unit (CEU) approval process.
2. IV therapy CEUs cannot be included in the 30 CEUs required for license renewal as a New Mexico Licensed Midwife.
3. The course instructor may be any person who is licensed to administer IVs and who can demonstrate sufficient and ongoing experience through maintenance of active midwifery or other clinical practice and/or certification to teach IV therapy, including hands-on skills, through a formal program.
4. Didactic portion of the course must include instruction in all intravenous formulary medications approved for use by these Guidelines.
5. Submission of the DOH approved IV Certification Form with license application.

### **C. NECESSARY COMPONENTS OF CERTIFICATION IN IV THERAPY**

1. Uses of IV therapy in midwifery care
2. Different IV fluids and their uses
3. Basic anatomy and physiology of the vasculature
4. Initiation and maintenance of an IV line
  - a. Administration of IV fluids, including rate control
  - b. Changing and discontinuing an IV line
  - c. Attaching a saline lock
  - d. Complications and troubleshooting the IV line
5. Administration of IV medications, including antibiotics and Pitocin
6. Practical skills evaluation, including:
  - a. Successful initiation of an IV line (NMDOH requires LMs to successfully start an intravenous catheter on a volunteer as part of recertification training at least once every two years)
  - b. Administration of IV fluids
  - c. Changing and discontinuing an IV line
  - d. Attaching a saline lock
  - e. Adding medication to an IV line

## **PHARMACOLOGY COURSE REQUIREMENT**

Licensed midwives (LMs) carry and administer an approved formulary of dangerous drugs and devices as part of safe practice. LMs must complete two pharmacology-related contact hours or a 2-hour pharmacology course for CEUs, every two years. Proof of a 2-hour pharmacology course should be submitted with the license renewal applications; it is also recommended prior to initial licensure.

## **TRANSPORT CLASS QUALIFICATIONS AND CURRICULUM CRITERIA**

Successful completion of a class on managing emergency transport is required for completion of the state apprenticeship process.

### **A. INSTRUCTOR QUALIFICATIONS**

Instructor must be a provider with demonstrated sufficient and ongoing experience transporting or receiving obstetrical emergencies.

### **B. CURRICULUM REQUIREMENTS**

1. Review practice guidelines for clinical scenarios which require transport to a medical facility
2. Specifically discuss etiology and management detailed in Section “Emergency Transport”
3. Review current evidence and guidelines around transport criteria
4. Participants should have written documentation of appropriate phone numbers (e.g., EMS, hospital) for their local area of practice
5. Review “Best Practice Guidelines for Transfer from Planned Home Birth to Hospital” at [https://www.homebirthsummit.org/wp-content/uploads/2014/03/HomeBirthSummit\\_BestPracticeTransferGuidelines.pdf](https://www.homebirthsummit.org/wp-content/uploads/2014/03/HomeBirthSummit_BestPracticeTransferGuidelines.pdf)

## **TRANSFER OF CARE OR DISCONTINUATION OF CLIENT/MIDWIFE RELATIONSHIP FOR THE NON-ADHERENT CLIENT**

For the midwife, the primary goal in any course of care is to have a healthy, safe outcome. This is true whether the midwife’s practice setting is at home, in a birth center, or in a hospital. There are times when the out-of-hospital setting is no longer safe or desirable and transfer of care is appropriate. These times can occur during the antepartum, intrapartum, postpartum, or interconception periods. Reasons for transfer can be psychosocial, physiological, or related to the scope of care required. In any event, it is the legal and ethical obligation of the midwife to transfer or discontinue care in a sensitive, respectful, and efficient manner.

Initiating a transfer of care is not an easy task. When it must occur, every effort must be made to assist the client in locating a suitable health care provider. Upon consent, all pertinent records should be given to the client or to the new provider in a timely manner to facilitate and promote continuous care. If the transfer occurs intrapartum, the midwife should accompany the client to the hospital and remain with the client until the case is transferred or resolved, as appropriate.

On occasion, it is also necessary to discontinue a client/midwife relationship for other pertinent reasons. Some indications from the client are:

1. Irresponsibility, unwillingness to change habits

2. Lack of compliance within necessary time frame
3. Dishonesty, intentional breach of contract
4. Unstable or dangerous home environment
5. Immaturity, questionable emotional status
6. Refusal to agree to necessary specified testing, emergency medical care, or transport
7. Unresolved conflicts or personality differences between client and midwife
8. Not honoring financial contract/commitment

The midwife is not ethically, morally, or legally bound to keep a client if it is not in the best interest of both parties. This is a difficult decision to make and should be done with integrity.

In the event of discontinuation or transfer of care, the midwife should:

1. Set a date
2. Notify the client in person if possible and/or send notification by certified mail
3. Document in chart
4. Provide the client with referrals to other care providers
5. Upon written consent, mail a certified letter including a copy of client's chart to client and/or to the new health care provider in a timely manner
6. Settle payments from client for services rendered to date, referring to the financial contract between client and midwife, and providing reimbursement if applicable

#### **TRANSFER OF CARE DURING LABOR FOR THE NON-ADHERENT CLIENT**

Perhaps the most difficult situation a midwife and client can face is when they are at an impasse on the appropriate level or setting of care during active labor. This particular situation is challenging for the midwife because it can put the midwife at odds with legal and licensing restrictions and the midwife's personal ethics. It can expose the midwife to increased legal and civil risks, and bring into question within both the midwifery and client communities the midwife's commitment to the legal and professional standards set forth in this document.

It is expected that the client understands and respects the boundaries the midwife must work within; boundaries that include the legal restrictions placed through licensing and professional standards of practice, as well as the midwife's individual ethical and moral bounds. In the event that a client in active labor declines to accept transfer of care despite the midwife's recommendation, this guideline has been provided to help the midwife and client navigate this situation.

Please note that this guideline does not negate the requirement of mortality reporting requirements per 16.11.3.12 NMAC) nor does it provide protection from disciplinary actions against the LM.

1. The LM should consider having a client sign a form at the time of initial hiring that states: "You hereby acknowledge that if your medical condition escalates to a level beyond the scope of practice of the LM, your care will be transferred to another provider and facility until your care can be transferred back to your midwife, if desired by yourself and the midwife. Should you refuse to the transfer of care and any transfer to another facility that may be accomplished by EMS to a hospital or other provider, you hereby acknowledge that

you assume the risk of any medical outcome resulting from a medical condition that you have been advised is beyond the scope of practice of the LM, and acknowledge that the LM may only provide care to you within the scope of the midwife's practice.”

2. The midwife is responsible for helping the client understand the risks involved, documenting the discussion, and having the client sign a document, if possible, to verify the discussion.
  - a. Notify the client in writing the reason you, the LM, believe a transfer of care is medically and/or legally necessary.
  - b. Have the client state in the client's own words verbally or preferably in the client's own writing and primary language, the reason why the client is declining a transfer.
  - c. If possible, have a member of the birth team (i.e. birth assistant, apprentice, doula), non-family member, or family member (order is in preference of signature) witness these interactions and sign with the date and time the discussion took place any written statements provided to and by the client.
3. The midwife should alert the hospital that is the most likely to receive the client, informing of the situation and that the midwife is trying to get the client's permission to transfer care.
4. The midwife should call EMS, state that there is an emergency, and go through standard procedure per EMS.
  - a. Stay with the client until EMS arrives.
  - b. If the client refuses to transfer with EMS, have an EMS technician sign, date, and time the LM's client chart to document refusal.
5. Having taken these measures, the midwife should stay with the client. While continuing to encourage transfer of care, the midwife should provide midwifery and emergency care to the best of the midwife's ability. Leaving the client at this point would be considered abandonment.

## **EMERGENCY TRANSPORT**

### **A. DEFINITION**

The emergency transfer of care of the dyad, client, or infant when the condition is outside normal parameters, the condition is further complicated by staying home, or a transport to a medical facility is deemed necessary.

Refer to and review best practices regarding transfer from planned home or freestanding birth center birth to hospital. The document “Best Practice Guidelines for Transfer from Planned Home Birth to Hospital” can be found at [Best Practice Guidelines: Transfer from Planned Home Birth to Hospital \(birthplacelab.org\)](http://BestPracticeGuidelines:TransferfromPlannedHomeBirthtoHospital(birthplacelab.org))

Also see “Determining Appropriate Client Care Provider” for a list of factors for which emergency (i.e. immediate) transport are required.

### **B. ETIOLOGY**

1. Placental
  - a. Abruptio placenta
  - b. Placenta accreta
  - c. Placenta previa
  - d. Retained placenta
2. Maternal
  - a. Uterine inversion

- b. Uterine rupture
  - c. Anaphylaxis
  - d. Hypovolemic shock
  - e. Postpartum hemorrhage uncontrolled and unresponsive to management
  - f. Signs of infection not responsive to treatment
  - g. Hematoma increasing in size or pain
  - h. Maternal desire
  - i. Any other condition at the midwife's discretion
3. Fetal and neonatal
- a. Prolapsed cord
  - b. Fetal distress
  - c. Transverse presentation in labor
  - d. Breech presentation diagnosed intrapartum if birth is not imminent
  - e. Twins diagnosed intrapartum if birth not imminent
  - f. Neonatal distress not responsive to resuscitation or treatment efforts
  - g. Respiratory distress syndrome
  - h. Neonatal seizures
  - i. Congenital anomalies, severe
  - j. Maternal desire
  - k. Any other condition at the midwife's discretion

#### C. MANAGEMENT

1. Implement and maintain emergency procedures to stabilize condition of the client and/or infant while initiating and throughout transfer
2. Activate EMS to facilitate transport
3. Notify physician and/or hospital of impending transport and current status of dyad, client, or infant
4. Accompany the client and/or infant to hospital and continue to provide stabilization procedures as indicated
5. Provide necessary records to admitting hospital personnel and exchange pertinent information leading up to the transport
6. Notify physician and/or hospital if situation resolves and decision is made not to transfer

### **INTRAVENOUS (IV) THERAPY**

#### A. DEFINITION

Infusion of liquid substances directly into a vein.

#### B. INDICATIONS

1. Dehydration
2. Postpartum hemorrhage
3. Administration of intrapartum antibiotics

#### C. REASONS TO DISCONTINUE IV

1. If medication is administered, discontinue when complete course of medication has been administered
2. Consider leaving saline lock in place

## **OXYGEN IN LABOR**

### **A. PURPOSE**

1. This section outlines procedures for administration of oxygen.
2. Indications for administration of oxygen shall be clearly documented in the client's chart.
3. A midwife is not required to use oxygen.

### **B. INDICATIONS**

1. Deteriorating vital signs
2. Excessive exhaustion, air hunger, faint
3. Over-exertion, excitement, pain, nausea, anxiety
4. Poor venous return, poor color
5. Maternal hemorrhage
6. Maternal shock
7. Prolapsed cord
8. Fetal heart rate irregularities
9. Resuscitation efforts as indicated by American Heart Association Cardiopulmonary Resuscitation guidelines
10. Initial newborn resuscitation (at a rate concurrent with American Academy of Pediatrics Neonatal Resuscitation guidelines)
11. Any reason not listed above to the client and/or newborn as deemed necessary

### **C. MANAGEMENT AS INDICATED BY THE CONDITION**

1. Administer as appropriate
2. Wean oxygen as appropriate based on improvement of vital signs and stabilization of the client

## **TREATMENT, SCREENING, AND REFERRAL FOR NEWBORNS**

Required initial neonatal testing by the state of New Mexico.

### **A. Newborn genetic screening test**

1. To obtain kits, contact the NM Newborn Genetic Screening Program 1-877-890-4692. Two-part testing kits are available to Licensed Midwives at a cost and are reimbursable by insurance.
2. First newborn screening test is administered at 24 hours of age
3. Second newborn screening test is administered at 10-14 days after birth (it is recommended by the State of New Mexico that an infant be screened twice for increased validity).
4. If Newborn Genetic Screening is declined, complete the Informed Dissent process:
  - a. Review risks/possible consequences of not screening and review the two brochures provided by newborn genetic screening program: 1) New Mexico's Newborn Screening disorders; 2) These Tests Could Save your Baby's Life.
  - b. Fax or otherwise securely submit the signed "Newborn Screening Test Refusal" form to the Newborn Screening Program (see NMDOH website for information and forms).

B. Newborn hearing screen

1. If hearing screening is planned, fax or otherwise securely submit the signed “Newborn Hearing Screening Referral Form” (see NMDOH website for information and forms).
2. If screen is declined, fax or otherwise securely submit the signed “Newborn Screening Test Refusal Form” (see NMDOH website for information and forms) within 48 hours of birth.
3. Additional information
  - a. Communicate the importance of newborn hearing screening to parents orally and in writing using the educational materials provided by the Newborn Hearing Screening Program (referral forms and educational materials can be ordered by calling Children's Medical Services at 1-877-890-4692).
  - b. More information about the NM Department of Health Newborn Hearing Screening Program can be found at <http://nmhealth.org/about/phd/fhb/cms/nbhs/>

C. Critical congenital heart disease screening

1. Screen at >24 hours of age
2. If screen declined, fax or otherwise securely submit the signed “Newborn Screening Test Refusal” (see NMDOH website for information and forms).
3. Referral for failed screens
  - a. Any infant who fails the screen should have a diagnostic echocardiogram,
  - b. The infant’s primary care provider (pediatrician, family physician, or advanced practice provider) should be notified immediately and help to facilitate appropriate referral

**NOTIFIABLE DISEASES OR CONDITIONS IN THE STATE OF NEW MEXICO**

The New Mexico Department of Health Regulations Governing the Control of Disease and Conditions of Public Health Significance requires the reporting of specific infections and conditions. NMAC 7.4.3 is available on the NMAC compilation website at <https://www.nmhealth.org/publication/view/regulation/372/> This link contains the list of all diseases and conditions of for which the LM must notify the DOH. Please check for updates to this list and reporting specifications.

**END OF DOCUMENT**