Northwest Territories Minister of Health and Social Services

MAR 30 2007

CHUCK PARKER
DEPUTY MINISTER

Midwifery Practice Framework with Prescription Drug List

I hereby authorize the adoption of the revised Midwifery Practice Framework with the inclusion of Schedules C and D, making up the lists of drugs and products registered midwives in the Northwest Territories may prescribe.

Floyd K. Roland

NWT Midwifery Practice Framework

1. Introduction

The *Midwifery Profession Act* (the Act) allows for the establishment of a Midwifery Practice Framework. The Framework sets out the midwifery model of practice and defines the principles on matters such as continuity of care, informed choice and collaborative care. In conjunction with the Act and its regulations, it guides the practice of Registered Midwives in the NWT. It should be noted that if there is a conflict between the Act and the Framework, then the Act prevails to the extent of the conflict. Appendix I-A includes the key sections of the Act, as it relates to this Practice Framework; Appendix I-B is a Glossary of terms. Appendix I-C is the Pharmacy List for Registered Midwives in the NWT, which lists which drugs and substances midwives in the NWT may prescribe. Appendix I-D addresses Schedule II and III Drugs and Medical Supplies and Equipment.

The NWT Midwifery Practice Framework was developed with the input of the Midwives Association of the NWT and NU, departmental representatives and other healthcare professionals in the NWT. In addition, national and international reference material from organizations such as the International Confederation of Midwives, World Health Organization, International Federation of Gynaecology and Obstetrics was considered. The GNWT Executive Council reviewed and recommended the adoption of this Practice Framework in March 30, 2005 and the Minister, Health and Social Services adopted this Practice Framework on March 30, 2005. The Executive Council recommended the revision of the Framework on March 30, 2007 to incorporate Appendix C and D. The Minister, Health and Social Services, adopted this revised Framework on March 30, 2007.

2. Philosophy of Midwifery Care in the NWT

Midwifery care is based on a respect for pregnancy as a state of health, and childbirth as a normal physiological process. Given that there is a great range of "normal" in pregnancy and childbirth, any decision to intervene in the natural process is made only after thoughtful and careful assessment. When pregnancy and birth deviate from normal or become complicated, supportive and appropriate care assists women to maintain a healthy perspective on the childbearing experience.

The practice of midwifery is founded on the understanding that pregnancy, labour and birth are profound experiences that carry significant meaning for a woman, her family and her community. Midwives acknowledge the social, emotional, cultural, spiritual, and psychological as well as physical aspects of these lifecycle events and strive to help women and their families to move through these transforming experiences safely and with power and dignity.

Midwifery care is woman-centred and family-centred and responds to the unique strengths and needs of each woman and her family. Midwives respect and support women as primary decision-makers who are capable of making thoughtful and appropriate choices for themselves and their babies based on current information available to them, in accordance with their own values and belief systems.

Midwives promote health in women, babies and families through the provision of a continuum of services from the preconception period right through to the period of infancy and early parenting. Midwives work with women and their family members to encourage awareness, self-

care, and growth in a manner that is flexible, creative, empowering and supportive, in accordance with s.2. (1) of the Act.

Midwives honour traditional and cultural birth practices. Midwives embrace the diversity of cultural lifestyles and strive to understand the wisdom of elders' teachings and the contributions of traditional midwifery.

3. Midwives as Autonomous Healthcare Providers

Midwives are autonomous primary health care providers whom clients may choose as their first point of entry to the maternity care system, in accordance with s.4 (a) of the Act.

As primary health care providers, midwives make autonomous decisions in collaboration with their clients and are fully responsible for the provision of primary health services within their scope of practice. They coordinate services to ensure continuity of care, identify conditions requiring management outside their scope of practice and refer such cases to other providers.

4. Accessibility of Midwifery Care

Midwives work with the families, communities and agencies that support their practice to ensure equitable access to midwifery care for all women regardless of their place of residence or circumstances.

Midwives offer their services to all women within their practice area and engage in outreach efforts approved by their Health Authority to facilitate the access of all women to midwifery care. Where the availability of midwifery services is limited, midwives make every reasonable effort to serve women in their own community and from outlying communities.

Midwives work with communities desiring midwifery services to develop appropriate and practical approaches to the provision of midwifery care. Wherever possible, midwifery services are provided as close to women's home communities as prudent.

5. Community Input

Community input is fundamental to the development, implementation, and evaluation of effective midwifery practice across all settings.

The relationship between midwives and communities they serve is historically and culturally important as well as being vital to the future well being of the community. Midwives are best able to respond to the needs of the community when the community is provided with meaningful opportunities to identify those needs and to work in partnership to meet them.

Community input is crucial during the development, ongoing delivery, and evaluation of midwifery services and education. Every midwife has, along with other stakeholders, a responsibility to facilitate community input.

6. Community-Based Practice and Practice Sites

Midwives provide community-based service with facility privileges enabling them to provide care in a variety of settings, including hospitals, health-care facilities, clinics, health units, community health centres, birth centres and homes.

Midwives are primary caregivers, visible in their community-based practice. They deliver their services within small group practices or as part of a multi-disciplinary team enabling them to ensure the provision of 24-hour availability to their clients.

Prenatal care is most appropriately provided in midwifery clinics, offices, or women's homes. Midwifery care for labour, birth and early postpartum is provided in an appropriate setting chosen by the woman. Midwifery care for postpartum women and their newborns is generally best provided in the home and later in the midwifery clinic or office. Midwives must be able to obtain privileges at health-care or hospital facilities that permit them to serve in their capacity as a primary care provider.

7. Choice of Birth Setting

Midwives respect the right of women to make informed choices about birthplace and setting, and are competent and willing to provide care in a variety of settings, including homes, hospitals, health-care facilities, and birth centres.

The ability to attend women in their chosen birth setting is an essential aspect of continuity of care and informed choice in midwifery practice. Midwives facilitate and document an informed choice discussion about appropriate birth setting with each of their clients. Ultimately, women choose a birthplace and setting, in consultation with their family, their midwife, and other caregivers where appropriate.

Within the context of the communities in which they practice, midwives offer women a variety of settings for their labour and delivery care including hospitals, health-care facilities, birth centres and homes. Midwives must be able to obtain privileges at hospitals and health-care facilities and be able to function within their scope of practice in all settings.

Choice of birth setting is a fundamental principle of the midwifery model of practice and as such serves to increase the likelihood that women will have equitable access to care in their chosen place of birth. This is particularly important in rural and remote communities where it is unlikely that women will have access to a choice of midwives.

8. Two Attendants at each Birth

Midwives work with a qualified second attendant to provide safe care at births.

The safest care can be provided when there are two qualified attendants physically present at each birth. Both attendants must be skilled in neonatal resuscitation and the management of maternal emergencies in accordance with s.2. (1) of the Act and the Registration Regulations under the Act.

The second birth attendant must understand and support the midwifery model of care, and could be another midwife, or a health care practitioner with the knowledge and skill required to assist the midwife, the birthing woman, and the newborn.

9. Partnership with Women

Midwives practice in partnership with women.

The provision of midwifery care is an interactive process that involves the promotion of shared responsibility between midwives, women and their families. Midwives contribute to the partnership through their knowledge, skills, understanding and professional judgement, and do so in a manner that is flexible, creative, empowering and supportive of women. Midwives encourage an open discussion with clients about the nature of their partnership and the partners' mutual expectations.

10. Informed Choice

Midwives respect the right of women to make informed choices and actively encourage informed client decision-making.

Informed choice and responsiveness to consumer needs are guiding principles of the midwifery model that form the cornerstone of regulated midwifery practice. Informed choice is a decision-making process that relies on a full and ongoing exchange of information in a non-urgent, non-authoritarian, co-operative manner.

Midwives support the principle of informed choice by:

- Recognizing and supporting women as primary decision-makers and promoting shared responsibilities between women, their families, and their caregivers
- Assisting women to obtain information and to utilize resources relevant to their decision-making process
- Discussing the scope and limitations of midwifery care with their clients.

11. Continuity of Care

Midwives provide to women and newborns a continuum of care in the pre-conceptual, prenatal, labour, birth, and postpartum periods in accordance with s.2 (1) of the Act. This includes counselling, education and support related to the woman's physical, psychological, and social needs.

Continuity of care is both a philosophy and a process that enables midwives to provide holistic care and to establish ongoing partnerships with their clients in order to build understanding, support and trust. Continuity of midwifery care is achieved when a relationship develops over time between a woman and her midwife or midwives. Continuity of care is facilitated when:

- One midwife is identified as the primary care provider for the woman, even within the context of group practice
- Wherever possible, the primary care provider is able to attend the birth of his/her client.
- A consistent philosophy of care and a coordinated approach to clinical practice is maintained by midwives and other caregivers
- Communication links are established and maintained between the caregivers in a woman's home community and the referral centre.
- A woman has input into the manner in which continuity of care is provided.

12. Collaborative Care

Midwives identify, assess, and respond to conditions and situations that warrant the involvement of other care providers, and collaborate with other health and social service professionals to ensure that their clients receive the best possible care.

As autonomous primary health care providers, midwives make decisions in partnership with their clients and are fully responsible for the provision of primary health services within their scope of practice as defined in the Act and the Standards of Practice as identified in the regulations under the Act. They identify conditions that necessitate consultation with or referral to other care providers. In situations where transfer of care to a physician is required, the midwife is expected to continue providing supportive care after transfer when possible, and will resume primary care if and when appropriate.

Collaboration with other health care providers occurs with informed client choice, in the best interests of the client, and in such a way that individualized client care and continuity of care are optimized.

13. Accountability and Evaluation of Practice

Midwives are accountable to their clients, their peers, and the wider community for safe, competent and ethical practice. Midwives continuously evaluate their practices to improve the quality of care they provide and to ensure their clients' needs are met.

Midwives' fundamental accountability is to the women in their care. Midwives are also accountable to the Minister of Health and Social Services, the health agencies that they practice with and to the public.

Midwifery practice incorporates evaluation that includes ongoing community input and participation in current practices and standards to ensure evidence-based midwifery practice. Results of these evaluations are widely distributed to influence policy, education and midwifery practice.

14. Research

Midwives develop and share midwifery knowledge.

Midwives initiate, promote and participate in research regarding midwifery care and/or related outcomes that meet ethical guidelines and legal requirements.

15. Education

Midwives have a responsibility to share their knowledge and experience with colleagues, clients and students of midwifery.

In keeping with the history and tradition of midwifery, midwives have a responsibility to participate in the education of midwifery students.

From the Act:

2. The registered midwife is entitled to apply midwifery knowledge, skills and judgement

(a) to provide counselling and education related to childbearing;
(b) to carry out assessments necessary to confirm and monitor pregnancies;
(c) to advise on and secure the further assessments necessary for the earliest possible identification of pregnancies at risk;
(d) to identify the conditions in the woman, fetus or newborn that necessitate consultations with or referral to a medical practitioner or other health care professional;
(e) to care for the woman and monitor the condition of the fetus during labour;
(f) to conduct spontaneous vaginal births;
(g) to examine and care for the newborn in the immediate postpartum period;
(h) to care for the woman in the postpartum period and advise her and her family on newborn and infant care and family planning;
(i) to take emergency measures when necessary;
(j) to perform, order or interpret prescribed screening and diagnostic tests;
(k) to perform episiotomies and amniotomies and repair episiotomies and lacerations not involving the anus, anal sphincter, rectum and urethra
(l) to prescribe and administer drugs authorized in the Midwifery Practice Framework; and
(m) on the order of a medical practitioner relating to a particular client, to administer any drugs by the route and in the dosage specified by the medical practitioner

4. A registered midwife may, in a accordance with this Act, the regulations and the Midwifery Practice Framework, engage in the practice of registered midwives as a primary health care provider who:
(a) is directly accessible to clients without referral from a member of another health profession;
(b) is authorized to provide the services of a registered midwife without being supervised by a member of another health profession; and
(c) consults with medical practitioners or other health care professionals if medical conditions exist or arise that may require management outside the scope of the practice of registered midwives.

5. (1) The Minister, on the recommendation of the Executive Council, may establish a framework respecting the practice of registered midwives.

(2) Where a framework respecting the practice of midwifery has been established by an association, person or body of persons in a province or another territory and is available in written form, the Minister, on the recommendation of Executive Council, may adopt the framework or the framework as amended from time to time, and upon adoption of the framework is in force in respect of registered midwives either in whole or in part or with such variations as may be specified in the instrument adopting the framework.

Glossary of Terms

This glossary of terms is for the purpose of the Midwifery Practice Framework and the Standards of Practice for Registered Midwives in the NWT.

Immediate Post-Partum Period:
means the puerperium: the period of 42 days (six weeks) following childbirth and expulsion of the placenta and the membranes. The generative organs usually return to normal during this time.
Source: Taber's Cyclopedic Medical Dictionary 16th edition, 1989

Infant:
means a liveborn fetus from the time of birth up to one year of age
Source: Taber's Cyclopedic Medical Dictionary 16th edition, 1989

Midwife:
means a registered midwife as defined by the Act

Newborn:
means an infant from birth to four to six weeks of age
Source: Taber's Cyclopedic Medical Dictionary 16th edition, 1989

Care of the Newborn:
means to examine and care for the newborn in the immediate post-partum period

Post-Partum Care of the Woman:
means care provided to the woman in the post-partum period

Post-Partum Period:
means a period of up to 12 months following childbirth and expulsion of the placenta and the membranes

Pharmacy List for Registered Midwives in the NWT

In accordance with the *Midwifery Profession Act* **s. 2(1) (l)** and pursuant to the *Pharmacy Act* **s. 20(1)(c)**, registered midwives are authorized to prescribe, order, and administer the drugs listed below within the midwifery scope of practice and/or in consultation with a physician, where clinical conditions warrant a consultation as outlined in the Standards of Practice for Registered Midwives in the NWT. Midwives are also authorized, on the order of a medical practitioner relating to a particular client, to administer any drugs by the route and in the dosage specified by the medical practitioner (Midwifery Profession Act **s. 2(1) (m)**.)

ITEM NUMBER	SUBSTANCE OR DRUG
1.	Amoxicillin and its salts and derivatives
2.	Ampicillin and its salts and derivatives
3.	Azithromycin and its salts and derivatives
4.	Bacillus Calmette-Guerin vaccine
5.	Betamethasone
6.	Blood products
7.	Calcium gluconate (injectable)
8.	Carboprost/Hemabate
9.	Cephalosporin C and its salts and derivatives
10.	Cervical caps
11.	Ciprofloxacin and its salts
12.	Clindamycin and its salts and derivatives
13.	Clotrimazole and its salts
14.	Cloxacillin and its salts and derivates
15.	Cotrimoxazole (sulfamethoxazole - trimethoprim)
16.	Crystalloid intravenous fluids
17.	Dexamethasone
18.	Dextrose in concentrated solutions for parenteral injection
19.	Diaphragms
20.	Dimenhydrinate
21.	Domperidone
22.	Doxycycline and its salts and derivatives
23.	Doxylamine and its salts (when sold or recommended for use in the nausea or vomiting of pregnancy)
24.	Econazole and its salts

ITEM NUMBER	SUBSTANCE OR DRUG
25.	Epinephrine and its salts
26.	Ergot alkaloids and their salts
27.	Erythromycin and its salts and derivatives
28.	Ferrous gluconate (injectable)
29.	Ferrous sulphate (injectable)
30.	Fluconazole
31.	Folic acid
32.	Hepatitis B immune globulin
33.	Hepatitis B pediatric vaccine
34.	Hormonal contraceptives
35.	Hydralazine and its salts
36.	Hydrocortisone
37.	Ibuprofen and its salts
38.	Indomethacin
39.	Intrauterine devices
40.	Labetolol
41.	Lidocaine hydrochloride without epinephrine, up to 2%
42.	Magnesium sulfate (injectable)
43.	Mefenamic acid and its salts
44.	Metoclopramide
45.	Metronidazole
46.	Miconazole and its salts
47.	Misoprostol
48.	MMR adult vaccine
49.	Naloxone and its salts
50.	Naproxen and its salts
51.	Nitrofurantoin and its salts
52.	Nitrous oxide (inhalation analgesia)
53.	Nystatin and its salts and derivatives
54.	Oxytocin
55.	Penicillin and its salts and derivatives
56.	Pentastarch plasma volume expander
57.	Promethazine
58.	Ranitidine

ITEM NUMBER	SUBSTANCE OR DRUG
59.	Rho D immune globulin
60.	Sodium bicarbonate 4.2%
61.	Sulphonamides and their salts and derivatives
62.	Support hose
63.	Terconazole and its salts
64.	Trimethoprim and its salts
65.	Varicella vaccine
66.	Varicella Zoster immune globulin
67.	Vitamin K

Schedule II and III Drugs and Medical Supplies and Equipment

Schedule II and III Drugs

For greater clarity, registered midwives, as autonomous primary health care providers (section 3. in the Midwifery Practice Framework) may also provide prescriptions for National Association of Pharmacy Regulatory Authorities (NAPRA) Schedule II and III drugs, pursuant to the *Pharmacy Act* **s. 17(3)** and **s. 18(3)**.

Medical Supplies and Equipment

For greater clarity, registered midwives, as autonomous primary health care providers (section 3. in the Midwifery Practice Framework) may also provide orders for medical supplies and equipment, which are available at pharmacies.