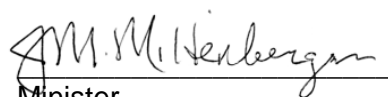


STANDARDS OF PRACTICE
FOR
REGISTERED MIDWIVES
IN THE NWT
FEBRUARY 2005

The Midwives Association of the NWT and Nunavut developed these “Standards of Practice for Registered Midwives in the NWT”, in consultation with the Department of Health and Social Services and Regional Health and Social Services Authorities. The Minister, Health and Social Services has approved these standards.

A handwritten signature in black ink, appearing to read "M. M. Heberger", written over a horizontal line.

Minister
Health and Social Services

February 6, 2005

Table of Contents

1.	General Competencies of Registered Midwives	1
1.1	<i>Registered midwives have the knowledge and skills necessary to:</i>	1
2.	Standards for Collaborative Care, Guidelines for Medical Consultation and Transfer of Care to a Physician	3
2.1	<i>Purpose of the Standard</i>	3
2.2	<i>General Criteria for Collaborative Care</i>	3
2.3	<i>Primary Care in a Multidisciplinary Environment</i>	3
2.4	<i>Primary Care Provided in Association with Other Practitioners</i>	4
2.5	<i>Consultation and Collaboration with Physicians</i>	5
2.6	<i>Indications for Medical Consultation</i>	7
3.	Standards for Birth in a Hospital	10
3.1	<i>Definition</i>	10
3.2	<i>Purpose</i>	10
3.3	<i>General Criteria</i>	10
3.4	<i>Considerations in Choosing a Birth in a Hospital</i>	10
3.5	<i>Roles in the Provision of Care</i>	11
4.	Standards for Birth Outside of a Hospital with Specialist Care	12
4.1	<i>Definition</i>	12
4.2	<i>Considerations in Choosing Birth outside a Hospital with Specialist Care</i>	12
4.3	<i>Equipment and Supplies Needed for Birth Outside a Hospital or Healthcare Facility</i> .	13
4.4	<i>Established Links and Prior Arrangements</i>	14
4.5	<i>Conditions requiring Transport to a Hospital with Specialist Care</i>	15
5.	Standards for Records	16
5.1	<i>Purpose</i>	16
5.2	<i>Completion of Records</i>	16
5.3	<i>Confidentiality</i>	16
5.4	<i>Storage</i>	17
5.5	<i>Accessibility</i>	17
6.	Standard on Informed Choice.....	17
6.1	<i>Purpose</i>	17
6.2	<i>Principles</i>	17
6.3	<i>Facilitation of the Informed Choice Process</i>	17
7.	Standard for Responding to Client Requests for Care Against Midwifery	19
7.1	<i>Purpose</i>	19
7.2	<i>Protocol for Responding to Request for Care Against Midwifery Advice</i>	19

STANDARDS OF PRACTICE FOR REGISTERED MIDWIVES IN THE NWT

In conjunction with the *Midwifery Profession Act* and its regulations, the Standards of Practice provides standards for the practice of Registered Midwives in the NWT. It should be noted that if there is a conflict between the Act and the Standards, then the Act prevails to the extent of the conflict. The Standards of Practice are not intended to extend the scope of practice contained in the NWT *Midwifery Profession Act*.

1. General Competencies of Registered Midwives

1.1 Registered midwives have the knowledge and skills necessary to:

1. Provide the necessary care and advice to women before and during pregnancy, labour, birth and the postpartum period
2. Provide health assessment, screening and care to woman and families within their scope of practice
3. Provide continuity of care over the childbearing cycle
4. Provide care that validates the woman's experience and respects the rights of women to control their pregnancies and birthing experiences
5. Provide culturally safe care
6. Promote physiological birth and use technology appropriately
7. Assess the need for external cephalic version and either perform or refer the client
8. Conduct deliveries and care for the newborn on their own responsibility
9. Apply the principles of clean and aseptic technique and universal precautions
10. Provide care in a variety of settings including home, clinic, health unit, health centre, birth centre or healthcare facility with specialist care
11. Work in a collegial manner in a variety of settings
12. Provide care consistent with the NWT Midwifery Practice Framework
13. Facilitate informed choice
14. Communicate the practice parameters of a Registered Midwife to clients, including limitations of practice
15. Develop, implement and evaluate an individualized plan for midwifery care
16. Provide education, health promotion and counselling related to childbearing, to the woman, her family and the community

17. Provide counselling regarding family relationships and consult as necessary, as it relates to the midwife's scope of practice
18. Evaluate risk factors before and during pregnancy, during labour and birth and the postpartum period and take appropriate action
19. Administer substances and devices as specified under appropriate NWT Acts and Regulations
20. Use appropriate complementary therapies
21. Order, perform and interpret results of prescribed screening and diagnostic tests in accordance with regulation and guidelines
22. Recognize abnormal conditions and recommend appropriate treatment and/or initiate consultations and referrals
23. Interpret research findings and apply to midwifery practice
24. Establish and maintain comprehensive and relevant records
25. Respect the confidentiality of information given
26. Use all of the emergency measures available to her/him in the absence of medical help
27. Perform the following invasive procedures, according to the scope of midwifery practice:
 - Amniotomy
 - Episiotomy
 - Repair of episiotomy and lacerations, not involving the anus, anal sphincter, rectum and urethra
 - Bladder catheterization
 - Injections
 - Venipuncture
 - Intravenous cannulation
 - Heel puncture of the newborn
 - Finger puncture of the mother
 - Lingual frenotomy
 - Neonatal resuscitation procedures consistent with NRP guidelines including:
 - oral intubation of the newborn
 - endotracheal suctioning of the newborn
 - placement of an umbilical venous catheter in the newborn
 - Taking cervical cytological smears
 - Taking intracervical, vaginal, and rectal swabs
 - Fitting cervical caps and diaphragms for contraceptive purposes
 - Application of a fetal scalp electrode

1.1.1. After documented in-service training and having been granted by a Board of Management, the privileges to:

- Perform vacuum assisted birth
- Perform manual evacuation of the uterus
- Assisting with a caesarean section, including performing the role of first assistant and receiving the infant

2. Standards for Collaborative Care, Guidelines for Medical Consultation and Transfer of Care to a Physician

2.1 Purpose of the Standard

The purpose of the Standard is to provide registered midwives with guidelines for collaboration with general practitioners, specialists, nurses, and other caregivers. The goal of collaboration is to balance continuity of care with the provision of appropriate levels of service to meet the specific needs of each client in such a way that individualised client care is optimised.

The Standard applies to all settings and is not intended to be exhaustive. Circumstances other than those identified in 2.6 Indications For Medical Consultation, may arise where registered midwives feel that consultation or transfer of care is warranted.

2.2 General Criteria for Collaborative Care

Registered midwives collaborate with other health care providers with informed client consent and in the best interests of the client.

The client is the primary decision-maker about her own care.

One health care professional has primary responsibility for client care at any one time, and the client's care is coordinated by that practitioner. The identity of the primary caregiver is known to the client and to all those involved in the provision of care, and is documented in the records of the primary caregiver and other health professionals involved.

Registered midwives, along with other caregivers, are responsible to communicate clearly and effectively, show courtesy and respect, ensure effective documentation, ensure continuity of care, contribute to the interdisciplinary plan of care, discuss and confirm who will be the practitioner most responsible for current care, and participate in the quality assurance process.

2.3 Primary Care in a Multidisciplinary Environment

Registered midwives work within a multidisciplinary framework. Obstetricians, pediatricians, neonatologists, family physicians, nurses, nurse practitioners, public health nurses, social workers, nutritionists, and mental health workers are among the caregivers who may be involved in aspects of the care of the childbearing woman and her newborn from time to time.

The roles and responsibilities of the various caregivers, and the relationships amongst caregivers, are clarified through the development of local policies and structures that ensure that:

- The midwife is the primary care provider for the mother and newborn as per the scope of midwifery practice unless primary responsibility is transferred to another caregiver and such transfer is clearly documented.
- The midwife maintains a current record of midwifery care of mother and newborn and ensures that this information is available to other practitioners in the multidisciplinary team, provided that consent to the exchange and release of information has first been obtained from the client in accordance with NWT legal requirements.
- The client may consult or be referred to a general medical practitioner or nurse practitioner for health conditions unrelated to pregnancy or the puerperium. In the event that an acute or chronic medical condition is diagnosed that could affect the pregnancy or the mother-infant unit, the midwife works with the client and the other practitioner(s) involved to develop an interdisciplinary care plan.

2.4 Primary Care Provided in Association with Other Practitioners

Registered midwives ordinarily work in partnership or group practice with other registered midwives to provide primary care and 24-hour coverage to women and their newborns. In some communities, particularly where there are insufficient numbers of registered midwives to provide 24-hour coverage on a year-round basis, registered midwives may provide primary care in association with practitioners other than registered midwives, i.e. physicians or nurses.

The roles of other practitioners and the extent of their involvement in the provision of primary care to midwifery clients will be determined by their professional scope of practice and the circumstances under which shared care is warranted. In some situations, registered midwives will be the main primary care provider, with other practitioners serving as second birth attendant or providing occasional primary care as required. In other situations, registered midwives may work in partnership/group practice with other primary care practitioners to share in the provision of coverage on an ongoing basis.

Roles and responsibilities must be clear to all members of the care team. In all instances, the identity of the primary caregiver responsible for coordinating client care will be known to the client and to all practitioners involved in the provision of care.

Where registered midwives work in partnership/group practice, ordinarily both the primary caregiver and any other practitioner should have seen the client for at least two prenatal visits, at least one of which should have been in the third trimester of pregnancy, in order to be on call for her birth.

Where registered midwives are part of a multidisciplinary team providing maternity care, a shared philosophy of care and shared practice protocols, consistent with the midwifery philosophy and model of practice, should be in place to help ensure that consistent care is provided by the team of caregivers.

2.5 Consultation and Collaboration with Physicians

Registered midwives providing primary care to women and their babies consult with a physician in the presence of conditions identified in the 2.6 Indications for Medical Consultation section below.

2.5.1. Obtaining a Consultation

As primary caregivers, registered midwives use their professional judgement in seeking the opinion of a physician competent to give advice in the relevant field. The physician may be a general practitioner, family physician, obstetrician, neonatologist, pediatrician, anesthesiologist, internist, psychiatrist, or other. Registered midwives' choice of consultant will be influenced by the nature of the condition warranting consultation, the level of care required, the availability of appropriate medical resources in the community, and the urgency of the situation.

Where appropriate and feasible, consultations and transfers of care will be managed at the community level. However, when registered midwives judge that the opinion of a specialist is required, and no specialist is available in the community, they may consult directly with specialists located in referral centres outside of the community. In the event of emergent situations, registered midwives will notify the nearest available medical practitioner, even while they are in the process of initiating a specialist consultation or arranging for a transfer of care outside of the community to a hospital with specialist care.

2.5.2. Procedure and Documentation of Consultation

The urgency of the condition will determine the timing of the consultation. Certain conditions require immediate consultation, while others may be assessed and managed in a timely but non-urgent manner.

Pre- and post-natally in non-urgent situations, registered midwives obtain written consent to the release and exchange of information from the client prior to initiating the consultation. Intrapartum consultation is often initiated with verbal consent from the client, which is subsequently documented by the midwife.

Where feasible, registered midwives initiate a consultation in writing, providing a summary of the condition requiring consultation accompanied by relevant documentation. Where urgency, distance, or climatic conditions make in-person consultation and assessment of the client difficult or infeasible, registered midwives seek advice from physicians by phone or other similar means such as e-mail, facsimile communication, or teleconferencing.

Registered midwives may expect that the consultation will involve an assessment of the condition that led to referral, including an in-person assessment of the client where indicated and feasible, and the prompt communication of any findings or recommendations to the client and/or the referring midwife.

Depending on the circumstances of the consultation, the physician may provide information, advice, and/or therapy directly to the woman/newborn, or may provide information, advice, and/or prescribe therapy for the woman/newborn via the midwife.

Registered midwives document all requests for consultation and the outcome of consultations, and discuss with clients the advice received.

2.5.3. Outcome of the Consultation

Following the consultation, the midwife, the client and the physician will collaborate to determine that either:

- Advice regarding appropriate management of the condition is all that is required and the midwife remains the primary caregiver, or
- Specific aspects of care will be managed by the physician while the midwife remains the primary caregiver, or
- The condition requires medical management to the extent that the physician should assume the role of primary caregiver.

In some instances the outcome of the consultation will also bear on the determination of the most appropriate choice of birth setting.

2.5.4. Transfer of Care

The decision to transfer primary responsibility or responsibility for aspects of care involves the professional judgement of the midwife and the physician and the informed consent of the client, and becomes part of the mutually agreed care plan for the client.

The care plan is clearly documented, detailing the involvement of the various caregivers and their respective areas of responsibility. If a care plan other than the one mutually agreed upon is carried out, the consultative partner is informed of this including the reasons and all relevant information.

Where transfer of responsibility for primary care takes place, the midwife may continue to provide supportive care within the midwifery scope of practice to the extent agreed to by the client, physician, and midwife.

Primary care may be transferred on a permanent or temporary basis, i.e. care may be transferred back from the physician to the midwife if the reason for transfer no longer exists.

In an emergency situation, where the physician and the midwife deem transfer of care appropriate, transfer of care will take place without delay.

In an urgent or emergent situation that clearly warrants medical care, the midwife seeking to transfer care to a physician may expect a physician to accept the transfer.

Protocols should be in place at the level of the Health Authority and the regional referral centre, clearly laying out the steps a midwife should take if she encounters difficulty in obtaining consultation or accomplishing a transfer of care in a timely and safe manner.

It is ultimately the client who decides from whom she will receive care. However, registered midwives have the right and the obligation to inform the client of their professional limitations when asked to provide care outside their scope of practice or experience.

Registered midwives will make every reasonable effort to work with the client to develop an acceptable care plan and to transfer care to an appropriate care provider, and will document these efforts.

2.6 Indications for Medical Consultation

The following indications for medical consultation identify conditions which may signal that a pregnancy, labour, birth or post-partum situation is no longer considered normal or entirely within the scope of midwifery practice. Registered midwives are responsible to identify these conditions and initiate medical consultation. These indications serve as a guide for risk assessment, which in all cases will be undertaken on an individual basis.

2.6.1. Initial History and Physical Exam

- Any current medical condition that may be aggravated by the pregnancy or that may have an adverse effect on the pregnancy. Examples of such conditions are cardiovascular disease, neurologic disorders, endocrine disorders, diabetes mellitus, or hypertensive disorders
- Congenital defects of the reproductive organs
- Family history of genetic disorders, hereditary disease and/or congenital anomalies
- History of repeated consecutive spontaneous abortions (e.g. 3 or more)
- History of severe postpartum hemorrhage
- History of severe psychological problems (including postpartum psychosis)
- History of two or more premature labours or history of low birth weight infant(s)
- History of severe pregnancy induced hypertension
- Marked skeletal abnormalities
- Marked obesity
- Previous operations or injuries to the uterus or vagina (e.g. operations for prolapse, cervical conization, myomectomy, vesicovaginal and recto-vaginal fistulae, caesarean section, etc.)
- Previous reconstructive bladder surgery
- Previous stillbirth or neonatal loss that may effect the current pregnancy
- Rhesus isoimmunization or the presence of other blood group antibodies that may adversely affect the fetus
- Significant use of drugs, alcohol, or other toxic substances
- Suspected or diagnosed congenital anomaly that may require immediate medical management after delivery
- Repeated vaginal bleeding this pregnancy

2.6.2. Prenatal Care

- Medical conditions arising or exacerbated during the prenatal period, e.g. cardiac disease, diabetes, endocrine disorders, hypertension, renal disease, acute pyelonephritis, thromboembolic disease, or significant infection
- Severe varicosities of the vulva or lower extremities
- Abnormal pap smear
- Active sexually transmitted disease or known HIV positive
- Primary or recurrent genital herpes infection
- Persistent anemia (e.g. < 90g/l)
- Abnormal glucose tolerance test
- Documented post term pregnancy (consider consult > 41 weeks)
- Exposure to known teratogens (e.g. chemicals, infections)

- Fetal anomaly
- Hyperemesis
- Molar pregnancy
- Abnormal fetal/fundal growth pattern
- Multiple pregnancy
- Persistent abnormal presentation (after 36 weeks)
- Persistent abuse of drugs or alcohol
- Polyhydramnios or oligohydramnios
- Pregnancy induced hypertension, persistent proteinuria, or other signs of pre-eclampsia
- Threatened premature labour
- Rupture of membranes before term
- Rhesus isoimmunization or presence of other blood group antibodies which may adversely affect the fetus
- Serious psychological problems
- Continued or unexplained vaginal bleeding
- Confirmed abnormal placental location / placental abnormalities
- Unexplained sudden and severe abdominal pain
- Extra-uterine pregnancy
- Evidence of change in fetal status (e.g. reduction in fetal movements, non-reactive non-stress test)
- Antepartum fetal death

2.6.3. During Labour and Birth

- Abnormal fetal heart patterns unresponsive to therapy
- Abnormal presentation
- Active genital herpes at onset of labour
- Ketonuria unresponsive to treatment
- Multiple pregnancy
- Excessive vaginal bleeding
- Unexplained sudden and severe abdominal pain
- Premature labour
- Abnormal labour pattern unresponsive to therapy (e.g. dystocia, non-dilatation, non-descent of presenting part)
- Prolonged rupture of membranes
- Persistent fever greater than 38° C
- Prolonged second stage
- Pregnancy induced hypertension or other signs of preeclampsia
- Prolapsed cord
- Retained placenta
- Thick meconium
- Uterine rupture
- Maternal request for epidural anesthesia or narcotic analgesia

2.6.4. Post Partum (Maternal)

- Lacerations involving the anus, anal sphincter, rectum or urethra area
- Vulvar hematoma
- Hemorrhage unresponsive to therapy

- Secondary post-partum hemorrhage
- Inversion of the uterus
- Persistent hypertension
- Post partum eclampsia
- Unexplained persistent chest pain or dyspnea
- Serious psychological problems
- Signs of puerperal infection
- Suspected retained placental fragments or membranes
- Thrombophlebitis or thromboembolism
- Breast infection unresponsive to therapy
- Persistent bladder dysfunction

2.6.5. Post Partum (Infant)

- APGAR lower than 7 at 5 minutes
- Abnormal findings on physical exam, e.g.
 - Abnormal abdominal distension
 - Abnormal cry
 - Abnormal movement of any extremity
 - Abnormal neurological signs, including hypotonia
 - Less than 3 vessels in umbilical cord
 - Congenital anomalies
 - Ambiguous genitalia
 - Abnormal pigmentation
 - Excessive bruising other than a cephalhematoma, and/or generalized petechiae
 - Abnormal heart rate or pattern (less than 100 with activity or greater than 160 at rest, or any abnormal sounds noted)
- Respiratory distress
- Persistent tachypnea beyond the first 4 hours of life
- Failure to pass urine within 24 hours or meconium within 48 hours of birth
- Difficulty in feeding
- Feeding intolerance with vomiting or diarrhea
- Persistent cyanosis or pallor
- Suspected pathological jaundice
- Infection of umbilical site
- Seizure-like activity
- Significant weight loss (e.g. > 10% of birth weight)
- Failure to regain birth weight within 14 days
- Temperature above or below normal that is unresponsive to therapy
- Infant born to mother:
 - with active genital herpes
 - who is hepatitis positive
 - who is HIV positive
 - with a history of significant drug or alcohol use
- Conditions that cause concern in either the parents or the midwife

3. Standards for Birth in a Hospital

3.1 Definition

For the purpose of this standard, a birth in a hospital is defined as a birth that takes place in a hospital that offers inpatient and outpatient care and where specialized care (obstetrical, paediatric, surgical, and/or anaesthetic services) may or may not be provided on site.

3.2 Purpose

The purpose of the standard is to provide registered midwives with guidelines for the provision of intrapartum care within hospitals.

3.3 General Criteria

Registered midwives are primary health care providers as per the scope of midwifery practice. The midwife is responsible for monitoring and supporting the woman and her healthy newborn.

Registered midwives providing intrapartum care in hospitals, must apply for privileges or similar standing arrangements with hospitals in the communities in which they practise which grant them the right to access specified hospital resources in their capacity as primary care providers.

Access to hospital resources may include, but is not limited to,

- Admitting to inpatient beds
- Referring to outpatient clinics or services
- Ordering tests from clinical laboratories
- Ordering tests from diagnostic imaging
- Prescribing and ordering drugs
- Ordering treatments
- Discharging patients
- Consulting with staff or other practitioners with privileges
- Accessing health records

Registered midwives become part of the accountability structures and process within the hospital. These structures may have their basis in legislation, accreditation guidelines, bylaws and policies and procedures. Registered midwives should be included in the development and periodic review of these structures.

3.4 Considerations in Choosing a Birth in a Hospital

3.4.1. Documented Informed Choice Discussion

Registered midwives work in partnership with women to explore their preferences for birth setting and to evaluate the appropriateness of birth in a hospital in relation to the individual client.

Registered midwives facilitate and document an informed choice discussion in accordance with the *Standard for Informed Choice*. This discussion will include accurate, up-to-date information that relates to the benefits and risks of each birth setting that the woman is considering.

It will also include a review of the factors that may arise during the course of labour and birth, the effect that distance and time away from her home and family may have on her birth outcome, and a consideration of the woman's unique circumstances.

3.4.2. Client Considerations

Registered midwives use the 2.6 Indications for Medical Consultation to identify conditions that require a medical consultation. In some instances, the outcome of a medical consultation will bear on the determination of the most appropriate choice of birth setting.

There are a number of situations in which birth should be planned to take place in a hospital with specialist services. Multiple birth, breech or other non-vertex presentation, pre-term labour prior to 37 weeks of pregnancy, and documented post-term pregnancy of more than 42 weeks are examples of such situations. Other situations in which birth in a hospital with specialist care should be planned, will be assessed by registered midwives and their clients on an ongoing basis during pregnancy and the intrapartum period, with appropriate medical consultation as indicated.

Clients may express a preference for birth in a hospital, even a hospital with specialist services, in the absence of particular risk factors. Registered midwives will support their clients' choice of birth setting and endeavour to work with clients to develop an acceptable care plan that includes the preferred birth setting and provisions for continuity of care.

3.4.3. Environmental Considerations

Registered midwives will work with clients to develop a care plan that includes a birth setting where an appropriate level of care can be provided to meet the anticipated needs of the woman and her baby. In evaluating the appropriateness of birth in a hospital, registered midwives will take into account the level of service, including technology and human resources, at the hospital under consideration.

Where hospitals are located in communities distant from the regional referral centre and do not provide specialist services, registered midwives comply with the Standard for Birth Outside of a Hospital with Specialist Care.

3.5 Roles in the Provision of Care

Registered midwives normally attend their clients in the healthcare facility throughout active labour, birth, and the immediate postpartum. The presence of the midwife may result in an altered role for other health care providers in the care of midwifery clients.

4. Standards for Birth Outside of a Hospital with Specialist Care

4.1 Definition

The purpose of the standard is to provide guidelines for registered midwives in the planning and provision of intrapartum care in settings outside a hospital with specialist care. Examples of these facilities could include homes, health care facilities, birth centres and some hospitals.

4.2 Considerations in Choosing Birth outside a Hospital with Specialist Care

4.2.1. Documented Informed Choice Discussion

Registered midwives work in partnership with women to explore their preferences for birth setting and to evaluate the appropriateness of a birth outside a hospital with specialist care in relation to the individual client. Registered midwives facilitate and document an informed choice discussion in accordance with the *Standard for Informed Choice*. This discussion will include accurate, up-to-date information that relates to the benefits and risks of each birth setting that the woman is considering. It will also include a review of the factors that may arise during the course of labour and birth, the effect that distance and time from the nearest hospital with specialist services may have on her birth outcome, and a consideration of the woman's unique circumstances.

4.2.2. Client Considerations

Registered midwives use 2.6 Indications for Medical Consultation to identify conditions that require a medical consultation. Cases may also be reviewed at a multidisciplinary forum. In some instances, the outcome of a medical consultation or multidisciplinary forum review will bear on the determination of the most appropriate choice of birth setting. There are a number of situations in which birth in a hospital with specialist care should be planned. Multiple birth, breech or other non-vertex presentation, pre-term labour prior to 37 weeks of pregnancy, and documented post-term pregnancy of more than 42 weeks are examples of such situations. Other situations in which birth should be planned to take place in a hospital with specialist care will be assessed by registered midwives and their clients on an ongoing basis during pregnancy and the intra-partum period, with appropriate medical consultation as indicated.

Registered midwives will make every reasonable effort to work with clients to develop an acceptable care plan that includes a birth setting where an appropriate level of care can be provided to meet the anticipated needs of the woman and her baby. Where clients continue to request birth outside a hospital with specialist care, contrary to registered midwives' standards, practice guidelines, or professional judgement regarding safe care, registered midwives will follow 7. *Standard for Responding to Client Requests for Care Against Midwifery Advice*.

4.2.3. Environmental Considerations

In working with clients to evaluate the appropriateness of a birth outside a hospital with specialist care, registered midwives will take into account the availability of backup support systems within the community and the recommendations of a multidisciplinary review. These include communication and transportation infrastructure, technology and supplies available at the local hospital or health care facility, and human resources including the presence of a skilled second birth attendant. Registered midwives will also consider factors such as family and social supports, distance to the nearest referral centre, and prevailing weather conditions.

4.3 Equipment and Supplies Needed for Birth Outside a Hospital or Healthcare Facility

Registered midwives who attend births outside a hospital or health care facility are responsible for carrying well-maintained equipment, supplies, and drugs that may be required during labour, birth and the post-partum period. This list constitutes the minimum equipment and supplies required.

4.3.1. Equipment and Supplies

- Absorbent pads and sponges
- Amnihook
- Antiseptic solution
- Blood pressure cuff
- Blood collection tubes
- Bulb syringe
- Cord clamps
- Doppler / fetoscope (waterproof)
- Equipment for I.V. infusions and I.M. injections
- Equipment /supplies for performing an episiotomy
- Equipment / supplies for repairing an episiotomy / laceration
- Heating pad
- Infant weighing scales
- Light source
- Oxygen delivery system for mother and neonates
- Resuscitation equipment for adults
- Resuscitation equipment for neonates, including oral intubation equipment
- Sharps disposal container
- Stethoscopes for adult and infant
- Sterile and non-sterile examination gloves
- Sterile birth instruments including hemostats and scissors
- Sterile lubricant
- Sterile speculums
- Suction equipment (mechanical)
- Swabs for culture and sensitivity
- Tape measure
- Test strip/swab to screen for pH change
- Thermometer
- Urinary catheterization supplies
- Urinalysis supplies

4.3.2. Essential Medications

- Crystalloid intravenous fluids
- Local anesthetics
- Oxygen, sufficient to allow for transport of mother and baby to nearest healthcare facility
- Medications for treatment of anaphylactic shock
- Medications for treatment of post-partum hemorrhage
- Medications for routine neonatal prophylaxis
- Medications for management of neonatal resuscitation

4.4 Established Links and Prior Arrangements

4.4.1. Health Authority and Local Hospital or Healthcare Facility

Registered midwives providing intrapartum care outside hospitals with specialist care will maintain a relationship with the health authority and with the local hospital or healthcare facility in the community where birth takes place and with referral centres. This relationship should include admitting privileges that permit the midwife to act in the role of primary caregiver until such time as transfer of care to a physician is deemed appropriate or until the client is transferred to a regional referral centre.

4.4.2. Physician Backup

Registered midwives providing intrapartum care outside of hospitals with specialist care will maintain communication links with collaborating physicians available for consultation and emergency support at the nearest hospital or healthcare facility or regional referral centre. At a minimum, telephone and facsimile communication must be available at all times to permit consultation between registered midwives and physicians. Registered midwives attending births in communities distant from the regional referral centre will also maintain a working relationship with general practitioners, if located in the community, in the event that consultation and transfer of care at the community level is deemed appropriate.

4.4.3. Ambulance Service / Emergency Transportation

Registered midwives will work with local ground ambulance and regional air ambulance services to develop protocols for the efficient coordination and management of emergency medical transportation. The local health authority and physicians providing consultation and emergency support at the regional referral centre must also be involved in the development of these protocols.

Registered midwives and local ground ambulance services are encouraged to develop a system for the pre-registration of births that are planned to take place in a setting outside of the local hospitals or healthcare facility. This system would include written notification to the ambulance service of approaching births, as well as notification when the birth has been completed.

Wherever possible, registered midwives will accompany their clients during transportation, in collaboration with emergency personnel, unless responsibility for care has already been transferred to another primary care provider who is present with the client.

4.5 Conditions requiring Transport to a Hospital with Specialist Care

Registered midwives must advise each client of potential conditions and circumstances that may require transport to a hospital with specialist care and/or transfer of primary responsibility for care to a physician.

There are a number of situations in which birth should be planned to take place in a hospital with specialist services. Multiple birth, breech or other non-vertex presentation, pre-term labour prior to 37 weeks of pregnancy, and documented post-term pregnancy of more than 42 weeks are examples of such situations.

Other situations in which birth should be planned in a hospital with specialist care will be assessed by registered midwives and their clients on an ongoing basis during pregnancy and the intrapartum period, with appropriate medical consultation as indicated.

Despite prenatal screening, conditions may arise during labour, birth, or the postpartum period that necessitate transport to a hospital with specialist care. If any of the following conditions are present, a midwife must take steps to initiate transport of the client to a hospital capable of dealing with the condition:

4.5.1. Conditions Noted During Labour and Birth

- Gestational hypertension, with or without proteinuria or adverse conditions
- Active genital herpes at the outset of labour
- Abnormal labour pattern unresponsive to therapy
- Abnormal presentation
- Unexplained sudden or severe pain
- Prolapsed cord
- Non-reassuring fetal heart rate patterns unresponsive to therapy
- Excessive vaginal bleeding
- Retained placenta
- Unexplained fever or other signs of chorioamnionitis
- Any circumstance where the safety of the mother, child, and/or midwife cannot be assured

4.5.2. Conditions Noted During Postpartum (Maternal)

- Hemorrhage unresponsive to therapy
- Inversion of the uterus
- Postpartum hypertension, with or without protein or adverse conditions
- Lacerations involving the anal sphincter

4.5.3. Conditions Noted within the First 48 Hours (Newborn)

- Abnormal heart rate or pattern
- Respiratory distress
- Persistent cyanosis or pallor
- Suspected pathological jaundice
- Extensive bruising other than a cephalhematoma and/or generalized petechiae
- Significant congenital abnormalities
- Temperature above or below normal that is unresponsive to treatment
- Seizure-like activity
- Hypotonia

- Lethargy unresponsive to therapy
- Feeding intolerance with vomiting or diarrhea

This list is not exhaustive. There may be other circumstances where the midwife or client or consultant believes transport to a hospital with specialist care is advantageous.

5. Standards for Records

5.1 Purpose

The purpose of the standard is to provide midwives with guidelines for the maintenance and management of health records related to the care of women and their infants, within the context of the family.

Complete and accurate health records facilitate:

- Communication between health care providers, and the woman, to facilitate continuity of care
- The process of continuous quality improvement
- The demonstration of clinical judgement in the provision of care
- The management of medico-legal risk.

5.2 Completion of Records

The completion of health records shall be in accordance with midwifery professional standards and practice guidelines, facility and regional policies, and medico-legal recommendations.

Midwives will utilize the standardized forms approved for use by the Department of Health and Social Services for midwifery/obstetrical care. Additionally, midwives may use any other forms deemed appropriate for the recording of client care information. These forms shall also constitute part of the client care record. Midwives will use the electronic health record when it becomes readily available.

Health records shall be completed in a legible, accurate, timely and complete manner during the provision of care, or as soon as possible after care has been completed when emergent situations occur. Any entry out of chronological order shall be deemed to be a "late entry" with the date and time of the actual recording indicated. Each entry in the health record will include the time, date, signature and professional designation of the care provider.

5.3 Confidentiality

The confidentiality of health, personal or third party information shall be protected in compliance with all federal and territorial legislation. Disclosure of information from the health record to a third party is governed by territorial legislation and health authority policy.

5.4 Storage

All records will be maintained in a confidential, secure manner at all times, for a period of twenty-one years. If the midwife is an employee of a health region, the health region's record management protocol will assume precedence. Where a midwife is an independent practitioner, the midwife will retain a copy of the client files and the original files may be transferred into the care of another practitioner, with the client's consent, or given to the client.

5.5 Accessibility

All registered midwives are obligated to provide a copy of the complete midwifery record to the woman upon request. The midwife must make an effort to ensure that records are in a format that is accessible to the woman.

6. Standard on Informed Choice

6.1 Purpose

The purpose of this standard is to provide registered midwives with guidelines for facilitating the informed choice process in partnership with their clients.

6.2 Principles

The woman is recognised as the primary decision-maker.

Informed choice is arrived at through an interactive process that emphasises shared responsibility. It involves the midwife and the client, at a minimum. Where appropriate, it may include members of the client's family, other community members, and / or other caregivers.

The informed decisions made by the woman are respected, even when they are contrary to the judgement or belief of the midwife.

Registered midwives will at all times strive to provide the highest standard of care possible within the limitations of the care options chosen by the woman.

6.3 Facilitation of the Informed Choice Process

Registered midwives are responsible for facilitating the ongoing exchange of knowledge and information in a non-urgent, non-authoritarian, co-operative manner.

Registered midwives take all reasonable steps to ensure that the client's choice is voluntary and is not made under duress.

Registered midwives are responsible for presenting information in such a way that the client can understand it. Educational, cultural, and linguistic considerations may bear on the methods and approaches that are employed. Methods of communication may include verbal discussion, written materials, and audio or video recordings. The use of an interpreter may be appropriate and shall be noted in the midwife's documentation.

Registered midwives are responsible to confirm that the client understands the information that has been presented. In some situations, this may require that registered midwives become familiar with specific cultural processes for signifying understanding and affirmation.

Registered midwives encourage and assist women to seek out further information and resources that may help them in their decision-making process.

Registered midwives ensure that the client is given ample time and opportunity to discuss information shared and any issues or concerns she may have around potential choices.

In an emergency situation, registered midwives will strive to give to the client as much information as is reasonably possible in the time available in order to facilitate decision-making by the woman.

Registered midwives are responsible to document all discussions with the client about care options, including the outcome of those discussions, in accordance with the Standard on Record Keeping.

6.3.1. Initial Disclosure

At the outset of a course of care, registered midwives are required to provide to the client the following information:

- Education and experience of the registered midwives providing care
- Midwifery model of practice and services provided
- Standards of practice and protocols
- Roles and responsibilities of the client and caregiver
- Right to obtain a second opinion or transfer of care, and how this would be accomplished
- Contact information, including arrangements for 24 hour availability
- Second attendant arrangements, if applicable
- Confidentiality and access to records
- Any student placements or supervised practice arrangements
- Any other information relevant to the practice environment

6.3.2. Ongoing Facilitation of Informed Choice

Throughout the course of care, registered midwives will provide care that is individualized and sensitive to changes in the woman's circumstances.

Registered midwives will continue to facilitate an informed choice process that takes into account all relevant information, including:

- the current status of the mother and her baby
- what is currently known and unknown about the potential risks, benefits, limitations, and consequences of all care options, including procedures, tests, and medications
- relevant research evidence
- the experience, feelings, beliefs, values, and preferences of the client, and, where appropriate, of family members
- community values, standards, and practices

7. Standard for Responding to Client Requests for Care Against Midwifery

7.1 Purpose

The purpose of this standard is to provide registered midwives with a protocol in circumstances where a client requests care outside the midwifery scope or standards of practice or is contrary to the midwife's judgement of safe care. The protocol is designed to ensure that reasonable steps are taken to protect client autonomy, the health and well being of mother and child, and the professional standing of the midwife.

7.2 Protocol for Responding to Request for Care Against Midwifery Advice

When a client initially requests care outside the midwifery scope or standards of practice, or care that in the judgement of the midwife poses a significant risk to mother or baby, the midwife will ensure that a full discussion with the client is facilitated and documented in accordance with the *Standard on Informed Choice*.

As part of this process, the midwife will

- a. Discuss with the client the limitations of the midwifery scope of practice, the rationale for the standard, or the reasons for the midwife's judgement. This discussion should reflect the best available research evidence as well as the midwife's assessment of potential risks based on clinical evidence and practical experience. The discussion may also reflect the input or recommendations of any other caregivers that have been involved in the woman's care up to that point
- b. Invite the client to discuss her preferences and her reasons for them, including feelings, beliefs and values, and personal circumstances
- c. Discuss with the client other options for care that in the midwife's judgement would be within the bounds of safe practice, and make every reasonable effort to work with the client to develop an acceptable alternative care plan, including transfer of care to another care provider where appropriate

Should the client continue to request care outside the midwife's scope of practice or contrary to the midwife's judgement of safe care, the midwife will:

- d. In communities where a multidisciplinary forum exists, invite the client (with family and/or community members where appropriate, and with the client's consent) to attend a meeting to discuss her care plan
- e. In communities where such a forum does not exist, invite the client to take part in a discussion with the midwife and other health care provider(s) in the community (in person) or regional referral centre (by telephone)
- f. Where the client declines to participate in a consultation, seek a second opinion from another midwife, physician, or peer review group and share this opinion with the client

If the midwife's assessment of the situation remains unchanged and the client continues to request care outside the midwife's scope of practice or contrary to the midwife's judgement of safe care, the midwife will:

- g. Inform the client of the midwife's intention to make a referral to an appropriate caregiver, and the reasons why this is necessary

- h. With client consent, make the referral to an appropriate health care provider and, where a transfer of care is appropriate, ensure that the identity of the primary caregiver is clearly known to the client and all caregivers

Where the client refuses consent to a referral or transfer of care, and in circumstances where it is possible for the client to obtain care from another more appropriate care provider in the same community, the midwife will:

- i. Clearly communicate to the client that the midwife is no longer able to provide primary care, but may continue providing supportive care to the extent deemed appropriate by the midwife and client. This information will be conveyed verbally, with witness and/or interpreter present, and in a letter, by means of assured delivery
- j. Document this communication, including a copy of the letter, in the client health record
- k. Continue to offer assistance to the client in finding another appropriate primary care provider
- l. Cease providing primary care, except in emergency situations where immediate transfer of care is not possible or where the client refuses to accept or facilitate transfer of care or transport to a hospital or health care facility

Where the client refuses consent to a referral or transfer of care, and in circumstances where it is not possible for the client to obtain care from another more appropriate care provider in the same community, the midwife will:

- m. Continue to provide care to the client to best of the midwife's ability and within the full scope of midwifery care, including taking emergency measures where necessary in the absence of medical help
- n. Inform appropriate clinical staff and health care managers in the community and the regional referral centre of the client's refusal to accept midwifery advice and the nature of the potential risks to mother and/or baby, and document this communication in the client's health record
- o. Maintain communication with local and regional health care personnel in order that they may be as prepared as possible to ensure the client's health and safety, should the need for emergency care arise
- p. Continue to offer the client a referral to a more appropriate caregiver outside of the community at any time

Nothing in this Standard requires a midwife to perform any procedure or do anything that the midwife is not qualified to do or that is contrary to the ethical practice of midwifery.