APPENDIX 27-3

SAMPLE CERTIFIED NURSE-MIDWIFE (CNM) PROTOCOL (Per Rule 64B9-4, Florida Administrative Code (2007))

[Note: This is a sample for illustrative purposes only. Any such forms must be modified to individual skills, experience and circumstances. Consult a qualified health law attorney.]

I. Requiring Authority:

Chapter 464, Florida Statutes (Florida Nurse Practice Act), Florida Administrative Code, Rule 64B9-4, and Section 458.348, Florida Statutes.

II. Parties to Protocol:

A. Jane Roe, C.N.M., _____, Orlando, Florida 32____, Florida Nursing License #_____, Nurse-Midwifery Certificate #_____ AND

B. Loretta Smith, M.D., _____, Orlando, Florida 32_____, Florida License # ME _____, DEA # _____.

III. Certified Nurse-Midwife:

A Certified Nurse Midwife (CNM) is an individual educated in the two disciplines of nursing and midwifery, who possesses evidence of certification according to the requirements of the American College of Nurse-Midwives (ACNM). Licensure as an Advanced Registered Nurse Practitioner (ARNP) is required in the state of Florida.

IV. Nature of Practice:

This collaborative agreement is to establish and maintain a practice model in which the certified nurse midwife (CNM) will provide health care services under the general supervision of Loretta Smith, M.D., a board certified obstetrician-gynecologist (OB/GYN). This practice shall encompass women's health issues, concentrating on obstetrics and pre-natal care, as well as labor and delivery, as further defined and limited below. It shall also involve wellness and health education and counseling, and the treatment of common health problems of obstetrics patients. The Practice Location is: 123 XYZ Lane, Orlando, Florida 32____.

V. Nurse-Midwifery Practice:

Nurse-Midwifery practice is the independent management of women's health care, focusing on pregnancy, childbirth, the postpartum period care of the newborn and the family planning and gynecological needs of well women. The Certified Nurse Midwife practices within a health care system that provides for collaborative management, with consultation and/or referral indicated by the health status of the client. Certified Nurse-Midwives practice in accord with the current "Standards of or the Practice of Nurse-Midwifery" as defined by the American College of Nurse-Midwives. In Florida, a certified nurse midwife practices according to the requirements set forth by the Florida Board of Nursing.

Nurse-midwifery care is primarily intended for healthy women. However, when women experience medical, gynecological or obstetrical complications, the Certified Nurse-Midwife can continue to be instrumental in their care.

VI. Purpose of Nurse-Midwifery Care:

The purpose of nurse-midwifery care is:

A. To provide the highest quality of obstetrical and well-woman care possible.

B. To collaborate with the existing obstetrical service to establish standards of care.

C. To educate the patient population and professional staff regarding the profession of nurse-midwifery and its area of expertise.

D. To ensure patients' knowledge and understanding in the childbearing process so that they may contribute to the decision-making process regarding their pregnancy.

E. To provide patient education and counseling in all aspects of well-woman health care.

F. To foster the development of an interdisciplinary maternal-child program for comprehensive health care.

G. To provide continuity of care to an identified group of families whose childbearing course is essentially normal. Continuity of care provides for a higher quality of care, promotes the development of meaningful, productive relationships, and maximizes client and nurse-midwifery satisfaction.

VII. Types of Management:

A. **Definitions.**

1. Consultation is a process whereby a Certified Nurse-Midwife maintains primary management responsibility for a patient's care, but seeks the advice or medical opinion of a physician.
2. Collaboration is a process whereby a Certified Nurse-Midwife and a physician jointly manage the care of a woman or newborn who has become medically, gynecologically or obstetrically complicated. The scope of collaboration may encompass the physical care of the client, including delivery by the Certified Nurse-Midwife, according to a mutually agreed upon plan of care. If the physician assumes a dominant role in the care of a patient due to an increased risk status, the Certified Nurse-Midwife may continue to participate in physical care, counseling, guidance, teaching and support. Effective communication between the Certified Nurse-Midwife and the physician is essential for the on-going collaborative management of a patient.
3. Referral is the process by which the Certified Nurse-Midwife directs a patient to a physician or another health care professional for management of a particular problem with the patient's care.

B. **Nurse-Midwifery Management**. The nurse-midwife is able to assume responsibility for the management of obstetric and gynecologic care of patients who are determined to be essentially low risk. Such management includes:

1. Observation, assessment and treatment of patients according to written protocols.

2. Management of patients with selected deviations from normal when;
   a. The diagnosis is clear with an expected, predictable outcome;
   b. A written policy for management exists; and
   c. Consultation with the physician results in a mutual decision for continued nurse-midwifery management of the patient's care. The identification of criteria for

patients appropriate for nurse-midwifery management is a joint responsibility of physicians and nurse-midwives, and is dependent upon mutual agreement.

C. **Collaborative Management.** During the course of care, the Certified Nurse-Midwife will consult the physician when deviations from the normal arise or when a course of action is not already specified in the written protocols. If a condition requires frequent and/or continuing management by a physician, but certain aspects of care remain within the scope of nurse-midwifery management, a situation of collaborative management exists. Under collaborative management, patients will be followed by both the physician and the Certified Nurse-Midwife. Thus, collaborative management requires careful communication between the physician who assumes responsibility for overall direction of care and the Certified Nurse-Midwife who assists in the provision of that care. Management discussions, decisions, plans for care, and actual procedures carried out will be carefully and sequentially documented by the physician and the Certified Nurse-Midwife on the medical records. Collaborative management should be entered on the problem list under plan of care.

D. **Physician Management.** When a patient develops a condition which requires complete management by the physician, she is transferred to physician management. The Certified Nurse-Midwife completely transfers all medical aspects of care for this patient to the physician, but may continue to provide teaching and support services to the patient. Such transfer of responsibility should be noted in the patient's chart on the problem list. The physician must be notified verbally and acceptance by the physician is indicated in writing on the chart. Transfer requests cannot be denied by the physician.

E. **Emergency Management.** The Certified Nurse-Midwife may utilize accepted emergency procedures for patients requiring immediate assistance. Approved practice agreements will be utilized and medical assistance and consultation will be obtained as indicated and as possible under the circumstances.

VIII. Criteria for Patient Selection:

A. The Certified Nurse-Midwife is able to assume responsibility for the management of an obstetric patient:
   1. Whose medical, surgical and obstetrical history reveals no condition that interferes with the normal course of pregnancy.
   2. Whose pregnancy is progressing normally.
   3. Who desires the services of a Certified Nurse-Midwife.

B. The Certified Nurse-Midwife may manage the gynecologic care of the essentially normal patient, consulting or referring as necessary.

C. The Certified Nurse-Midwife is able to assume care of the newborn at the time of delivery including emergency resuscitation measures.

D. Criteria for co-management. The consulting physician should be informed in the following situations or as deemed necessary:

   1. Abnormal presentation.

2. Bleeding other than "show."
3. Cervical Incompetence.
4. Documented placental complication.
5. Gestational Diabetes.
6. Hypertension (BP > 140/90 x2 readings).
7. Intrauterine growth retardation.
8. Moderate to thick meconium stained fluid.
9. Non-reassuring fetal surveillance.
10. Premature labor (< 36 weeks).
11. Previous cesarean delivery.
12. Post dates > 42 weeks.
13. Ruptured membranes > 12 hours with no active labor.
14. Undiagnosed multiple gestation.

SPECIFIC PRACTICE PROTOCOLS FOR INTRAPARTUM MANAGEMENT FOR THE CERTIFIED NURSE-MIDWIFE

IX. Labor Management:

A. **First Stage**

1. Vital Signs.
   a. Temperature q 4 hours with intact membranes, q 2 hours with ROM.
   b. BP-P-R q 1 hour or more if indicated.
   c. Monitor fetus via fetal monitor or auscultation.
2. Enema may be given prn.
3. Ice chips/clear liquids/popsicles may be given in labor.
4. Intravenous infusion may be initiated at discretion of Certified Nurse-Midwife.
5. Evaluation of progress of labor ongoing by Certified Nurse-Midwife and/or nursing staff.
6. Oxytocin per protocol may be initiated by Certified Nurse-Midwife. Physician will be notified as soon as possible or prior to the initiation if consultation required (i.e., trial of labor, induction, etc.).
7. Notify Physician for
   a. NRFS.
   b. Any bleeding other than show.
   c. Maternal distress.
   d. Prolonged 1st stage of labor - primigravida 18 hrs., multigravida 12 hrs.
   e. SROM longer than 12 hours without labor.
   f. Secondary arrest of labor > 2 hours with adequate contraction pattern.
   g. Moderate to thick meconium stained fluid.
   h. Any problems requiring co-management (i.e., Gest DM, IUGR, Hypertension, Previous Cesarean delivery, Postdates > 42 weeks).

B. **Second Stage**

1. Notify Physician of prolonged second stage as indicated.

2. Position for delivery at discretion of Certified Nurse-Midwife.
3. Vital signs as ordered or as indicated.
4. Pudendal block or local filtration as needed.
5. Performs and repairs episiotomy and/or lacerations.
6. Performs vaginal delivery.
7. Suctions infant with DeLee/wall suction on the perineum whenever possible when meconium stained fluid is present. Pediatrician/RT will be notified of meconium stained fluid for intubation/tracheal inspection.

C. **Third Stage**

1. Delivers placenta and membranes and inspect for completeness.
2. Manually removes placenta in an emergency situation. Notify physician for PP hemorrhage, retained placenta >30 minutes, continuous bleeding.
3. Oxtocin may be given IM or IV. Methergine or Ergotrate IM may be given if necessary and patient not hypertensive.
4. Hemobate 250 mcg/ml IM may be given if necessary. Notify physician.
5. Uterine exploration, cervical and vaginal inspection as indicated.
6. Repair of 3rd degree laceration may be done by Certified Nurse-Midwife.
7. Repair of 4th degree laceration to be done by physician. Physician may be called as needed and present for extensive repairs.
8. Anesthesia for repairs - pudendal block or local infiltration of 1% Lidocaine.

D. **Newborn Management:**

1. Anticipate need for pediatrician/RT at delivery by evaluation of laboring patients, history, fetal monitoring and amniotic fluid.
2. Routine immediate care of newborn done by Certified Nurse-Midwife or L&D RN per ANRP protocols.

X. Intrapartum Management:

A. **Amniotomy**

1. Maybe performed when indicated:
   a. Active labor established.
   b. Vertex engaged.
   c. FHR pattern unsatisfactory by external monitor.
   d. Labor induction.

B. **Bladder Distention/Urinary Retention**

1. Catheterize is unable to void and has a palpable bladder.
2. Catheterize post epidural if can't void.
3. Catheterize if suspected shoulder dystocia.

C. **Cervical Ripening**

1. Indication - ripening of an unfavorable cervix in a pregnant woman at or near term with a medical and/or obstetric reason for labor induction.
2. Methods:
   a. Prostin E2 gel 2.5 - 4.0 mg intravaginally q 4-6 hrs.
   b. Misoprostol 25 - 50 mg intravaginally q 4-6 hrs.
3. Begin induction with Bishop Score adequate (usually $\geq$ 7).

D. **Fever (>100.4°F)**

1. Obtain history.
   a. URI, GI/GU, UTI/Pyelonephritis.
   b. Labor status, membrane status.
   c. Fever prior to labor.
   d. Recent exposure to infectious disease or viral syndrome.
2. Physical exam to rule out site of infection other than uterus.
3. Obtain lab studies.
   a. CBC/UA - urine C&S as indicated.
   b. Blood culture as indicated.
   c. Cervical cultures as indicated.
   d. Rapid strep screen as indicated.
4. Management
   a. Consult with physician.
   b. If etiology known, treat appropriately and document.
   c. If low grade fever without obvious etiology, hydrate with IV fluids.
   d. Monitor temperature q 1 hour.
   e. If delivery estimated in <2 hours, try to withhold antibiotic therapy so cultures of infant will not be affected.
   f. Notify nursery and pediatrician of maternal status.
   g. Obtain cultures of placenta post-delivery.
   h. Educate parents for possible steps pediatrician may take in evaluating the infant.

E. **Gestational Diabetes**

1. Check glucose level Q 4 hours as appropriate (Acoucheck).
2. Consult with physician for abnormal values.

F. **Group Beta Strep Prophylaxis**

1. Recommended for:
   a. Preterm labor <37 weeks.
   b. SROM <37 weeks.
   c. ROM>12 hours unless delivery imminent.
   d. Temperature >100.4.
   e. Previous sibling with group B strep infection.
   f. Previous UTI due to group B strep.
   g. With + culture obtained >35 weeks.
2. Antibiotics.

a. Aqueous Penicillin G 5 million units IVPB and then 2.5 million units q 4 hrs.
b. Ampicillin 2 Gm IVPB initially and 1 Gm q 4 hrs.
c. Cleocin/Clindomycin 900 mg IVPB q 8 hrs or Eruthromycin base 500 mg IV q 6 hrs.

3. Notify pediatrician/nursery.

G. **Hemorrhage**

1. First and second stages - usual etiologies are placenta previa, placental abruption, cervical bleed, vasa previa, marginal sinus separation.
   a. Consult with physician.
   b. If possible, obtain pelvic ultrasound.
   c. Apply fetal monitor.
   d. Start IV fluids.
   e. Order Type and screen or type and crossmatch 2 units PRBC per individual evaluation and case..
   f. Give oxygen by mask.
   g. If placenta previa ruled out by ultrasound and fetal vertex at 0 station.
   h. Anticipate rapid delivery by whatever means necessary.
2. Third Stage.
   a. Diagnosed by excessive vaginal bleeding or abnormal rise in fundus.
   b. Check for placental separation and delivery placenta if possible.
   c. Bolus IV fluids or begin IV fluids if none infusing.
   d. Assure empty bladder - catheterize if necessary.
   e. If > 1000 cc blood loss, T&CM for 2 units PRBCs and obtain STAT, CBC. If hgb < 7, consult.
   f. If bleeding brisk and physician has not yet arrived gently remove placenta by manual extraction if possible.
   g. Institute shock precautions (↓ HOB, warm blankets, frequent VS, etc.,). Consider starting second IV.
3. Fourth stage.
   a. Bi-manual compression of uterus - continue until uterus is firm.
   b. Determ. cause of hemorrhage-uterine atony or cervical/vaginal laceration.
   c. Assure empty bladder - catheterize if necessary.
   d. Assure all placenta delivered - re-examine for retained fragments prn.
   e. Oxytocin 20 units to IV fluids/1000 cc, rapid infusion or oxytocin 10 units IM (up to 30 units).
   f. May use Methergine 0.2 mg IM if normotensive.
   g. Consult physician if not correct by above measures.
   h. Consider prostaglandin (Hemobate 250 mcg - 1 amp.) IM or into uterine muscle directly.
   k. If > 1000cc blood loss, T&CM for 2 units PRBCs and obtain STAT CBC. If hgb < 7, consult.
   l. Institute shock precautions (↓HOB, warm blankets, frequent VS. etc.). Consider starting second IV.
   m. Notify charge nurse and anesthesia for stand-by.
   n. Consider Methergine 0.2 mg PO q 4h x 2-6 doses.
4. Cervical/Vaginal lacerations:

a. Tie off bleeders if possible.
b. Notify physician as indicated.

H. **Hepatitis B (+ at delivery)**

1. Mother and infant highly contagious. Hepatitis B can be transmitted through contaminated needle sticks, skin breaks and absorbed through mucous membranes. Consider blood and amniotic fluid as contaminated.
2. Leave membranes intact during labor as long as possible.
3. Avoid use of fetal scalp electrode, scalp pH if possible.
4. Clamp umbilical cord as soon as possible to avoid maternal-fetal transfusion.
5. Obtain extra tube of cord blood for HBsAg, anti Hbe and anti HBc.
6. Alert pediatrician and nursery so that Hepatitis B Immune Globulin and Hepatitis vaccine may be administered as soon as possible.
7. Breast feeding is contraindicated.

I. **HIV**

1. Consult with or refer to physician as soon as detected.
2. Mother and infant considered contagious. Consider blood and amniotic fluid as contaminated.
3. Order AZT per protocol to help prevent transmission to infant.
4. Leave membranes intact during labor as long as possible.
5. Avoid use of fetal scalp electrode, scalp pH if possible.
6. Clamp umbilical cord as soon as possible to avoid maternal-fetal transfusion.
7. Alert pediatrician and nursery so that AZT prophylaxis can be administered within 6 hours of delivery.
8. Breast feeding is currently contraindicated.

J. **Hypertension** (BP $\geq$ 140/90 or if systolic BP $>$ 30mm or diastolic BP $>$ 15mm Hg over baseline.)

1. Perform physical exam.
   a. Palpate RUQ for hepatic tenderness.
   b. Assess location and amount of edema.
   c. Elicit DTRs and check for clonus.
   d. Check urine for protein with dipstick with each void, at least q 2h.
2. Consult with physician.
3. The following may be ordered in an emergency situation:
   a. NST.
   b. CBC with differential.
   c. ALT, AST, Uric Acid, BUN, Creatinine, Fibrinogen, FDP, Antitrombin III.
   d. Clotting studies prn.
   e. 24 hour urine for protein, calcium, creatinine, creatinine clearance.
   f. Continuous fetal monitoring.
   g. MgSO4 per protocol.
4. Patient may be managed by collaboration. The Certified Nurse-Midwife may deliver at the discretion of the physician.

5. Do not administer Methergine if hypertensive.

K. **Labor Augmentation/Induction**

1. Oxytocin augmentation or induction of labor may be started by the Certified Nurse-Midwife.
2. Oxytocin administration - 15 units in 250 cc LR. Begin at 1 mu/min. and increase 1-2 mu/min q 15-30 min. until labor pattern of uterine contractions q 2-3 minutes.
3. Decrease or stop oxytocin infusion at Certified Nurse-Midwife's discretion.
4. Stop oxytocin at end of second stage or as indicated.
5. If tetanic uterine contractions occur with any evidence of NRFS, discontinue oxytocin, bolus IV fluids, administer Oxygen via face mask, turn patient to side and notify physician.
6. Terbutaline .25 mg SQ for tetanic contraction with decreased FHTs.
7. After delivery of placenta: 20 units/1000cc IV fluids, or continue IV infusion from induction/ augmentation at 50-75 cc/hr, or 10 units IM if no IV.

L. **Laboratory Studies: (as needed)**

1. CBC/Hgb/Hct.
2. Urinalysis.
3. VDRL.
4. Rubella titer.
5. Type and Rh.
6. Others as indicated (but not limited to):
   a. Urine Drug Panel/Screen.
   b. HBSAG.
   c. T&CM/Screen.
   d. Chemistry profile.
   e. PT, PTT, fibrinogen.
   f. Culture and Sensitivity.
   g. Ultrasound, biophysical profile.
   h. Chest X-ray.
   I. HIV with consent.

M. **Malpresention**

1. Perform Leopold's maneuvers to ascertain presentation, position, lie.
2. Perform vaginal exam to palpate presenting path.
3. Consult with physician.
4. If suspected face presentation:
   a. Allow time for mentum posterior to rotate anteriorly.
   b. Consult with physician once diagnosis is made and especially if mentum is persistently posterior in late first stage.
5. If suspected brow presentation:
   a. Allow time for brow to convert to an occiput/face presentat. if unengaged.
   b. If brow presentation is well engaged, consult with physician and prepare

patient for both operative or spontaneous delivery.

c. If spontaneous delivery, anticipate need for generous episiotomy to allow passage of large head diameter.

N. **Meconium Stained Amniotic Fluid**

1. Apply fetal scalp electrode during labor when indicated.
2. Suction the oropharynx and nasopharynx prior to delivery of the shoulders with bulb syringe, DeLee trap attached to wall suction.
3. Notify pediatrician and RT to be present at delivery when indicated.
4. With heavy or thick meconium - cut cord promptly so transfer to Peds/RT can be facilitated quickly for assessment of presence of meconium below the vocal cords. Intubate and perform endotrachial suctioning rapidly before the first breath if possible. This may be done by the NICU team (Peds/RT/RN).

O. **Medications** *

1. Sedatives/hypnotics.
   a. Seconal 100 milligrams PO or IM prn.
   b. Nembutal 100 milligrams PO or IM prn.
2. Analgesics/narcotics.*
   a. Demerol 25 -75 milligrams IM or 12.5 - 50 milligrams IV q 3-4 hrs. prn, not to exceed 75 milligrams if given in conjunction with ataractics.
   b. Stadol 0.5 - 2 milligrams IV or IM q 1-2 hours, prn.
   c. Nubain 2.5 - 10 milligrams IV or IM 1-2 hours, prn, not to exceed 40 mg. in 24 hrs.
3. Ataractics.
   a. Phenergan 12.5 - 50 milligrams IM or 12.5-25 mg IV q 3-4 hrs, prn.
   b. Vistaril 25 - 100 milligrams IM q 3-4 hrs, prn.
4. Anesthetic Agents.
   a. Lidocaine 1% not to exceed 50 cc (for pudendal and/or local).
5. Analgesia.
   a. May order walking epidural/regular epidural for pain management.
6. Back labor.
   a. May order sterile water papules .01-.02 cc in 4 locations in lower back for management of back labor.

***Note: This is for general guidance only. Remember, in Florida, Nurse Practitioners are not allowed to prescribe controlled substances.**

P. **Non-Reassuring Fetal Surveillance (NRFS)**

1. Diagnosed by the following:
   a. Consistent late decelerations (x3 episodes).
   b. Any late decelerations in conjunction with other complicating factors (i.e., meconium fluid, pre-eclampsia, DM, maternal fever, etc.).
   c. Severe variable decelerations.
   d. Decrease in fetal heart rate baseline to $<$110 bpm or and increase to $>$ 170

bpm.

2. The Certified Nurse-Midwife will simultaneously:
   a. D/C oxytocin infusion if infusing.
   b. Begin oxygen by mask.

   c. Rotate maternal positions to obtain optimal fetal perfusion - sides, hands/knees.
   d. Bolus IV fluids.
   e. Vaginal exam to assess progress or abnormalities (i.e., cord prolapse, etc.).
   f. Place internal fetal scalp electrode if membranes ruptured. If not ruptured, perform amniotomy if possible and apply electrode (consult with physician if vertex above -2 station).
   g. Consider terbutaline 0.25 mg SQ.
3. Consult with physician if no improvement. Keep physician informed of patient's progress.
4. If continuance of NRFS without resolving, prepare patient for most rapid means of delivery (prepare for emergency C/delivery, if needed).

Q. **Premature Labor**

1. Defined as labor < 36 weeks gestation as determined by dates, size and/or sonogram.
2. Presence of regular uterine contractions with cervical change (defer exam in presence of vaginal bleeding, unless sonogram has ruled out placenta previa).
3. Notify physician as soon as possible.
4. Start IV fluids for bolus.
5. Apply fetal monitor.
6. If patient will be delivered, notify neonatologist/pediatrician.

R. **Prolonged or Arrested Active Labor**

First Stage:

1. Diagnosed by the following:
   a. Active labor: > 4 cm dilation and 75% effacement.
   b. Lack of progress in dilation or effacement for 2 hours in the presence of good contractions.
2. In the absence of other complicating factors:
   a. May relax with analgesic; change positions, or ambulate.
   b. May begin oxytocin augment. of labor, consult with physician if indicated.
   c. In presence of other complicating factors, consult physician.

Second Stage:

1. Diagnosed by the following:
   a. Full dilation of the cervix.
   b. Lack of descent after 30 minutes in a multiparous patient or one hour in a nulliparous.
2. In the absence of other complicating factors, may try position changes, or change in

coaching techniques.

3. In presence of other complicating factors, or if the above measure to not help in 15-20 minutes, consult physician.

S. **Retained Placenta**

1. If patient is bleeding, follow protocol for third stage hemorrhage.
2. If patient is not bleeding:
   a. Observe for signs of separation.
   b. If breast feeding, put baby to breast.
   c. If cervix is clamped closed, may medicate for relaxation.
   d. If expulsion of the placenta has not occurred within 30 minutes:
      1. Give 10 units of oxytocin in 20cc NS into umbilical vein.
      2. Attempt manual removal of placenta.
      3. Call physician if midwife unable to remove placenta.
   e. Consult with physician regarding antibiotic prophylaxis and follow-up hematologic lab studies.

T. **Rupture of Membranes**

1. Documentation of rupture of membranes:
   a. Obtain history.
   b. Perform sterile speculum exam.
   c. Positive findings - pooling, ferning + nitrazine.
   d. If unable to document ROM but history is suspicious, place patient on bed rest and re-examine for pooling after 1-2 hours. Consult with physician regarding use of ultrasound for Amniotic Fluid Index.
2. Documented premature rupture of the membranes (PROM) at 37-42 weeks:
   a. Admit to L&D.
   b. Obtain FHR tracing at least 20 minutes to assess fetal well-being and presence of uterine contractions.
   c. Perform digital vaginal examination.
   d. Ambulate if vertex is engaged or well applied to cervix.
   e. Encourage oral fluids.
   f. If no signs of labor within 8 hours after ROM, consult with physician for orders for inductioncervical ripening.
   g. Limit vaginal examinations.
3. Documented Premature Preterm Rupture of Membranes (PPROM) at < 37 weeks gestation.
   a. Admit to ASCU.
   b. Obtain FHR tracing at least 20 minutes to assess fetal well-being and presence of uterine contractions.
   c. Consult with physician.
   d. Collect at least 3cc amniotic fluid for L/S ratio and PG if appropriate.
   e. Obtain cervical cultures for GC, Chlamydia, GBS as appropriate.
   f. Defer vaginal examinations.
   g. Order CBC with differential.

U. **Shoulder Dystocia**

1. Diagnosed by failure of the shoulder to deliver after the head is delivered; may notice head is very snug to perineum and it may rapidly become phlegmatic.

2. If anticipated, consult with physician.
3. If encountered, call physician STAT.
4. Request readiness for full scale newborn resuscitation effort.
5. Anticipate immediate postpartum hemorrhage.
6. Ask for McRobert's maneuver (exaggerated flexion of the mother's hips) and/or change to the left lateral position.
7. Check shoulder position and rotate to one of the oblique diameters of the pelvis.
8. Request firm suprapubic pressure while applying firm downward pressure on the head to deliver the anterior shoulder.
9. Cut or enlarge the episiotomy.
10. Assure an empty bladder.
11. Perform vaginal exam to rule out other possible causes of labor dystocia (short umbilical cord, thorax or abdominal enlargement).
12. Attempt delivery again with McRobert's maneuver and suprapubic pressure.
13. Perform Wood's corkscrew maneuver.
14. Attempt to deliver the posterior arm, perform Wood's corkscrew maneuver so the anterior shoulder is posterior and deliver.
15. Attempt to deliver to posterior arm.
16. If unsuccessful, fracture the baby's clavicle.
17. If unsuccessful, attempt cephalic replacement.

V. **Subinvolution of the Uterus**

1. If satisfactory involution of uterus has not occurred and bleeding heavy, may give Methergine 0.2 mg PO q 4 hrs x 2-6 doses.
2. In case of elevated BP, may give oxytocin 10 units IM q 4 hrs x 2-6 doses.
3. Order antibiotics if fever present and suspect endometritis.

W. **Trial of Labor After Cesarian (VBAC)**

1. If previous cesarean delivery, obtain records to verify previous incision. Review records with physician to determine options.
2. Type and screen on admission.
3. The physician should be notified of patient's admission and labor status.
4. Physician or Certified Nurse Midwife should be readily available throughout labor.
5. Monitor fetus during active phase.
6. The labor can be augmented following the standard protocol.
7. Notify physician for signs of possible uterine rupture (i.e., excessive pain, decelerations, overt hemorrhage, signs of shock, hypotonic or absent contractions, loss of fetal station).

X. **Vacuum Extraction (if permitted by hospital)**

1. The vacuum extractor may be applied after notification of physician (in absence of clinical evidence of CPD) in the following circumstances:
   a. NRFS if delivery imminent (caput visible at introitus in unresolved bradycardia).
   b. Maternal exhaustion with vertex at +2 station or lower.

c. When extended pushing efforts deemed undesirable after steady progress and descent (i.e., hypertension).

2. At time of notification of physician, preparation of forceps delivery or cesarean delivery should be initiated by physician.

Y. **Umbilical Cord Prolapse**

1. Patient presents with SROM and suspected or known prolapsed cord or NRFS.
2. Call for help STAT. Have someone call physician STAT and notify charge RN to have OR crew stand-by for emergency Cesarean delivery.
3. Do a vaginal exam to elevate presenting part off of the umbilical cord. Keep hand in vagina elevating the presenting part until catheter is in place and the bladder is full. May attempt to remove hand if FHR remains stable while doing this.
4. D/C oxytocin if infusing. May give terbutaline 0.25 mg SQ q 30 minutes to reduce contractions if indicated.
5. Begin O2 by face mask at 8-10 L/min. Bolus IV fluids or begin IV if not in place.
6. Change position to achieve maximum oxygenation (i.e., knee-chest, trendelenburg). Transfer to OR in this position.
7. Insert foley catheter. Using an irrigation syringe, instill sterile water into bladder via foley until bladder is full (500-1000cc).
8. If the umbilical cord is protruding from the vagina, wrap loosely in a towel wet with normal saline.
9. Continue monitoring the fetus until delivered.

Z. **Routine Postpartum Management**

1. Routine postpartum order.
2. Daily assessment should include:
   a. Review of chart and vital signs.
   b. Physical exam to include:
      1. Breasts.
      2. Abdomen.
      3. Lochia.
      4. Perineum.
      5. Bladder/Bowels.
      6. Extremities.
      7. Any other area of concern.
      8. General physical and psychological well-being.
   c. Documentation daily postpartum note.
   d. Teach/reinforce patient regarding self and infant care.
   e. Discharge patients who meet the following criteria:
      1. Vital signs within normal limits.
      2. Physical exam within normal limits.
      3. Lab data within normal limits.
      4. RhoGam given if indicated.
      5. Rubella injection given if indicated.
      6. Counsel and order contraceptive measures.
   f. Notify physician of pending tubal ligation to allow for scheduling.

g. Discharge patients with prenatal vitamins, iron and/or other prescriptions as needed.
h. Counsel regarding follow-up appointment.
I. Consult physician for any abnormal findings.

3. Postpartum Problem Management After Pains.
   a. Etiology - clamping down of uterus to return to its nonpregnant state.
      1. Keep bladder empty.
      2. Teach patient to massage fundus.
      3. Try to express any clots.
      4. Heat to lower abdomen.
      5. Analgesics.
      6. Encourage lying prone.
   b. Anemia.
      1. History - review previous Hgb levels, review estimated blood loss at delivery and amount of lochia since delivery. Subjective data: dizziness, fatigue, etc.
      2. Physical exam to include:
         (1) Vital signs.
         (2) Examine perineum for hematomas.
         (3) Check amount of lochia.
      3. Laboratory studies - may repeat H&H as necessary to evaluate blood loss.
      4. Management education.
         (1) Encourage adequate fluid intake and rest.
         (2) Order iron supplement TID with meals, citrus until 6 week PP exam.
         (3) Patient education - constipating effects of iron, iron rich foods, susceptibility to infection in anemic state.
         (4) Consult with physician as indicated.
   c. Constipation.
      1. Etiology - dehydration in labor, fear of pain due to pisiotomy/laceration repair hemorrhoids.
      2. Treatment:
         (1) Laxatives pm.
         (2) Encourage PO fluids/fiber in diet.
         (3) Ice pack to hemorrhoids.
         (4) Sitz bath, tucks.
   d. Cracked Nipples.
      1. Etiology - improper position while breast-feeding, improper breaking of suction of infant off breast after breast-feeding.
      2. Treatment:
         (1) Air exposure, breast shields, prn.
         (2) Teach proper method for breaking suction after breast-feeding.
         (3) Careful cleaning of breast without soap.
         (4) Refer to Lactation Specialist/Consultant.
   e. Engorgement.
      1. Apply tight breast binder with ice to breasts.

2. May need analgesics for pain.

f. Hemorrhage.
   1. Definition: excessive bleeding after 24 hrs. to 6 weeks postpartum.
   2. Etiology: retained placental fragments, subinvolution of placental site.
   3. Diagnosis: persistent red lochia which may be accompanied by a boggy uterus.
   4. Treatment:
      (1) Methergine 0.2 PO TID x 3 days if normotensive.
      (2) If red lochia persists after Methergine, advise patient to save all clots and return immediately.
      (3) Consult with physician as indicated.
      (4) Moderate to severe bleeding.
         (a) Attempt to express clots from uterus.
         (b) Give Methergine 0.2 mg IM stat, if responds follow with Methergine 0.2 mg q 6 hours x 2-3 days.
         (c) If bleeding severe or doesn't respond, have patient return to hospital if already discharged, and consult physician.
         (d) Draw T&S, CBC.
         (e) Begin IV 1000cc RL with oxytocin 20 units.
         (f) Sterile speculum exam to evacuate any products of conception that may be present in cervix or cervical canal.
         (g) Check vital signs frequently.
         (h) Repeat H&H q 12 hours prn.

g. Hemorrhoids.
   1. Education: measures to avoid constipation; adequate fluids, high fiber diet, regular bowel habits, Kegel exercises to improve blood flow to area.
   2. Ice packs to hemorrhoids for 30-60 min, D/C for one hour. Reapply pm
   3. Warm sitz bath if no relief from ice.
   4. Order local anesthetic ointments or sprays, hemorrhoidal creams or suppositories, especially those containing hydrocortisone.
   5. Reinsert external hemorrhoids if possible and maintain position by Kegel exercises.
   6. Stool softener may be ordered.
   7. Consult for extensive or thrombosed hemorrhoids unrelieved by above measures.

h. Hypertension. Consult physician.

I. Mastitis.
   1. Etiology: usually staphylococus aureus or milk statis.
      (1) Diagnosis:
         (a) Fever, chills, malaise, throbbing breast pain, redness, induration and pain in a wedge shaped area of breast.
         (b) Usually occurs between 8th postpartum day to 3 weeks postpartum.

(2) Treatment:
(a) Tylox, or Tylenol #3 one q 4 hours PO for breast pain.
(b) Hot compresses six times/day for 20-30 mins.
(c) Frequent nursing of expression of breast milk.
(d) Adequate rest.
(e) Antibiotic therapy as indicated.
(f) If no improvement in 48 hrs., consult physician.

j. Subinvolution.
1. Etiology: over-distension of bladder due to lessened sensitivity to fluid tension, anesthesia, edema and pain due to lacerations of the urethral area, trauma from catheterization, excessive IV fluids.
2. Review delivery record for completeness of placenta and membranes. Note length of time from ROM to delivery.
3. Measurement of fundal height, fundal tenderness, boggy uterus may be noted.
4. Lochia: may note foul smelling rubra lochia more than 3 days or lochia reverting to rubra, hemorrhage may occur.
5. Treatment:
(1) If cause undetermined, but retained products not suspected, repeat course of Methergine 0.2 mg PO TID for 3 days if normotensive.
(2) If unresolved after repeat course of Methergine, consult physician.
(3) Educate patient regarding symptoms of hemorrhage.
(4) Suspected uterine infection: treat with antibiotics then consultation with physician if no improvement in 24 hours.

k. Urinary Retention.

1. Etiology: over-distention of bladder due to lessened sensitivity to fluid tension, anesthesia, edema and pain due to lacerations of the urethral area, trauma from catheterization, excessive IV fluids.
2. Diagnosis:
(1) Patient voids small amounts frequently.
(2) Dysuria and urgency common.
(3) Displaced and/or high fundus.
(4) Palpable distended bladder.
(5) Excessive bleeding.
3. Treatment:
(1) Encourage emptying bladder q 2-4 hours.
(2) Encourage increased fluid intake.
(3) Record I & O.
(4) Obtain urine specimen for C&S if indicated.
(5) Treat secondary UTI with appropriate antibiotic.
(6) Straight or foley cather prn.

XI. These Protocols will remain in effect for as long as Loretta Smith, M.D. and Jane Roe, C.N.M., M.N. are associated in the practice of medicine, but in any case not longer than twelve (12) months after the date they signed these Protocols. Review and renewal of these Protocols shall take place not less than annually, and both parties shall share equally in the responsibility of reviewing these Protocols as needed.

XII.

Physician shall file a notice with the Florida Board of Medicine within thirty (30) days of the execution of these Protocols. In the event that these Protocols are terminated, physician shall file notice of such termination with the Florida Board of Medicine within thirty (30) days of any such termination. The CNM must file a protocol at the time of renewal or when there are changes with the Board of Nursing. Alterations or amendments should be signed by all parties and filed with the Board of Nursing within 30 days.

The protocol and any amendments or changes are to be mailed on behalf of the CNM to the **ARNP Department, Board of Nursing, 4052 Bald Cypress Way, Bin #C02, Tallahassee, FL 32399-3252**. If there are no changes to the protocol, only a dated signature page is needed with a statement that there have been no amendments or changes since the last submission. A copy for each review period should be kept by each party for a period of four years.

AGREED TO BY AND BETWEEN:

_____/_____ /License # RN9999999
Jane Roe, C.N.M., M.N. /Date

_____/ _____ /License #ME 999999 /DEA # 999999
Loretta Smith, M.D. /Date

RENEWAL: THE ABOVE IS RENEWED FOR A PERIOD OF _____ YEARS.

_____/_____ /License # RN9999999
Jane Roe, C.N.M., M.N. /Date

_____/ _____ /License #ME 999999 /DEA # 999999
Loretta Smith, M.D. /Date

K:\Fla Nursing Law Manual\Ch-27 Scope of Prof Nursing Practice & Protocols App 27-3.rtf

APPENDIX 27-4

ADVANCED REGISTERED NURSE PRACTITIONER PROTOCOL
(Psychiatric ARNP)
(Per Rule 64B9-4, Florida Administrative Code (2007))

[Note: This is a sample for illustrative purposes only. Any such forms must be modified to individual skills, experience and circumstances. Consult a qualified health law attorney.]

I. Requiring Authority:

Chapter 464, Florida Statutes (Florida Nurse Practice Act), Florida Administrative Code, Rule 64B9-4, and Section 458.348, Florida Statutes.

II. Parties to Protocol:

A. **Jane Doe, ARNP, ARNP-99999**
9999 99th St.
Orlando, FL 32801

B. **John Smith, M.D., # ME-1111** DEA number is: **BF-6666**
6666 66th St.
Orlando, FL 32801

III. Nature of Practice:

This collaborative agreement is to establish and maintain a practice model in which the nurse practitioner **Jane Doe, ARNP** will provide Psych/Mental Health services under the general supervision of Dr. John Smith. This practice shall encompass Psych/Mental health as applicable and shall focus on mental health screening, mental wellness, mental health education, mental health counseling, and the administration of non-controlled substances.

General Area of Practice, Including but not limited to various Out-patient settings (Offices), In-patient setting (Hospitals), PHP's, ECF's, SNF's, ALF's, and various residential treatment centers. **This protocol only pertains to offices and facilities where Jane Doe, ARNP is working under the direct supervision of Dr. Smith.**

IV. Description of the Duties and management areas for which ARNP is responsible:

Jane Doe, ARNP many manage the mental health care for those clients/patients for which he/she has been educated. A practitioner currently licensed under chapter 458, chapter 459, or chapter 466 shall maintain supervising for directing the specific course of mental health treatment. Within the established framework, an advanced registered nurse practitioner man:

(a) Monitor and alter drug therapies.

(b) Initiate appropriate therapies for certain psychiatric conditions.

(c) Perform additional functions as may be determined by rule in accordance with sect.

464.003(3)(c).1., Fla. Stat. The observation, assessment, nursing diagnosis, planning, intervention, and evaluation of mental health care; mental health teachings and counseling of the ill, injured, or infirm; and the promotion of mental health wellness, and maintenance of good mental health.

(d) The nurse practitioner may perform any or all of the following acts within the framework of established protocol:

Manage selected mental health problems.

Establish behavioral problems and diagnosis and make treatment recommendations.

The administration of medications and treatments as prescribed or authorized by a duty licensed practitioner authorized by the laws of this state to prescribe such medications and treatments.

The supervision and teaching of other personnel in the theory and performance of any of the above acts.

Individual Psychotherapy, Group Therapy, Medication Management.

Evaluate patient on admission and conduct rounds.

Initiate referrals.

(e) The conditions for which the ARNP may initiate treatment include,, but are not limited to:

Psych/Mental Health: Depression, anxiety, psychosis, obsessive compulsive disorders, post traumatic stress syndrome, and other mental health disorders.

(f) Treatments that may be initiated by the ARNP, depending on the patient's condition and judgment of the ARNP:

Psych/Mental Health: Initial evaluation of patient, Individual/group/family psychotherapy, Medication management visits, Evaluation and management visits in the office, hospital, or other facilities.

(g) Additional Measures may be initiated by the ARNP:

Psychosocial and Physical History
Mental Status Exam and obtain medical history
Brief Neurological Assessment
Routine Admission and Discharge Orders Including referrals to other health care providers.
--re-initiate psychotropic medication
--special psychiatric precautions
Order routine lab and diagnosis tests such as CBC with Diff, TB, T4, TSH, Folate, B12 levels, EKG, Chest x-rays, urinalysis, RPR.
Order restraints, diets or dietary supplements
Assess, monitor and manage psychiatric disorders

Physical examinations
Consultations and referrals
Initiate, monitor, and alter medications and treatments within approved protocols
Collect and interpret data
Conduct rounds
Appropriately refer to other specialities and disciplines
Individual psychotherapy
Group psychotherapy
Marital and family therapy
Psychiatric evaluations

(h) The following medication may be prescribed, initiated, monitored or altered by the A.R.N.P. in accordance with education and management protocols.

Antidepressants
Mood stabilizers
Antipsychotic agents
Anxiolytics, non-narcotics
Hypnotics, non-narcotics
Antiparkinsonian agents
Antihistamines
Laxatives and stool softening agents
Anticholinergics
Smoking deterrents
Non-narcotic analgesics
Nonsteroidal Anti-inflammatory agents (NSAIDS)
Vitamins
Antidiarrheal agents
Antacids
Antiemetics
Antibiotics
Antifungal
Antiviral
Antiarrhythmic agents
Antianginal agents
Antihypertensive
Anticonvulsants
Respiratory agents
Antidiabetic/Hyperglycemic agents
Thyroid/Antithyroid agents
Diuretics

Also included with the above noted medications is any prescription medication which is not listed as a controlled substance and which is within the scope of training and knowledge base of the nurse practitioner. **Controlled substances may NOT be prescribed by the ARNP.**

V. Descriptions of the duties of the physician:

John Smith, M.D. will provide supervision for routine mental healthcare and provide consultation and/pr accept referrals for complex mental health problems. **Dr. Smith** will be available by telephone through 24 hour service at (888) 852-6672 when not physically available on the premises. If **Dr. Smith** is not available, his associate

Dr. Jones, ME-4444 will serve as backup for consultation, collaboration and/or referral purposes.

VI. Specific Conditions and Requirements for Direct Evaluation.

Any psychiatric complication outside of the scope of the nurse practitioner's education and training will be referred to the physician for direct evaluation.

VII. Signatures:

All parties to this agreement share equally in the responsibility for reviewing treatment protocols as needed and no less annually.

_____	_____
Jane Doe, ARNP	**John Smith, M.D.**
_____	_____
Date	Date

NOTE:

Practicing ARNPs must file a protocol at the time of renewal or when there are changes with the Board of Nursing. Alterations or amendments should be signed by all parties and filed with the Board within 30 days.

The protocol and any amendments or changes are to mailed to the **ARNP Department, Board of Nursing, 4052 Bald Cypress Way, Bin #C02, Tallahassee, FL 32399-3252**. If there are no changes to the protocol, only a dated signature page is needed with a statement that there have been no amendments or changes since the last submission. A copy for each review period should be kept by each party for a period of four years. The supervising physician is responsible for submitting a notice to the Board of Medicine that he/she has entered into a supervisory relationship with an ARNP.