

**South Dakota CPM Scope of Practice: Support and Management of Out-of-Hospital Pregnancy Loss: Spontaneous Abortion, IUFD**

A licensed Certified Professional Midwife (CPM) shall adhere to the scope and practice standards when providing antepartum, intrapartum, postpartum, and newborn care. This includes the event of pregnancy loss over the course of an otherwise routine prenatal period.

Under no circumstances may a licensed certified professional midwife utilize pharmaceutical medications to induce contractions unless a pregnancy loss is confirmed.

First Trimester:

A first trimester spontaneous abortion (SA), more commonly known as a “miscarriage,” occurs between 0 and 12 weeks 6 days of pregnancy per most accurate Estimated Due Date (EDD). Expectant management of the spontaneous expulsion of the products of conception may be undertaken by a CPM in an Out-of-Hospital (OOH) environment so long as:

- a. Pregnancy non-viability has been confirmed by ultrasound documented in the client chart AND/OR spontaneous rhythmic contractions and bleeding have already commenced;
- b. Ectopic or molar pregnancy is not suspected;
- c. Sub-chorionic hemorrhage is not suspected;
- d. Client remains in stable condition; and
- e. Less than four (4) weeks has passed from medical confirmation of a non-viable embryo/fetus.

Conditions that would necessitate client transport to a medical facility include:

- a. Any conditions outlined in ARSD 20:86:03:04;
- b. Suspected ectopic or molar pregnancy; and
- c. More than four (4) weeks elapsed between an ultrasound diagnosis of fetal non-viability and the commencement of spontaneous expulsion (active contractions and bleeding).

Management of a first trimester spontaneous abortion may include:

- a. Administration of pharmaceutical medications to assist in the expulsion of a missed abortion after a diagnosis of non-viability, or manage a postpartum hemorrhage;
- b. Monitoring of maternal vitals;
- c. Cervical visualization; and
- d. Bereavement support.

Second and Third Trimester:

Fetal loss in the second and third trimester is termed an “Intrauterine Fetal Loss” (IUFD). Intrapartum management of an IUFD carries the risk of additional complications not normally found in low-risk pregnancies. IUFD diagnosis may be precipitated by discoveries made in the CPM’s routine course of care, such as inability to auscultate fetal heart tones or other conditions that necessitate medical consultation or transport as outlined in ARSD20:86:03:02 or ARSD 20:86:03:04.

Management of an intrapartum complicated by an IUFD diagnosis may be attended by a CPM in an OOH environment under the following conditions:

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- a. IUD has been confirmed documented in the client chart;
- b. Client has undergone consultation with a Nurse-Practitioner, Certified Nurse Midwife, and/or Medical Doctor;
- c. Client has signed an informed consent documented in the client chart, including elevated risk of postpartum hemorrhage and retained placenta;
- d. Client otherwise meets the conditions for a “low-risk pregnancy.”
- e. Ectopic or molar pregnancy is not suspected; and
- f. Client remains in stable condition.

Conditions that would necessitate client transport to a medical facility include:

- a. Any conditions outlined in ARSD 20:86:03:04 and;
- b. Suspected ectopic or molar pregnancy.

Management of an intrapartum complicated by an IUD may include:

- a. Administration of pharmaceutical medications, particularly for management of postpartum hemorrhage or retained placental;
- b. Rh immunoglobulin administration, if applicable;
- c. Submission of placenta for pathological evaluation;
- d. Preparation of formal medical records, including photographs of relevant medical conditions, with signed client consent;
- e. Monitoring of maternal vitals;
- f. Cervical visualization; and
- g. Bereavement support.

Additional considerations for the CPM include communication with the local medical examiner or funerary providers at the discretion of the client.