College of Midwives of British Columbia

NEWSLETTER

June 30, 2013

PROGRESS REPORT

Midwifery Scope and Model of Practice Review

This June the College of Midwives and the Midwives Association of BC signed a letter of agreement to work in partnership on the first steps of the Midwifery Scope and Model of Practice Review. Together our two organizations have contracted with midwife consultant Sarah Hilbert-West to complete a literature review, a midwifery jurisdictional comparison of the scope and model of practice across Canadian provinces and territories as well as selected international jurisdictions such as New Zealand, Australia, the United Kingdom and the Netherlands, and with the support of the project's reference group, to write a discussion paper to provide background and context for registrants and other key stakeholders to participate in the review's first surveys and focus groups.

Background

After more than 15 years of regulated midwifery practice we believe that it is time for a systematic review of midwives' regulated scope and model of practice – a review that can look at both the needs of women and families across the province and of midwives themselves. We want to find out how well the existing scope, standards and systems for midwifery support or get in the way of midwives providing care that meets the needs of childbearing women in varying settings and circumstances in a sustainable way.

In 2011, the College began informal discussions with the Ministry of Health about the need for a review, and in the spring of 2012 we submitted a formal proposal. While it was positively received, funding discussions did not move forward. In the fall of 2012 we put forward the plan again in the context of the Ministry's draft Maternity Care Action Plan and this spring we worked with a group of consultants led by IC Possibilities on a preliminary literature review and a more detailed proposal which we submitted to the Ministry in early April, 2013. A week later College of Midwives and Midwives Association reps had a very positive meeting with Ministry Directors of Primary Care, Strategic HHR and Professional Regulation, but because of the upcoming election at that point, a discussion of Ministry funding for the review wasn't possible.

Why CMBC is Proposing to do this Review in Partnership with the MABC and the Ministry

The CMBC is proposing to undertake this review because, among the other duties and objects of a college in the Health Professions Act, all BC health regulatory colleges have a mandate to *promote and enhance:*

- *collaborative relationships with other colleges established under the Act, regional health boards designated under the Health Authorities Act and other entities in the Provincial health system, post-secondary education institutions and the government;*
- *inter-professional collaborative practice between registrants and persons practicing other health professions; and*
- *the ability of registrants to respond to changes in practice environments, advances in technology and other emerging issues in health care.*

We are proposing to undertake this Review in partnership with the Midwives Association and the Ministry of Health because, if the review is to seriously consider all of the interlinking parts of the maternity system that affect midwifery, we believe that partnership is important. We also hope to consult with and include the UBC midwifery program and Perinatal Services BC.

Objects of the Review

Since BC midwives were first registered & regulated the profession has grown to more than 200 registrants. While midwifery numbers have increased and the health care system in which midwives practice has changed over the past 15 years, the

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midwife's scope has only had minor changes and the profession has been given no additional resources to implement them. The midwifery model of practice, as set out in the CMBC bylaws, has remained largely constant. Within this model, midwives have consistently provided women-centred primary care that is safe, effective, efficient, and satisfying to the women receiving that care. That said, the College recognizes that there are limitations within both the scope and the requirements of the care delivery model that need examining to see what additional flexibility may be needed to best support and utilize midwifery's strengths, reduce strain on midwives, and improve access to midwifery services across BC. We believe some communities require a broader range of care and services for mothers and babies and that midwives are well placed to deliver these services.

Through the review process we want to look at how to create more flexibility in systems, processes and standards without losing what works well - without throwing the baby out with the bath water. We want to hear from midwives and women, and collect the input and information needed to be able to put forward well-grounded arguments to government for the extended roles and expanded scope of practice, and bylaw and policy changes that midwives need to best care for mothers and babies.

The review will engage government, various partners, stakeholders, midwives, and women and their families in:

- identifying challenges and barriers to access to care, and challenges for midwives in delivering care;
- reviewing the regulations, bylaws and policies governing the profession, as well as other aspects of the system that support midwifery such as how the profession is funded and insured;
- identifying barriers to integration and inter-professional collaboration - e.g. in rural and remote communities, in urban centres, in serving vulnerable populations; and
- identifying opportunities to ensure the sustainability of the profession, support integration of midwifery in primary care in new communities & hospitals, and strengthen collaboration between midwifery and other disciplines; and to serve more women.

REMINDER

Counting birth experience for active practice:
When a conditional or student midwife is in the hands-on role of principal midwife, both the midwife doing the hands-on care and the supervising midwife can count the birth as a primary care birth toward active practice requirements. Also, up to 20% of transfers of care can be counted as principal midwife births so long as the midwife in attendance carried out the transfer and remained involved in the birth in a supportive role.

Looking at key issues and challenges

We want to better understand what is working well for midwives and the women they care for – as well as where changes or increased flexibility will allow for improvements.

With these questions in mind, we want to look at the impact of:

- regulations, standards, policies, resource access;
- the current scope and model of practice;
- the effect of the funding model and the liability system;
- issues of workload & burnout among midwives;
- barriers to inter-disciplinary maternity care created by any of the above; and
- the impact of resources (or lack of resources) on quality of care, professional development and practice generally.

Challenges to Midwifery Meeting the Demand for Care

We know that there are BC women and whole communities who want midwifery care who cannot access that care, and we know that practices in many areas have significant wait lists. We want to know:

- how technological changes and environmental pressures are affecting midwives;
- more about the barriers to midwives starting practices in new communities and how those barriers might be addressed; how to better utilize and support part-time practitioners; and
- how the university and the midwifery community can best be supported to increase the numbers of midwives available to provide care, and what the relevant Ministries need to know and understand in order to step up and provide that support.

Research Plan

We propose to use the following methodology – or sources of information from which data would be collected:

- A literature and document review will ground the review process in an understanding of best practices in Canada and internationally. This review can update and build on the work done by the College of Midwives of Ontario in their Model of Practice Review which they are willing to share with us.
- Survey and focus groups – We believe it is very important to hear from all BC midwives. We have proposed that the CMBC and the MABC jointly conduct a survey of all midwives and carry out follow-up focus groups. We want to ask: *"What are the challenges and frustrations you face? What do you find difficult about your work? What care do you feel capable of providing that you are not allowed to*

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do? What do you love about your work? What feeds your soul and makes you want to stay? What wears you out, makes you mad, makes you think about quitting?"

- It will also be important to also hear from women, both those who have experienced midwifery care and those who want midwifery care but cannot access midwives in their communities. Ontario did a review of a year's worth of "Client Evaluations of Care", so that is one possibility. The UBC led study that is now underway will also provide valuable information. We are currently exploring other possibilities, such as focus groups, to ensure that the review includes the voices of childbearing women.
- We'll also want to hear from physicians, nurses and others who work with midwives. What do they understand about midwifery? What works and what is not working, and how could it be made to work better, from their perspective? Working in partnership with the Ministry of Health and other agencies such as Perinatal Services BC will be very important for this aspect of the review process. We are envisioning a survey followed by a facilitated world café style consultation.

While we are waiting for a response from the Ministry of Health to our request for funding support for the review, the College and the Midwives Association agreed that the issues before us were both too important to wait and too interconnected to not be considered in a comprehensive process. We are pleased to be able to pool resources and begin. We hope to hear from the Ministry of Health soon that they will support and partner with us in this important project.

Working with BC Ambulance on Home Birth Transport Issues

The College of Midwives has been in dialogue with the BC Ambulance Service (BCAS) to follow up on a number of concerns expressed by BC midwives. We were not successful in changing any processes or procedures. For example, BCAS told us they could not assist midwives with access to priority loading for ferry transportation when attempting to reach a woman in labour on a Gulf Island, as had been suggested by BC Ferries, so other solutions will need to be found. However, we were able to improve understanding and communication between our organizations, which we hope will help us assist midwives and ambulance attendants in working together to safely manage transport from home to hospital in emergency situations.

In May 2012, the College and the MABC had a joint meeting with BCAS' Medical Director and Director of Special Projects. It was identified that, despite BCAS having a transport protocol in place for "Maternity Responses with Midwives in Attendance" since 2001, many ambulance personnel still did not clearly understand the scope of practice or competencies of BC registered midwives. Communications with BCAS have been ongoing since that meeting.

As one follow-up, the College compiled a four-page package, with information on midwives' scope and competencies, for distribution to BC ambulance attendants. With a special focus on what ambulance attendants need to know, this material describes midwives' education, scope of practice, and midwifery competencies, especially those related to providing intrapartum care including resuscitation and emergency management skills, as well as the equipment and medications midwives carry to home births. This spring BCAS incorporated the material we provided into a 13 page BCAS document titled "Working with BC Registered Midwives" which we hope will be provided to ambulance attendants soon.

This document will remind ambulance attendants that midwives have hospital privileges, carry both College and hospital ID that ambulance personnel can check, have Home Birth Transport Plans in place with local hospitals, and have the authority to direct an ambulance to the most appropriate hospital for the given situation and to provide primary care during transport. The role of the second midwife, as well as the limitations of the role of a second birth attendant who is not a midwife, is also addressed.

Registered Midwives have the authority to act in the role of primary caregiver or "medical escort" in an ambulance, including directing the ambulance to the appropriate hospital facility, usually the hospital where the midwife has her privileges.

All BC ambulance attendants should soon be aware that BC Registered Midwives:

- Are university educated as primary care providers and specialists in low risk maternity care (UBC degree in midwifery or equivalent);
- Make midwifery diagnoses, order diagnostic tests, and prescribe and administer medications on their own responsibility;
- Are trained to manage neonatal and maternal obstetrical emergencies;
- Have hospital privileges, back-up plans and the ability to consult directly with physicians at their hospital; and
- Can direct an ambulance to the most appropriate hospital and provide patient care during transport.

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In our meetings, we also learned a number of things that may assist midwives in understanding BCAS policies and procedures.

Information for Midwives about BC Ambulance & Making 911 Calls:

- A 911 call should only be made when an ambulance is requested immediately and not to notify and alert dispatch that a client may need ambulance transport at some future time.
- If there are issues of access to the home, midwives should provide specific instructions e.g. top floor, stairs, back door, etc.

An ambulance is dispatched out within 40 seconds of a 911 call

- All questions you are asked by the BCAS 911-call-receiver must be answered, even those questions which seem irrelevant or out of order. Ambulance services all over North America have a standard set of questions for childbirth. BCAS confirmed to us that this protocol cannot be altered. The BCAS 911-call-receiver may not deviate from those questions. E.g. even if you have already said "the baby is born", when asked "Can you see the head?" simply repeat "The baby is already delivered" (Remember: you are talking with someone who is following the rules who may not know very much about childbirth. Expressing frustration will only lengthen the conversation.)
  The good news is:
  The BCAS 911-call-receiver will have sent a message to a BCAS dispatcher within 20 seconds of your phone call being received, even while still asking the required list of questions.
- The information you provide to BCAS over the phone and to ambulance personnel on the scene should always be concise and clear.
  Give specifics with times and precise assessments, similar to what you record in the chart e.g. "Her BP at 10:20 was 125/85" not "Her BP is normal".
- The BCAS 911-call-receiver is also required to keep callers on the phone until the ambulance arrives. If you have access to another phone to call the hospital or for other urgent matters, pass the phone with the 911-call-receiver to a non-medical support person, so that you can carry on with necessary care and communication. If this is the only phone available, politely tell the BCAS call receiver that you are hanging up to call the hospital, etc. Remember: after 40 seconds a dispatcher has already sent an ambulance out.
- When ambulance personnel arrive at the woman's home, show them your CMBC photo ID or your Hospital ID badge.
- Remember, ambulance personnel have a legal responsibility to do their own assessment and complete a record, even though you, as a registered midwife, will remain primary care provider.
- You can assist the transport in moving forward efficiently and effectively by reporting your own assessments and the times they were done, clearly and specifically to the ambulance crew.
- If the birth is imminent and you want the crew to stand by, you need to allow at least one member of the ambulance team to come in, meet the mother, and do a visual assessment of the situation. If for any reason the mother is refusing care from ambulance attendants, she must do that directly and in-person. You cannot do that on her behalf.
- Ambulance attendants will work with you, as the registered midwife in the primary caregiver role for both mother and newborn, assisting you with care as requested, including the delivery if you do not yet have a second midwife or second attendant present. You should use the same communication skills and professional collaborative approaches that you would use in working with a member of the inter-professional team in hospital.
- Ambulance personnel have varying levels of training, ranging from entry level Emergency Medical Responders (EMRs) to Primary Care Paramedics (PCPs) to Advanced Care Paramedics (ACPs). This is sometimes related to the geographical area served. In urban areas, for example, there may be ACPs serving the area. Some ambulance personnel are trained to perform intubation while others are not. There are also other specialized teams of PCPs that are dispatched in certain situations. For example, a specially trained group make up the Infant Transport Team based out of BC Women and Children's Hospital.

- At this time, midwives cannot prearrange priority loading for ferry transportation.
- Your professional ID is important. When a BCAS ambulance team arrives at a planned or unplanned home birth where only a family member or an untrained lay birth attendant is in attendance, ambulance attendants will assume primary care responsibility, assist with delivery if it is imminent, and take appropriate emergency measures to stabilize the patient(s) for transport to hospital.

Coming January 2014:
A *Hormonal Contraceptive Certification Course for Midwives* will be available through BCIT. More information will be provided at a later date.

Reminder to all Midwives

Home Birth Equipment Requirements

The additions to the *Required Equipment and Supplies for Home Birth* which are listed below and were circulated to registrants on February 5, 2013, are required to be carried by all Registered Midwives as of **July 1st, 2013.**

New NRP Related Items: Summary and Rationale for Inclusion

Pulse Oximeters – are useful in determining if a baby has a satisfactory blood oxygen level. A pulse oximeter can provides immediate feedback on the effectiveness of resuscitative efforts. It can also help prevent over oxygenation, avoiding medicating with oxygen when it isn't needed, and provide important feedback in making decisions about the need to transport to hospital. While it is an important tool in supporting good clinical judgement, it is not a replacement for close observation and assessment.

Pressure Gauges for Flow and Self-Inflating Resuscitation Bags – are considered most appropriate for resuscitation at home. An appropriate pressure gauge is now required as the pop off is no longer acceptable on its own. The pressure gauge ensures the system's pressure release valve releases at the right level. Overinflating of the lungs is less likely with a pressure gauge. Due to higher pressures being used (up to 30mm H20 pressure gauges are needed to ensure accuracy. Adapters, tubing and a pressure manometer are available for self-inflating bags.

Positive End Expiratory Pressure (PEEP) Valve – ensures positive pressure is being maintained at a set rate during expiration. Positive end expiratory pressure can only be administered if an additional valve is attached to a self-inflating system.

$C0_2$ Detectors – provide feedback on the effectiveness of positive pressure ventilation (PPV) should intubation become necessary. A C02 detector can be attached to a self-inflating system.

For the complete updated list of equipment that midwives must carry to home births refer to your updated Registrant's Handbook or the memo sent February 5, 2013.

Acupuncture Certification

In March 5, 2012, the certification program for acupuncture for managing pain relief in labour and the postpartum was approved by the College. Nine midwives have taken the acupuncture certification course to date. The following acupuncture certifications are being offered for midwives in the fall of 2013:

Fall Course Vancouver

Module One: October 12 – 13, 2013
Module Two: October 26 – 27, 2013.
Module Three: November 9 – 10, 2013
Module Four: November 23 – 24, 2013
(All sessions run 9 am – 5 pm at Acubalance Studio, Suite 120 – 828 W 8th Avenue)

Intensive Program Vancouver

Course: November 18 – 22, 2013
Review: November 23, 2013
Exam: November 24, 2013
(All sessions run 9 am – 5 pm at Acubalance Studio, Suite 120 – 828 W 8th Avenue)

For all course information and registration please visit: www.acupunctureformidwifery.com

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