



South Dakota Board of Nursing

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CNM Out-of-Hospital Birth Practice Agreement

A Certified Nurse Midwife (CNM) licensed pursuant to SDCL [36-9A](#) may perform professional midwifery services pursuant to [36-9A-13](#) and [36-9A-13.1](#) in accordance with education, training, and competence. The South Dakota Board of Nursing (Board) recognizes the following nationally recognized documents that describe standards of practice and competencies for nurse midwifery practice:

- *Standards for the Practice of Midwifery* (2011, September): <http://www.midwife.org/Quality-Improvement-and-Patient-Safety>; and
- *American College of Nurse-Midwives (ACNM): Core Competencies for Basic Midwifery Practice* (2012, December): <http://www.midwife.org/Quality-Improvement-and-Patient-Safety>.

Pursuant to SDCL [36-9A](#) and [ARSD 20:62:03:10](#), a licensed CNM may attend out-of-hospital (OOH) births upon submitting to the Board a signed OOH birth practice agreement agreeing to follow practice guidelines.

This agreement shall not take effect until the agreement has been filed in the office of the Board.

The CNM, upon submitting this signed agreement, may perform OOH birth services in accordance with the guidelines in this document. It is further agreed that after the signed agreement has been approved by the Board the agreement shall remain in effect unless terminated by either the CNM or the Board.

The goal of selection criteria in an OOH midwifery practice is to identify the woman who, by all current medical and midwifery standards and knowledge, has an excellent prognosis for a normal, healthy pregnancy, birth, and postpartum course. Determining birth site selection is an ongoing process throughout pregnancy, labor, and the postpartum period. Ongoing evaluation includes risk screening to assess and identify conditions which may indicate a deviation from normalcy. The identification of those conditions may require consultation with a physician and or alternate birth place. In making this assessment, a CNM relies on training, skill, and clinical judgment. The CNM must provide evidence for the following:

1. Documentation of definition of suitable women for OOH birth care;
2. Documentation of indications for consultation, referral or transfer of care document;
3. Documentation of "Informed Consent" for an OOH birth which reflects the midwife's and woman's joint acceptance of the written "Plan of Care" document;
4. Appropriate medications and equipment and certifications necessary to assure safety;
5. Mechanism for documentation of care, record keeping, continuous quality improvement and peer review, and compliance with [ARSD 20:62:03:09](#).

Plan of Care Agreement (POC)

A POC document is designed to assist in decision making for the woman and CNM. The POC will be written or translated in a language understandable to the woman. The POC shall include information regarding the CNM's responsibilities, woman's rights, and CNM's practice guidelines. The practice guidelines will be reviewed by each potential client. The CNM will keep on file a signed statement, or informed consent, verifying that a client (woman) has read and understood the initial POC and practice guidelines. The ongoing POC does not require signature and may be incorporated into routine patient records. The POC may include but is not limited to:

1. Philosophy of practice and care;
2. Credentials of the CNM;
3. Benefits and risks of OOH birth;
4. CNM's emergency care plan;
5. Care and equipment provided;
6. Woman's right to give informed consent prior to any procedure or administration of medication to the mother or newborn, including risks, benefits, options, and alternatives;
7. CNM's expectations of the woman's responsibilities and the CNM's right to discontinue care;
8. Legal requirements regarding mandated newborn screening for metabolism (PKU), hearing, eye prophylaxis, reporting communicable diseases, and registration of birth and death certificates;
9. Woman's financial agreement; and
10. HIPAA Compliance information.

Addendums to the POC may include but are not limited to:

1. Acceptance/refusal of the CNM's recommended care. The woman's decision to refuse/decline recommended care will be made in writing, signed by the woman, and kept with the POC.
2. Information regarding a woman's conditions/concerns for which a CNM may need to consult with or refer to a physician and/or transfer out of the CNM's care to a physician's care; and
3. The CNM will give a copy of the initial POC to the woman and keep a copy in the woman's records.

Nurse Midwifery Record Keeping and Reporting of Birth Information

In addition to complying with requirements in [ARSD 20:62:03:09](#), the CNM shall:

1. Document completely and accurately the woman's history, physical exam, laboratory tests results, prenatal visits, consultation reports, referrals, labor and birth care, postpartum care/visits, and neonatal evaluations at the time services are delivered and when reports are received;
2. Maintain the confidentiality of records in accordance with HIPAA regulations;
3. Provide complete copy of records as necessary for transfer of care, with a signed release of information from a woman.
4. Retain records for a minimum of five years;
5. Provide SD Department of Health (DOH) required birth registration information in a timely manner including appropriate prenatal data and reportable diseases in accordance with SD law for vital statistics reporting;
6. Provide the Board quality review data on the form provided by the Board. Data should be submitted on a quarterly basis for each SD OOH birth attended. Aggregate data will be reported to the Board annually;
7. Provide additional documentation to the Board upon request for review; and
8. Report to the Board within 48 hours any neonatal or maternal death for clients for whom care was provided in the perinatal period.

Practice Guidelines

The woman shall be seen by the CNM or other appropriate health care provider at least once every four weeks until 30 weeks gestation, once every two weeks from 30 until 36 weeks gestation, and weekly after 36 weeks gestation, or as appropriate. The responsibilities of the CNM shall include, but are not limited to:

A. Prenatal Care

1. Initial and subsequent prenatal visits
2. History/assessment of general health.
3. History/assessment of obstetric status.
4. History/assessment of psychosocial status.
5. Physical Exam
6. Laboratory Tests; the woman will be offered the following laboratory tests to include but not limited to:
 - Hemoglobin, Hematocrit, or CBC
 - Urinalysis
 - Syphilis serology
 - Blood group, Rh type, and antibody screen
 - Hepatitis B surface antigen
 - Rubella screen
 - Genetic screening
 - Gonorrhea
 - Chlamydia
 - HIV
 - Group B Strep
 - Ultrasound for fetal well being and dating
 - Glucose, for Gestational Diabetes
 - Others as indicated
7. Determine the appropriateness of the birth site according to ACNM guidelines.

B. Intrapartum Care

During labor, the CNM shall monitor and support the natural process of labor and birth, assessing mother and baby throughout the birthing process. The responsibilities of the CNM shall include, but are not limited to:

1. Assess and monitor fetal well-being through intermittent auscultation of fetal heart tones in accordance with ACNM guidelines.
2. Assess and monitor maternal well-being. While in attendance assess vital signs at least every 4 hours, or as indicated;
3. Monitor the progress of labor;
4. Monitor membrane status for rupture, relative fluid volume, odor, and color of amniotic fluid;
5. Assess cervical dilation, effacement, station, and position during each exam; document in woman's chart.
6. Assist in birth of baby; and
7. Inspection of placenta and membranes.

C. Postpartum Care

After the birth of the baby, the CNM 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 CNM shall include, but are not limited to:

1. Immediate Postpartum Care

- a. Overall maternal well-being;
- b. Bleeding; including emergency management of postpartum hemorrhage as needed;
- c. Vital signs;
- d. Abdomen, including fundal height and firmness;
- e. Bowel/bladder function;
- f. Perineal exam and assessment;
- g. Repair of episiotomy or laceration, as indicated;
- h. Facilitation of maternal-infant bonding and family adjustment; and
- i. Maternal nutritional status assessment.

2. On-going Postpartum Care

- a. Overall maternal well-being;
- b. Bleeding;
- c. Abdomen, including fundal height and firmness;
- d. Bowel/bladder function;
- e. Perineal exam and assessment, as indicated;
- f. Facilitation of maternal-infant bonding and family adjustment;
- g. Maternal nutritional status assessment; and
- h. Lactation assessment.

D. Newborn Care

After the birth of the baby, the CNM 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. The responsibilities of the CNM include but are not limited to:

1. Immediate Newborn Care

- a. Overall newborn well-being;
- b. Vital signs;
- c. Color;
- d. Tone/Reflexes;
- e. APGAR scores at 1 and 5 minutes, and at 10 minutes when indicated;
- f. Temperature;
- g. Feeding;
- h. Bowel/bladder function;
- i. Clamping/cutting of umbilical cord;
- j. Newborn physical exam, including weight and measurements;
- k. Eye prophylaxis upon consent;
- l. Administration of Vitamin K, orally or intramuscularly upon consent; and
- m. Concerns of the family.

2. Ongoing Newborn Care

- a. Vital signs, including color and temperature;
- b. Tone/Reflexes;
- c. Feeding;
- d. Bowel/Bladder function;
- e. Weight gain;
- f. Newborn screening (PKU) as required by state law;
- g. Evaluation / treatment /referral for newborn jaundice;
- h. Referral for hearing screening;
- i. Circumcision as requested; and
- j. Concerns of family.

E. Physician consultation and Referral

The CNM may consult with the woman's selected physician or facility whenever there are significant deviations from normal, including laboratory results, for the woman or newborn. If a referral is needed, the CNM will remain in consultation with the provider until resolution of the concern. It is appropriate for the CNM to maintain care of the woman to the greatest degree possible in accordance with the woman's wishes. The following conditions may require physician consultation, referral, and/or transfer of care.

1. Pre-existing Conditions, include but are not limited to:

- a. Asymptomatic cardiac disease;
- b. Active tuberculosis;
- c. Asthma, severe or uncontrolled by medication;
- d. Renal disease;
- e. Hepatic disorders;
- f. Endocrine disorders;
- g. Significant hematological disorders;
- h. Significant neurologic disorders;
- i. Essential hypertension;
- j. Active cancer;
- k. Diabetes mellitus;
- l. Previous Cesarean section;
- m. Current alcoholism or abuse;
- n. Current drug addiction or abuse;
- o. Current severe psychiatric illness;
- p. Isoimmunization;
- q. Positive for HIV antibody.

2. Pregnancy Related Conditions, include but are not limited to:
 - a. Labor prior to 37 weeks gestation;
 - b. Lie other than vertex at term;
 - c. Multiple gestations;
 - d. Significant vaginal bleeding;
 - e. Gestational Diabetes Mellitus, uncontrolled by diet;
 - f. Severe anemia, not responsive to treatment;
 - g. Evidence of pre-eclampsia;
 - h. Consistent size/dates discrepancy;
 - i. Deep vein thrombosis (DVT);
 - j. Known fetal anomalies or conditions affected by birth, with an infant compatible with life;
 - k. Threatened or spontaneous abortion after 12 weeks;
 - l. Abnormal ultrasound findings;
 - m. Isoimmunization;
 - n. Documented placental anomaly or previa;
 - o. Post-term pregnancy;
 - p. Positive HIV antibody test;
 - q. Abnormal fetal surveillance;
 - r. Known hemoglobinopathy or thrombophilia.

3. Intrapartum Conditions, because of time urgency during certain intrapartum situations, it may be necessary to institute emergency interventions while waiting for physician consultation. These conditions include but are not limited to:
 - a. Fetal intolerance of labor;
 - b. Abnormal bleeding;
 - c. Thick meconium-stained fluid with birth not imminent;
 - d. Development of pre-eclampsia;
 - e. Maternal fever >100.4 degrees Fahrenheit, unresponsive to treatment;
 - f. Abnormal Presentation
 - g. Presence of herpes lesions;
 - h. Prolapsed cord;
 - i. Woman's desire for pain medication.

4. Postpartum Conditions, because of time urgency during certain postpartum situations, it may be necessary to institute emergency interventions while waiting for physician consultation. These conditions include but are not limited to:
 - a. Seizure
 - b. Significant hemorrhage, not responsive to treatment;
 - c. Adherent or retained placenta;
 - d. Sustained maternal vital sign instability;
 - e. Uterine prolapse;
 - f. Uterine inversion;
 - g. Repair of lacerations(s)/ beyond CNM's level of expertise;
 - h. Anaphylaxis.

5. Neonatal Conditions, because of time urgency during certain postpartum situations, it may be necessary to institute emergency interventions while waiting for physician consultation. These conditions include but are not limited to:
 - a. Apgar score less than 7 at five minutes of age, without significant improvement at 10 minutes;
 - b. Persistent respiratory distress;
 - c. Persistent cardiac irregularities;
 - d. Central cyanosis or pallor;
 - e. Prolonged temperature instability or fever >100.4 degrees Fahrenheit, unresponsive to treatment;
 - f. Significant clinical evidence of glycemic instability;
 - g. Evidence of seizure;
 - h. Birth weight <2300gms;
 - i. Significant clinical evidence of prematurity;
 - j. Significant jaundice or jaundice prior to 24 hours;
 - k. Loss of >10% of birth weight/failure to thrive;
 - l. Major apparent congenital anomalies;
 - m. Significant birth injury.

F. Medications

The CNM shall prescribe and/or administer all necessary medications for safe birth in accordance with SDCL 36-9A-13 and ARSD 20:62:03:11. The CNM shall document in the woman'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.

G. Emergency Care

Certain emergency procedures and medications may be administered by the CNM in a situation in which the health and safety of the woman or newborn are determined to be at risk, including but not limited to:

1. Cardiopulmonary resuscitation of the mother or newborn in accordance with American Pediatric Association and American Heart Association Guidelines.
2. Manual exploration of the uterus for placenta to control severe bleeding.

H. Safe Environment for Birth:

In order to provide the safest possible birth, the CNM shall:

1. Assess the birth setting for freedom from environmental hazards and appropriateness for OOH birth, including but not limited to:
 - a. Making certain a woman has adequate social supports before and during birth;
 - b. Having a signed agreement to transfer the woman and/or infant to the hospital at the discretion of the CNM at any time during labor, delivery and postpartum;
 - c. Having a signed agreement to use anti-hemorrhagics when indicated;
 - d. Developed arrangements for emergency transport prior to 36 weeks;
 - e. Making certain the woman received adequate childbirth and breastfeeding education;
 - f. Making certain the woman has a clean birthing environment and that supplies are orderly;
 - g. Receipt and review of records from previous provider(s) for current or past pregnancies;
 - h. Making certain the woman has in-home help 24-hours a day for at least 3 days postpartum;
 - i. Making certain the woman has pediatric care arranged prior to 36 weeks pregnancy;
 - j. Making certain the woman is physically and mentally healthy and well nourished;
 - k. Making certain preparation of persons planning to be present at the birth is completed;
 - l. Making certain primary participants are mature and able to accept responsibility for outcome of birth;
2. Make certain the woman understands there will be no interventions unless medically necessary; and no use of labor pain medications.
3. Bring the woman’s records and the CNM’s own equipment, supplies to birth setting, as identified under sections “F” and “I” of this document.
4. Ensure a minimum of 2 health care professionals, who have current Neonatal Resuscitation Program (NRP) training and cardiopulmonary resuscitation (CPR) certification, are present at birth and have the knowledge and skills to independently make assessments and implement interventions as needed.
5. Promptly respond to the woman’s needs by providing the woman the CNM’s contact information, emergency contact, and backup plan information.

I. Equipment and Supplies

The CNM shall maintain in good working order all necessary maternal and infant equipment and supplies for safe birth including but not limited to:

- | | | |
|------------------------------------|----------------------|--|
| • Sterile instruments and supplies | • Resuscitation | • Medication and oxygen administration |
| • Doppler/Fetoscope | • IV therapy | |
| • Suctioning | • Sterile soft goods | |
| • Suturing | • Lab | |

Attestation

I, the undersigned, declare and affirm that this document has been examined by me, and I agree to follow these guidelines.

I am aware that should I violate the terms of this document, such an act may constitute cause for termination of this agreement, and I may be subject to discipline of my license to practice in South Dakota.

I understand that this agreement shall not take effect until the agreement has been filed in the office of the Board and written approval from the Board has been received by me.

Signature of Certified Nurse Midwife

Date

Print / Type Name

SD CNM License Number

Email address

Phone Number