VANDERBILT UNIVERSITY SCHOOL OF NURSING
NURSE-MIDWIFERY FACULTY PRACTICE

CLINICAL PRACTICE GUIDELINES

The Vanderbilt Nurse-Midwifery Faculty Practice is a group of Certified Nurse-Midwives (CNMs) and Women’s Health Nurse Practitioners (WHNPs) that offers full-scope midwifery and well-woman care. The CNMs and WHNPs practice independently and consult, collaborate and refer to board-certified obstetrician/gynecologists and other health care professionals (e.g. physician specialists, nurse practitioners, social workers, nutritionists, genetic counselors) as indicated by a woman’s condition and the expertise of the individual provider.

Philosophy

CNMs/WHNPs of the Vanderbilt Nurse-Midwifery Faculty Practice support the philosophy of the American College of Nurse-Midwives (ACNM). In particular, we believe that culturally competent, family-centered midwifery care should be available to all women from a variety of ethnicities, cultures and socioeconomic groups. We support the concept of informed consent and patient participation in healthcare management decisions. We support the appropriate use of technology in childbearing, and we believe that management decisions should be based on the best evidence available. We believe that education of future CNMs, medical and nursing colleagues is an important part of our professional role. We value our relationship with medical colleagues and support the concepts of consultation, collaboration, and referral as defined by the ACNM for specified diseases or complications of normal processes not responsive to midwifery care. We value our relationship with nursing and other health care colleagues, and respect their contributions to the care and health of our patients. We value a collegial relationship with each other, and we support practices that promote continuity of care and personal and professional growth.

Definitions

Consultation: the process whereby the CNM/WHNP seeks the advice of another health care professional. In general, when a consultant’s advice is solicited, the ultimate plan of care will be developed and mutually-agreed upon with the woman and her family. This plan is documented in the medical record. Select conditions for which medical consultation is suggested are listed in the practice guidelines. The CNM/WHNP may also consult with another CNM/WHNP or advanced practice nurse with specialty certification or expertise in a particular area. These consultations are documented in the patient’s medical record. Following consultation, the patient may remain in the care of the CNM/WHNP while her care is being managed collaboratively with another health care provider; alternatively, the patient may be transferred to another provider for care (permanently or temporarily) to ensure the best possible patient outcome.

Collaboration: the process whereby more than one health care provider jointly participates in the healthcare a patient. A physician or other provider may manage specific aspects of the woman’s care while the CNM/WHNP manages aspects that are within the scope of midwifery practice according to a plan developed and mutually agreed upon during a...
consultation. The patient remains in the CNM/WHNP caseload. Collaborative management is documented in the medical record.

Referral: the process by which the CNM directs the patient to another health care professional for continued care. Referral may be temporary, when care is transferred back to the CNM/WHNP after resolution of the problem, or the transfer may be permanent, when the remaining care is provided by a physician, or other provider, to whom she was referred. Referral to another provider is documented in the medical record. The CNM/WHNP may remain involved in aspects of the patient’s care that are in the scope of midwifery practice as desired by the patient, the physician, and the CNM/WHNP.

Note that the level of physician and CNM/WHNP communication or involvement, from consultation through referral, may change at any point in the spectrum of patient care. A status change should be clearly documented.

At any time, a CNM/WHNP may elect to transfer patient care to the physician team for any situation which they believe has unfolded outside of midwifery scope of practice, or for circumstances where a patient’s refusal of standard of care may jeopardize her or her baby’s safety.
A. Antepartum Conditions requiring OB generalist physician *consultation*

a. Planned TOLAC or history of prior VBAC
   a. Previous Cesarean birth x 1, including those who have had 1 successful VBAC
      1. Requires an in person consultation
b. Previous Cesarean birth with 2 or > successful VBAC
   a. Send chart for review
   b. In-person consultation only indicated upon physician recommendation
c. Planned repeat Cesarean birth (even if >1 previous Cesarean birth)
   a. If planned repeat Cesarean, schedule with Dr. Kellett at 32 weeks for consult visit
   d. Preeclampsia
e. Gestational hypertension not on medication & stable
f. Chronic HTN not on medication & stable
g. Fetal demise >13 weeks’ gestation, calculated by EDD (based on best dating criteria)
h. Labor induction <39 weeks
i. Current pyelonephritis
j. Refractory hyperemesis
k. HELLP
   l. History of preterm labor
m. History of seizures, on medication but stable

B. Conditions requiring OB generalist physician *referral (transfer)*

*After consultation is completed, OB generalist physician and CNM/WHNP will determine if the patient is a candidate for midwifery care based on the acuity of the clinical condition and associated risk factors. This may be co-management with OB generalist & CNM/WHNP, or complete transfer of care back to CNM/WHNP care.

a. Pre-existing diabetes or A2GDM (medications)
b. History of >1 previous Cesarean birth
c. History of previous Cesarean birth with vertical scar on uterus
d. Narcotic abuse/use, or methadone/Subutex transfer to Drug Dependency Clinic (Dr. Young)
e. Other conditions as indicated

C. Antepartum Conditions requiring Maternal Fetal Medicine* consultation*

*After consultation is completed, MFM and CNM/WHNP will determine if the patient is a candidate for midwifery care based on clinical acuity and risk factors. This may be co-management with MFM & CNM/WHNP, or complete transfer back to CNM/WHNP care.

a. Unstable or newly diagnosed hypothyroidism
b. Prior pregnancy with congenital genetic or physical anomaly (genetic counseling)
c. Fetal genetic abnormality
d. Abnormal genetic screening
e. Documented fetal growth abnormality
f. History of preterm birth
   a. Preferably obtain consult prior to 16 weeks EGA
g. Previous stillbirth
h. Documented shortened cervix, <25 mm, or ultrasound < 24 weeks EGA
   a. Do not obtain cervical length if > 24 weeks
i. Maternal cardiac disease
j. Fetal physical abnormality
   1. Refer to genetic counseling
   2. Refer for MFM ultrasound scan via Fetal Center at Vanderbilt (FCAV)
k. ETOH abuse
   1. MFM ultrasound & consult
l. Advanced maternal age ≥40 yr. by EDD
   1. MFM consult
   2. Ultrasound with OBUS
   3. Offer genetic counseling
m. Recurrent pregnancy loss
n. Recent history of seizures, taking or not taking medication
o. Thrombophilia
   a. Factor V Leiden
   b. Prothrombin gene mutation
   c. Antithrombin III
   d. Protein C
   e. Protein S deficiency
p. Other conditions as indicated

D. Conditions requiring MFM referral (transfer)

   a. Multiple gestation
   b. HIV positive
   c. System lupus erythematosus or other collagen vascular disease
   d. Liver and renal disease
   e. Hyperthyroidism
   f. Epilepsy or active seizure disorder
   g. Fetal arrhythmia requiring physician management
   h. Rh alloimmunization
   i. Asthma requiring hospitalization, intubation, or steroids this pregnancy
   j. Incompetent cervix
   1. Previous DVT
   2. Previous pulmonary embolism
   k. Recurrent pregnancy loss and put on Lovenox
   l. Other conditions as indicated

E. Conditions that DO NOT require MFM consultation

   a. Marginal cord insertion
      i. Do obtain growth ultrasound 3rd trimester with MFM or OHO
   b. Methylene tetrahydrofolate reductase (MTHRF)

F. Conditions requiring genetics consultation only, unless there is another concern

   a. Advanced maternal age ≥40 yr.
   b. Soft markers on ultrasound (e.g. echogenic intracardiac focus, echogenic bowel, choroid plexus cyst, pyelectasis)
G. Other Antepartum Conditions requiring *endocrinology or MFM consultation*
   a. Gestational diabetes diet controlled (A1GDM)
   b. Hypothyroidism
      1. Newly diagnosed
      2. Stable on medications *only* if indicated per discretion of CNM/WHNP

II. Intrapartum Scope of Practice

A. Conditions requiring physician *consultation* or their designee
   a. Gestational age 34 0/7 weeks to 36 6/7 weeks (OB & pediatrics)
   b. Labor dystocia
   c. Intrauterine fetal demise
   d. Instrument assisted births (forceps or vacuum)
   e. Gestational HTN
   f. Other intrapartum abnormalities as determined by the nurse-midwife

B. Conditions requiring physician *collaborative management* or designee
   a. Maternal hyperglycemia, requiring insulin infusion
   b. Indication for operative vaginal birth
   c. Retained placenta unresponsive to initial removal attempt
   d. Diagnosis of labor with gestational age 32 0/7 weeks to 33 6/7 weeks
   e. 3rd or 4th degree laceration, unless CNM privileged for this
   f. History of previous Cesarean birth (no matter type of birth)
   g. Abnormal vaginal bleeding
   h. Chorioamnionitis
   i. Persistent category II & III fetal heart rate patterns
   j. Post-partum hemorrhage, unresponsive to initial interventions
   k. Preeclampsia
   l. Gestational HTN requiring medication
   m. Maternal cardiac disease or arrhythmia*

C. Conditions requiring physician *referral (transfer)* or designee (*needs MFM consultations*)
   a. Unresolved placenta previa, accreta, or vasa previa
   b. Abruptio placenta
   c. Diagnosis of labor with gestation age less than 32 0/7 weeks
   d. HELLP syndrome
   e. Non-vertex presentation
   f. Indication for surgical birth
   g. *Maternal thromboembolic event*
   h. Eclampsia*
   i. *Disseminated intravascular coagulation (DIC)*
   j. *Diabetic ketoacidosis (DKA)*
   k. *Maternal cerebral vascular accident (CVA)*
II. Postpartum Scope of Practice

A. Daily inpatient assessment and discharge of patients

B. Conditions requiring at least OB generalist physician *consultation*
   a. Endometritis
   b. Post-partum hemorrhage, unresponsive to initial interventions
   c. Hypertension: stable
   d. Symptomatic anemia requiring transfusion
   e. Abnormal post-operative course, such as incision breakdown
   f. Others as indicated

C. Conditions requiring OB generalist physician *referral (transfer)*
   a. DVT
   b. Hypertension: new onset, unstable
   c. Dehiscence of scar
   d. Others as indicated

II. Gynecologic/Primary Care Scope of Practice

A. Conditions requiring OB generalist *consultation*
   a. Serious infection or infection unresponsive to medication
   b. Abnormal endocrine function
      1. Send for chart review to determine individual plan of care as indicated
   c. Abnormal uterine bleeding of undetermined etiology when CNM/WHNP unable to independently manage
   d. Suspected ectopic pregnancy
   e. Pelvic pain unresponsive to treatment
   f. Condition with potential need for surgical intervention
   g. Other conditions as identified by the CNM/WHNP
APPENDIX A

• CDC Group B Strep (GBS) Home page: http://www.cdc.gov/groupbstrep/index.html

• CDC GBS Algorithms Relevant to Obstetric Providers page: http://www.cdc.gov/groupbstrep/clinicians/obstetric-providers.html#algorithms

• CDC GBS Q&A’s About Implementing the 2010 Guidelines for Obstetric Providers: http://www.cdc.gov/groupbstrep/clinicians/QAs-obstetric.html

APPENDIX B

Controlled Substances

The CNM must follow the Tennessee state law requirements for reviewing the Tennessee Controlled Substance Monitoring Database prior to prescribing controlled substances including benzodiazepine.


• Further information found on CAPNAH website: http://www.mc.vanderbilt.edu/root/vumc.php?site=CAPNAH&doc=22033

Formulary

The CNM may prescribe from the following categories of medications, including controlled agents in Schedules II-V

| Analgesics | Eye, Ear, Nose, & Throat Preparations |
| Anesthetics | Gastrointestinal Drugs |
| Anticoagulants | Hormones and Synthetic Substitutes |
| Anticonvulsants | Hypolipidemics |
| Antidepressants | Migraine Preparations |
| Antiemetic’s | Muscle Relaxant Preparations |
| Antihistamines, H1 and H2 blockers | Narcotic Antagonists |
| Anti-hypertensives | Oxytocics |
| Anti-infectives | Ovulation induction agent |
| Anti-inflammatory Agents | Psychotropics |
• Antispasmodics and Anticholinergics
• Antivirals
• Autonomic Drugs
• Blood Derivatives
• Blood Formation and Coagulation
• Bronchodilators
• Cardiovascular Drugs
• Central Nervous System Drugs
• Contraceptive Drugs and Devices
• Diabetic Agents
• Electrolytic, Caloric, and Water Balance Preparations
• Expectorants and Cough Preparations

• Serums, Toxoids, and Vaccines
• Skin and Mucous Membrane Preparations
• Smoking Cessation Aids
• Smooth Muscle Relaxants

APPENDIX C

Textbooks and Reference Materials

I. Obstetrics
   • Obstetrics: Normal and Problem Pregnancies 7th Edition. Steven G. Gabbe (online through Vanderbilt’s Eskind Library)
   • Varney’s Midwifery 5th Edition. Helen Varney (online through Vanderbilt’s Eskind Library)
   • Committee Opinions. The American College of Obstetricians and Gynecologists. 
     http://www.acog.org/Resources_And_Publications/Committee_Opinions_List

II. Women’s Health

III. Pap Guidelines
   • ACOG Guidelines

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IV. Reproduction Endocrinology
   • Clinical Gynecology, Endocrinology, and Infertility. Leon Speroff (online through Vanderbilt’s Eskind Library)

V. Primary Care
   • Clinical Guidelines in Family Practice. Uphold and Graham, 54th Edition

VI. General Standards of Care
   • The American College of Nurse Midwives: http://www.acnm.org
   • The American College of Obstetricians and Gynecologist: www.acog.org
   • Center for Disease Control: www.cdc.gov
   • American Society of Colposcopy and Cervical Pathology: www.asccp.org
   • Association of Women’s Health, Obstetric and Neonatal Nurses: www.awhonn.org
Vanderbilt University School of Nursing  
Nurse-Midwifery Faculty Practice  

Signature Agreement  
Clinical Practice Guidelines  

I, ____________________________, CNM/WHNP have read and reviewed, in its entirety, the (printed provider name) Clinical Practice Guidelines of the Vanderbilt University School of Nursing, Nurse-Midwifery Faculty Practice, and agree to serve in a collaborative practice as outlined in this agreement. I am aware that these guidelines will be reviewed and updated annually by the Nurse-Midwifery Clinical Practice Director, all faculty certified nurse-midwives, women’s health nurse practitioners, and the consulting physician(s). It is my responsibility to maintain knowledge of the most current version of the practice’s Clinical Practice Guidelines, and to practice in accordance with the guidelines set forth within this document. By signing below, I acknowledge that I have been provided a copy of these guidelines for my own personal reference, and agree to the practice terms included in the document. 

Provider Signature: ____________________________ Date: ____________

Consulting Physician Signature: ____________________________ Date: ____________

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