

<i>Guideline:</i>	Guideline to Prescribing and Administering Amended Ontario Regulation 884/93 Designated Drugs
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<i>Approved by:</i>	Council
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<i>Note:</i>	This Guideline replaces the rescinded standard <i>Prescribing and Administering Drugs</i> originally approved by Council on May 28, 2008



Guideline to Prescribing and Administering Amended Ontario Regulation 884/93 Designated Drugs

The following guideline applies to the substances that have been added to the Ontario Regulation 884/93 Designated Drugs (as of February 2010), which midwives are able to independently prescribe and administer for their clients in the community, hospital or other sites of midwifery practice. Midwives may not independently prescribe or administer any drugs or substances other than those specified by the Designated Drugs regulation of the *Midwifery Act*, 1991. Midwives are expected to ensure that they remain informed of the current clinical requirements and maintain their competencies in regard to these substances. Any drug that can be administered by a midwife according to the Ontario Regulation 884/93 Designated Drugs can be prescribed by the midwife.

ANTIBIOTICS

When prescribing and administering antibiotics midwives are expected to adhere to recommendations to minimize the risk of developing antibiotic resistance. The safest effective available agent should be prescribed or administered.

Antibiotics, intravenous:

1. Group B Streptococcus

Ampicillin, Cefazolin, Clindamycin, Erythromycin, Penicillin G

Intravenous (IV) antibiotics may only be prescribed and administered on the member's own responsibility to the expectant mother for the prophylaxis of neonatal Group B streptococcus during the intrapartum period.

When a pregnant woman requires treatment for or prophylaxis for Group B streptococcus and she is allergic to penicillin G, laboratory confirmation of drug sensitivities to the culture should be obtained to ensure that the most appropriate antibiotic is selected. Ampicillin is an alternative choice to penicillin, and cefazolin is recommended in penicillin allergic patients. In patients at high risk for anaphylaxis to penicillin, intravenous clindamycin or erythromycin is recommended.¹

Intravenous antibiotics cannot be prescribed on the member's own responsibility in any other situation.

¹ Centre for Infectious Disease Preventions and Control, Canadian Task Force on Preventive Health Care's *Prevention of Early-onset Group B Streptococcal Infection in the Newborn* (updated 2002). Available online at <http://www.ctfphc.org/>

SOGC clinical practice guidelines no. 149, September 2004. "The prevention of early-onset neonatal group B streptococcal disease." JOGC, Sept 2004: 826-32

Antibiotics, oral:

Oral antibiotics may only be prescribed by the member in the course of routine provision of midwifery care. This includes treatment for:

1. Urinary tract infections (UTI)²

Ciprofloxacin, Sulfamethoxazole-trimethoprim, Nitrofurantoin, Trimethoprim

Oral (PO) antibiotics should be prescribed after culture and sensitivities have been identified. Sulfamethoxazole-trimethoprim and trimethoprim should be avoided in first trimester of pregnancy due to increased risk of neural tube defects (NTDs). If clinically required during first month of pregnancy, a high dose of folic acid (4mg/day) should be given to prevent NTDs.³

Sulfamethoxazole-trimethoprim should be avoided in the last 2 to 6 weeks of pregnancy since sulfonamides may displace bilirubin from albumin binding sites and cause kernicterus in infants, especially at preterm.

Fluoroquinolones (e.g., ciprofloxacin) should not be prescribed during pregnancy unless the benefit outweighs the risk and all other antibiotic options have been eliminated.

*If symptoms persist after the prescribed course of treatment
referral to a physician for consultation is required.*

2. Mastitis

Amoxicillin-clavulanic acid, Cephalexin, Ciprofloxacin, Clindamycin, Cloxacillin

Antibiotics are prescribed only for fever and signs and symptoms of blocked duct that do not resolve within 24 hours or are worsening quickly after non-pharmacological treatment.

*If symptoms persist after the prescribed course of treatment
referral to a physician for consultation is required.*

² Urinary tract infections in pregnancy, M Lee RPh, P Bozzo, A Einarson RN, G Koren MD

³ Medication Safety in Pregnancy and Breastfeeding, by Gideon Koren MD, Motherisk

3. Bacterial Vaginosis Clindamycin, Metronidazole

Women with a past history of premature labour and who have Bacterial Vaginosis (BV), whether or not it is symptomatic, may benefit from treatment with antibiotics. Bacterial vaginosis during pregnancy is associated with premature rupture of the membranes, chorioamnionitis, preterm labour, preterm birth and post-cesarean delivery endometritis. During pregnancy, treatment is recommended for symptomatic patients and asymptomatic women with BV who have had a previous preterm birth. The goal is to reduce the risk of preterm prelabour rupture of the membranes and low birth weight.

*If symptoms persist after the prescribed course of treatment
referral to a physician for consultation is required.*

Antibiotics, topical:

1. Breast and Nipple Pain

Mupirocin-betamethasone valerate-miconazole (All Purpose Nipple Ointment)

Topical antibiotics may be used as part of a therapeutic regime for breast and nipple pain. All Purpose Nipple Ointment is a combination antibiotic, antifungal and low dose steroid cream that may be used to treat persistent nipple pain. It is used as a topical treatment for candidiasis of the nipple in the breastfeeding woman, with or without secondary bacterial infection. The cream should be applied sparingly to the nipples after each feeding and not washed or wiped off, even prior to the next feed. All Purpose Nipple Ointment is not recommended for use in pregnancy. While generally well tolerated, All Purpose Nipple Ointment should not be used over large areas of the skin, and is not intended for prolonged use.

*If the condition has not improved within a week
referral to a physician for consultation is required.*

Non-steroidal anti-inflammatory drugs (oral)

1. Postpartum Pain

Diclofenac, Naproxen

Oral non-steroidal anti-inflammatory drugs (NSAIDs) may be used to treat postpartum pain. The general approach to the use of NSAIDs in any population is to use the lowest dose for the shortest period of time to reduce the risk of any adverse events including GI bleeding. NSAIDs should not be given to clients who are asthmatic or allergic to ASA. Ibuprofen is the least potent of the NSAID group and at formulations up to 400

mg is available as an OTC. Naproxen and acetaminophen have been proven to have the same effect on postpartum pain.⁴

Anti-hemorrhagics and oxytocics

1. Management of postpartum bleeding Carbetocin, Misoprostol

Oxytocics and anti-hemorrhagics are to be administered for the management of postpartum bleeding on the member's own responsibility. The choice of agent and method of administration will be dependant upon the clinical scenario and availability of these medications.

Carbetocin - off label

Carbetocin (e.g., Duratocin®) is approved for use in Canada for the prevention of uterine atony and postpartum hemorrhage following elective cesarean section under epidural or spinal anesthesia. It was shown to be effective for the off-label treatment of postpartum hemorrhage following vaginal birth, and is used as a second-or-third line agent in Ontario hospitals, used only after oxytocin and ergonovine maleate, where available, have been attempted.

Midwives are not authorized to use Carbetocin to treat anything other than postpartum hemorrhage.

Misoprostol - off label

Misoprostol is a synthetic prostaglandin E₁ analog that is approved for use as an antisecretory agent with protective effects on the GI mucosa. It was shown to be effective for the off-label treatment of postpartum uterine atony or postpartum hemorrhage uncontrolled by the use of oxytocin. Misoprostol is a second-or-third line agent, used only after oxytocin and ergonovine maleate, where available, have been attempted. Misoprostol should not be taken by anyone with a history of allergy to prostaglandins. If misoprostol is administered as a third line agent in response to a postpartum hemorrhage occurring out-of-hospital, transport to hospital and consultation with a physician is indicated. The use of misoprostol for prevention of PPH or for the induction of labour is currently under evaluation. Its use for induction of labour in the presence of a living fetus is restricted to clinical trials. Midwives CANNOT prescribe or order misoprostol for this application. However, where a

⁴ Skovlund et al, European Journal of Clinical Pharmacology, 1991, Volume 40, Number 6, pg. 539-542.

physician has ordered misoprostol for induction of labour in a non-viable pregnancy, the midwife may continue to be involved in the woman's care.

Midwives are not authorized to use Misoprostol to treat anything other than postpartum hemorrhage.

Local Anesthetics

1. Perineal Repairs in Immediate Postpartum

Bupivacaine, Chlorprocaine

Local anesthetics are to be administered on the member's own responsibility for the management of pain during the repair of the perineum in the immediate postpartum period. The choice of agent and method of administration will be dependent upon the clinical scenario, the local community standard and availability of these medications.

Bupivacaine (MARCAINE)

Amide local anesthetic for infiltration block anesthesia for use during perineal repair that is slightly slower acting (5-10 minutes) but has a longer duration of effect (2-4 hours). Lidocaine (Xylocaine) is an amide local anesthetic and remains available to midwives.

Chlorprocaine (NESACAINE)

Ester local anesthetic for infiltration block anesthesia for use during perineal repair, that is rapid acting and has a shorter duration of effect (less than 30 minutes). This local anesthetic is more likely to cause hypersensitivity.

All local anesthetics are approved for use by midwives only on perineal repairs in the immediate postpartum.

Other Drugs

1. Domperidone - off label

Domperidone is an antidopaminergic drug approved for the treatment of nausea and vomiting. It has been used off-label to enhance breastmilk production in women where non-pharmacologic methods have proven ineffective and/or in women with a previous history of inadequate milk supply. Domperidone must not be given intravenously. Caution should be used in patients with hepatic disease and with those taking anticholinergics, since they may antagonize the effect of the domperidone in the GI

tract. It should not be co-administered with ketoconazole due to the increased risk of QTc prolongation and associated heart arrhythmias.

Midwives are not approved to use Domperidone treat anything other than inadequate milk supply. As noted in the CMO's Mandatory Indications for Discussion, Consultation and Transfer of Care, if the newborn has not regained birth weight by three weeks postpartum, consultation with a physician is required.

2. Measles / Mumps / Rubella (MMR) Vaccine

(e.g., M-M-R® II, Priorix®) Women found to be rubella-susceptible during the antenatal period should be offered MMR vaccine in the immediate postpartum period. Women without detectable antibodies or no prior vaccination for rubella should be immunized only if they are not pregnant at vaccination time and if pregnancy is avoided for 1 month following vaccination. MMR vaccine should not be administered to individuals who are pregnant (the possible effect on the fetus is not known), have acute febrile respiratory or other infections, or any acute illness, have a history of sensitivity to neomycin or gelatin; have blood dyscrasias, lymphomas or other generalized malignancies; have untreated active tuberculosis; or are undergoing treatment with immunosuppressive agents of any kind. Breastfeeding is not a contraindication to receiving this vaccination. Whenever vaccines are administered the midwife must send a record of immunization to the physician to whom care is transferred at 6 weeks postpartum. A record of immunization should also be sent to the local public health unit in communities where this is required.

3. Varicella Zoster immune globulin

(e.g., VariZIG™) Varicella zoster immune globulin is recommended for susceptible people, including pregnant women, provided that significant exposure has occurred. Administration of varicella zoster immune globulin is recommended for prevention or reduction of severity of maternal infections within 4 days of exposure to the varicella zoster virus. Greatest effectiveness of treatment is expected when it is begun within 4 days of exposure; treatment after 4 days is of uncertain value. Pregnant women may be at a higher risk of complications from chickenpox than healthy adults. The decision to administer varicella zoster immune globulin to a pregnant woman should be evaluated on an individual basis. The clinician should consider the patient's health status, type of exposure, and likelihood of previous unrecognized varicella infections before deciding whether to administer varicella zoster immune globulin. If after careful evaluation of all available information, which may include the use of reliable and sensitivity tests for varicella antibody, a normal pregnant woman with significant exposure to varicella is believed susceptible, varicella zoster immune globulin may be administered. It is not known whether it is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when varicella zoster immune globulin is administered to a nursing mother.