



Standards of Competency

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And Standards of Practice

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1 STANDARDS OF COMPETENCY

The Midwifery Regulation establishes criteria of eligibility for registration as a midwife in Alberta. The purpose of these criteria is to ensure that midwives have the knowledge and skills necessary for safe and effective practice. This section describes the competencies midwives are expected to possess and maintain throughout their careers.

1.1 DEFINITION OF A MIDWIFE

In defining the competencies of registered midwives, the Midwifery Regulation Advisory Committee began by endorsing the following definition of a midwife developed by the International Confederation of Midwives. This definition has been accepted by the Alberta Association of Midwives, the Health Disciplines Board, and such organizations as the World Health Organization and the International Federation of Obstetricians and Gynecologists.

- A Midwife is a person who, having been regularly admitted to a midwifery education program, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.
- The midwife must be able to give the necessary supervision, care and advice to women during pregnancy, labour, and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help.
- The midwife has an important task in health counseling and education, not only for patients, but also with the family and community. The work should involve antenatal education and preparation for parenthood, and extends to certain areas of gynecology, family planning and child care.
- The midwife may practice in hospitals, clinics, health units and domiciliary conditions or in any other service.

1.2 COMPETENCIES OF REGISTERED MIDWIVES

1.2.1 General Competencies

Midwives have the knowledge and skills necessary to:

- 1) provide holistic care and advice to women before pregnancy and during pregnancy, labour, birth and the postpartum period;
- 2) provide continuity of care throughout childbearing;
- 3) exercise appropriate clinical judgment as an autonomous primary-care provider;
- 1) provide culturally appropriate and sensitive care;
- 2) promote normal birth;
- 6) provide care in a variety of settings including hospitals, clinics, health units, community health centres, birth centres or homes;
- 7) provide education, health promotion and counseling related to childbearing and family planning for the woman, her family and the community;
- 8) facilitate informed decision-making;
- 9) independently conduct births and care for the women and the newborn;
- 10) assist the woman and her family in planning for an appropriate place of birth;
- 11) identify risk factors before and during pregnancy, during labour and birth and the postpartum period, and take appropriate action;
- 12) order, perform and interpret results of screening and diagnostic tests in accordance with the Midwifery Regulation and established guidelines;
- 13) identify abnormal conditions, recommend and initiate appropriate treatment and make referrals, as required;

- 14) provide objective information about care alternatives including options, risks and benefits, and assist client decision-making;
- 15) prescribe, order and administer pharmacologic agents in accordance with the Midwifery Regulation and established guidelines;
- 16) establish and maintain comprehensive, relevant and confidential records;
- 17) use emergency measures when necessary;
- 18) critically review, appraise and apply new information, including research findings relevant to midwifery practice;
- 19) practice in an ethical manner;
- 20) use technology appropriately;
- 21) limit the spread of disease by using appropriate infection control measures;
- 22) assist the woman and her family to access appropriate community resources;
- 23) act as an advocate for the client in all aspects of her care;
- 24) communicate the scope of practice of a registered midwife including limitations of practice.

1.2.2 Specific Competencies

➤ Antepartum Care

A. Midwives have knowledge of:

- 1) the importance and functions of pre-pregnancy counseling;
- 2) the importance and functions of antepartum care;
- 3) general anatomy and physiology;
- 4) detailed knowledge of the anatomy and physiology of the reproductive systems;

- 5) physical, emotional, sexual and social factors and changes associated with pregnancy, including those likely to influence its outcome;
- 6) genetics, embryology and fetal development and their implications;
- 7) nutritional requirements during pre-conception, pregnancy and lactation;
- 8) the physiology and management of common discomforts of pregnancy;
- 9) methods for confirmation of pregnancy, establishing due date, assessing gestational age and assessing the progress of pregnancy;
- 10) screening and diagnostic tests available and used during pregnancy;
- 11) pharmacologic agents and therapies used during pregnancy and their effects, side effects and interactions;
- 12) alternative therapies which may be used during pregnancy;
- 13) environmental, occupational, genetic, biologic and pharmacologic hazards to the woman and the fetus;
- 14) indications and causes, of variations of normal which may occur during pregnancy;
- 15) causes, recognition and treatment of abnormalities which may occur during pregnancy;
- 16) infections, including sexually transmitted diseases and vaginal infections prior to and during pregnancy and their implications;
- 17) principles and procedure for responding to fetal malpresentation such as external cephalic version.

B. Midwives have the ability to:

- 1) obtain a comprehensive health, social and family history;
- 2) assess and promote the pregnant woman's general health and well-being;
- 3) perform a physical examination of the woman, including a breast exam;
- 4) Perform a vaginal exam and assess the soft and bony structures of the pelvis, uterine size, shape, consistency and mobility;
- 5) Perform a speculum examination to assess cervical and vaginal health and obtain the necessary specimens to determine the presence of sexually transmitted infections, vaginal infections and cytological change;
- 6) Perform abdominal palpation and fundal height measurement to assess uterine size, fetal position and presentation, and to estimate fetal size, number and gestational age;
- 7) perform venipuncture and capillary puncture;
- 8) confirm pregnancy;
- 9) assess nutritional intake and provide or recommend counseling, as appropriate;
- 10) recognize variations of normal which may occur during pregnancy;
- 11) recognize abnormalities which may occur during pregnancy and take appropriate action;
- 12) manage common discomforts associated with pregnancy;
- 13) assess fetal well-being;
- 14) perform ongoing physical assessments of the woman during pregnancy to detect abnormalities and initiate treatment and/or consult or refer as appropriate;
- 15) counsel the mother and her family on the benefits and practice of breastfeeding.

➤ Intrapartum Care:

A. Midwives have knowledge of:

- 1) the process of labour including the mechanisms of labour and birth;
- 2) indicators and assessment techniques of maternal and fetal well-being;
- 3) assessment of the onset and progress of labour and birth;
- 4) comfort and support measures during labour and birth;
- 5) physiological methods to facilitate labour;
- 6) maternal pelvic anatomy and anatomy of the fetal skull and its landmarks as relevant to assessing fetal position and the progress of labour;
- 7) normal variation and abnormalities of fetal heart rate and methods of assessing the fetal heart rate in labour;
- 8) the principals of clean and aseptic technique and universal precautions;
- 9) the significance of ruptured membranes and methods of reducing risk of infection;
- 10) abnormalities of labour, birth and the immediate postpartum period;
- 11) prevention, assessment and management of exhaustion, dehydration and ketonuria during labour;
- 12) techniques to protect the perineum, avoid episiotomy and minimize perineal trauma;
- 13) indications and procedure for episiotomy;
- 14) indications and procedure for repair of lacerations or episiotomy;
- 15) prevention, recognition and treatment of postpartum hemorrhage;
- 16) pharmacological agents and other substances and therapies which may be used during the intrapartum period;
- 17) emergency measures, obstetrical procedures and interventions;
- 18) neonatal resuscitation¹ to the standard established by the Canadian Pediatric Society Standards;

¹ Neonatal resuscitation includes successful completion of a provincially recognized neonatal advanced life support program.

- 19) requirements for a safe birthing environment;
- 20) pharmacological agents and other therapies used for induction and/or augmentation of labour, their uses, effects and side effects;
- 21) methods of initiating epidural anesthesia, pharmacological agents used and methods of monitoring a woman with epidural anesthesia.

B. Midwives have the ability to:

- 1) provide emotional and physical support to the labouring woman and her support people;
- 2) assess the onset and progress of labour and take appropriate action;
- 3) recognize variations of normal and abnormal labour patterns and identify the probable causes and potential interventions when indicated;
- 4) assess fetal heart with a fetoscope, doppler and electronic fetal monitor, interpret findings and take action when appropriate;
- 5) determine the status of fetal membranes and perform amniotomy as necessary;
- 6) assess amniotic fluid;
- 7) assess the urinary full bladder and perform urinary catheterization as necessary;
- 8) protect the perineum, avoid unnecessary episiotomy and minimize lacerations;
- 9) conduct spontaneous labour and birth;
- 10) perform and repair episiotomy as necessary, in accordance with the Midwifery Regulation;
- 11) examine the perineal and vulval areas for lacerations, hematomas, and abrasions and take action in accordance with the Midwifery Regulation;
- 12) collect cord blood samples;
- 13) recognize signs of separation of the placenta; assist in the delivery of and inspect the placenta;

- 14) prevent, recognize and manage obstetrical emergencies such as shoulder dystocia, postpartum hemorrhage and maternal shock;
- 15) support the woman and assist with obstetrical interventions;
- 16) provide immediate assessment and care of the newborn;
- 17) perform neonatal resuscitation; according to the Canadian Pediatric Society Standards;
- 18) prescribe, order and administer pharmacologic agents as necessary in the intrapartum in accordance with Midwifery Regulation;
- 19) assess the need for relief of pain and intervene using non-pharmacological and pharmacological measures as required in accordance with the Midwifery Regulation and established guidelines;
- 20) give injections, insert an intravenous catheter and administer intravenous fluids and medications in accordance with the Midwifery Regulation and established guidelines;
- 21) administer inhalants in accordance with the Midwifery Regulation and established guidelines;
- 22) conduct induction or augmentation of labour after consultation according to Provincial Midwifery Guidelines;
- 23) assist with initiation of epidural anesthesia, monitor and manage epidural anesthesia according to institutional guidelines;
- 24) encourage and assist with the initiation of breast-feeding.

➤ **Postpartum Care of the Newborn:**

- A. Midwives have knowledge of:
 - 1) anatomy and physiology of the newborn;
 - 2) newborn assessment and gestational age assessment;
 - 3) growth and development of the newborn;
 - 4) newborn screening and diagnostic testing;
 - 5) nutritional needs of the newborn, including properties of breast milk and infant formula, and methods of infant feeding;

- 6) signs and symptoms of abnormal conditions in the newborn;
- 7) prophylactic medications commonly given to the newborn;
- 8) effects of prescriptive and non-prescriptive substances on the newborn, including those excreted in the breast milk ;
- 9) environmental, biological and pharmacologic hazards to the newborn;
- 10) physical and emotional needs of the newborn including appropriate safety considerations;
- 11) issues related to circumcision.

B. Midwives have ability to:

- 1) provide initial newborn assessment and care;
- 2) perform a complete physical examination of the newborn;
- 3) provide ongoing newborn care and assessment of well-being and development in the first six weeks of life;
- 4) recognize complication in the newborn and make appropriate referrals as necessary;
- 5) administer medications and immunizations to the newborn according to Midwifery Regulations and Standards;
- 6) perform a heel puncture to obtain blood samples;
- 7) assess the ongoing well-being and development of the newborn in the first six weeks of life and make referrals as necessary;
- 8) continue to educate parents regarding newborn growth, development, behaviour, nutrition and care;
- 9) provide information to parents on the benefits and risks of immunization; and
- 10) provide information to parents regarding available public health and community resources, and make appropriate referrals for ongoing care.

➤ **Postpartum Care of the Mother:**

C. Midwives have knowledge of:

- 1) Maternal anatomy and physiology in the postpartum period, and the normal progress of the postpartum period;
- 2) postpartum assessment of the woman;
- 3) emotional, psychological, social, cultural and sexual aspects of the postpartum period, breastfeeding and early parenting;
- 4) nutritional requirements of women during the postpartum period including for lactation;
- 5) anatomy of the breast, physiology of lactation and principles of effective breastfeeding including the normal process and necessary conditions and factors for its success and management of common breastfeeding problems;
- 6) stimulation and suppression of lactation;
- 7) pharmacological agents and other substances and therapies used during the postpartum period and their effects on breastfeeding;
- 8) postpartum discomforts and management;
- 9) the influence of environmental, occupational, biological and pharmacologic hazards to lactating women and breastfeeding;
- 10) assessment and management of postpartum complications, including postpartum depression and complications of breastfeeding;
- 11) methods of birth control and family planning, and their risks and benefits.

D. Midwives have ability to:

- 1) assess the health and monitor the progress of the woman in the postpartum period;
- 2) assist the mother to establish and maintain breastfeeding or her chosen method of infant feeding;
- 3) identify special or abnormal maternal or infant situations that may influence breastfeeding and develop an appropriate plan;
- 4) use appropriate therapies to support effective breastfeeding;

- 5) facilitate the introduction of the new family member;
- 6) educate clients regarding self-care, normal postpartum progress, and signs and symptoms of common postpartum complications;
- 7) recognize postpartum complications including postpartum depression and take appropriate action including consulting or referring as indicated;
- 8) prescribe, order and administer appropriate pharmacological agents as necessary in the postpartum period in accordance with the Midwifery Regulation and Standards;
- 9) conduct the six week postpartum assessment including vaginal and speculum examination where appropriate;
- 10) counsel clients in decision-making regarding contraceptive methods;
- 11) instruct clients in the use of their chosen contraceptive method;
- 12) fit diaphragms and cervical caps;
- 13) provide appropriate referrals for ongoing care.

➤ **Education and Counseling:**

A. Midwives have knowledge of:

- 1) the principles and processes of informed decision-making;
- 2) principles of adult education, communication and counseling;
- 3) theoretical approaches to prenatal and parenting education;
- 4) issues related to grief and loss in childbearing;
- 5) available community resources;
- 6) cultural influences on childbearing and child rearing; and
- 7) issues related to abuse and discrimination.

B Midwives have the ability to:

- 1) provide objective information about care alternatives, including options, risks and benefits, to facilitate informed decision-making;

- 2) utilize a broad range of communication skills to communicate effectively with clients and their support people;
- 3) assist the women and her family in planning and preparing for the birth experience and early parenting;
- 4) counsel and support the woman and her family in responding to grief and loss in childbearing;
- 5) provide prenatal and parenting education; and
- 6) assess the well-being of the woman in the context of her family and community and provide her with information, education and support according to her needs.

➤ **Sexuality:**

A. Midwives have knowledge of:

- 1) physiological and psychosocial components of human sexuality in general, during the childbearing cycle and human fertility;
- 2) normal reproductive health and signs and symptoms of pathology;
- 3) factors involved in women's responses to pregnancy and resources for counseling and referral, including women seeking termination.

B. Midwives have the ability to:

- 1) inform and advise clients on issues of human sexuality, fertility and unplanned pregnancies, and make referrals where appropriate.
- 2) Provide well-women care according to the Midwifery Regulation and Standards.

➤ **Professional, Legal and Other Aspects of the Profession:**

A. Midwives have knowledge of:

- 1) the roles and responsibilities of other health care providers and their standards of practice;
- 2) legislation and public health policies and procedures relevant to midwifery nationally and in Alberta;

- 3) the code of ethics, regulations and standards for midwifery in Alberta;
- 4) the history and philosophy of the midwifery profession in Canada;
- 5) the structure and function of professional and regulatory midwifery organizations in Alberta
- 6) the legal requirements of midwifery practice including those respecting privacy, freedom of information, informed consent and informed choice, recording and reporting and data collection requirements;
- 7) the health care system in Alberta including existing health services, protocols and regulations regarding communicable diseases, infection control and immunization as it pertains to midwifery;
- 8) the process of teambuilding and engaging in professional and inter-professional partnerships.

B. Midwives have the ability to:

- 1) Work in a collegial manner with other caregivers in a variety of settings;
- 2) Communicate and collaborate effectively and professionally with midwifery colleagues, students and other caregivers, facilitating referral, consultation and collaboration when appropriate;
- 3) Practice in accordance with the Alberta Midwifery Code of Ethics.

➤ **Professional Development:**

A. Midwives have knowledge of:

- 1) methods of assessing statistical evidence and critically appraising the research literature;
- 2) continuing education and quality assurance programs and requirements for the ongoing evaluation of midwifery practice;
- 3) midwifery practice management.

B. Midwives have the ability to:

- 1) engage in reflective practice;
- 2) share midwifery knowledge and participate in midwifery related research;
- 3) recognize personal and professional boundaries and limitations, practice appropriate self-care and seek support when needed.

(Disclaimer: as the profession of midwifery is predominantly female, the term “her/she” is used to refer to both female and male midwives.)

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2 STANDARDS OF PRACTICE

2.1 Professional Accountability and Evaluation of Practice and Quality Improvement

Midwives are accountable to their clients, their peers and the wider community for safe, competent, 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 their clients. They are also accountable to the regulatory body, the health agencies they practice with, and, as a member of the profession, to the public.

Midwives are responsible for participating in processes of evaluation of practice and quality improvement as required within their practice, their health region and province in a manner consistent with privacy legislation.

2.2 Research on Effectiveness of Midwifery Care

Midwives have a responsibility to initiate, promote and participate in research regarding midwifery outcomes and share the knowledge across the health care system. All midwives will be expected to participate in this endeavor and to use the findings to develop and enhance their practice.

2.3 Medical Consultation and Transfer of Care

2.3.1 Guidelines for Consultation and Transfer of Care

The Regulations make it clear that midwives can accept primary responsibility for the care of any woman experiencing a normal pregnancy, labour, birth or postpartum period. Midwives are responsible not only for care in support of normal childbearing, but also for the identification of conditions which require consultation with a physician.

Because of the inherent difficulties in defining a “normal” pregnancy, this term has been defined by exception. The guidelines for medical consultation (4.3.2) identify conditions which may indicate a pregnancy can no longer be considered normal and within the scope of midwifery practice. The presence of these conditions indicates consultation with a physician is necessary.

Midwives use their professional judgment, guided by this document and the Alberta Perinatal Risk Scoring System, to assess and manage the conditions outlined below. It is the midwife’s responsibility to identify these conditions and to initiate medical consultation.

The Midwifery Regulation states that:

- (1) In respect of normal pregnancy, a midwife may, in accordance with the guidelines approved by the Board,
 - (a) engage in the practice of midwifery as a primary health care provider, and
 - (b) provide services in a variety of settings.
- (2) If medical conditions exist or arise during pregnancy that may require management by a physician, a midwife shall consult with a physician in accordance with the guidelines approved by the Board.
- (3) If the result of the consultation referred to under subsection (2) is a determination that management by a physician is required, the midwife shall transfer primary

responsibility of care, or aspects of care, to a physician and may engage in the practice of midwifery in collaboration with the physician, to the extent agreed to by the client, physician and midwife.

Primary responsibility for care is transferred or care is shared if the result of the consultation so indicates. The decision to transfer primary responsibility involves the professional judgment of the midwife and the physician and the informed consent of the client. It is ultimately the client who decides from whom she will receive care. However, the midwife has the right to refuse to provide care that is outside the scope of practice of midwifery.

The midwife, the client and the physician collaborate to determine:

- 1) whether advice regarding appropriate management of the condition is all that is needed and the midwife remains the primary health care provider;
- 2) whether aspects of the woman's care should be handled by the physician while the midwife remains the primary health care provider or
- 3) whether the condition poses a medical threat to the woman and/or child to the extent that the physician should assume the role of primary caregiver.

If the physician is to assume the role of primary caregiver, the midwife may continue to be involved in the ongoing care of the client to the extent determined jointly by the client, the midwife and the physician. Care may be transferred on a temporary or a permanent basis. In some cases, the physician may choose to provide medical advice and information including prescribing therapy to the client via the midwife. In an emergency situation transfer of care will be immediate.

These guidelines will be reviewed and revised over time by the CMA, in consultation with the Health Disciplines Board and other stakeholders. Changes to the guidelines will be based on research, experience and

ongoing evaluation of midwifery practice to ensure their relevance to safe and effective midwifery care.

These guidelines apply to all settings and are not exhaustive. Other circumstances may arise where the midwife believes consultation or transfer of care is necessary.

2.3.2 Guidelines for Medical Consultation

The following conditions require consultation with a physician:

1) Initial History and Physical Examination

- 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, insulin dependent diabetes mellitus, or hypertensive disorders.
- Congenital defect(s) of the reproductive organs.
- Family history of genetic disorders, hereditary disease and/or congenital anomalies.
- History of repeated spontaneous abortions.
- History of severe postpartum hemorrhage.
- History of retained placenta.
- History of severe psychological problems.
- History of two or more consecutive premature labours or history of low birth weight infant(s).
- History of severe pregnancy induced hypertension.
- Marked skeletal abnormalities.
- Previous operations or injuries to the uterus or vagina (e.g. operations for prolapse, cervical conization, myomectomy, vesicovaginal and recto-vaginal fistulae, classical cesarean section, etc.).
- Previous still birth or neonatal loss which may affect the current pregnancy.
- Rh isoimmunization or the presence of other blood group antibodies which 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) Prenatal Care

- Medical conditions arising or exacerbated during the prenatal period, e.g. cardiac disease, insulin dependent diabetes, endocrine disorders, hypertension, renal disease, acute pyelonephritis, thromboembolic disease, significant infection.
- Abnormal fetal growth pattern.
- Abnormal pap smear.
- Active sexually transmitted diseases or known HIV positive.
- Persistent anemia.
- Antepartum fetal death.
- Documented post term pregnancy.
- Exposure to known teratogens.
- Fetal anomaly.
- Hyperemesis.
- Multiple pregnancy.
- Persistent abnormal presentation.
- Persistent abuse of drugs or alcohol.
- Polyhydramnios or oligohydramnios.
- Pregnancy induced hypertension, persistent proteinuria or other signs of pre-eclampsia.
- Threatened premature labour.
- Rh isoimmunization or presence of other blood group antibodies which may adversely affect the fetus.
- Serious psychological problems.
- Continued or unexplained vaginal bleeding.
- Unexplained sudden and severe abdominal pain.
- Rupture of membranes before term.

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.
- Prolonged rupture of membranes.
- Prolonged second stage.
- Pregnancy induced hypertension or other signs of pre-eclampsia.
- Prolapsed cord.
- Retained placenta.
- Thick meconium.
- Uterine rupture.

4) Post-Partum (Maternal)

- Lacerations involving the anus, anal sphincter, rectum or urethra area.
- Hemorrhage unresponsive to therapy.
- Inversion of uterus.
- Persistent hypertension.
- Post-Partum eclampsia.
- Serious psychological problems.
- Signs of puerperal infection.
- Suspected retained placental fragments or membranes.
- Thrombophlebitis or thromboembolism.
- Breast infection unresponsive to therapy.

5) Post-Partum (Infant)

- APGAR lower than 7 at 5 minutes.
- Abnormal findings on physical exam, e.g.
 - Abnormal abdominal distention.
 - Abnormal cry.
 - Abnormal heart rate or pattern.
 - Abnormal movement of any extremity.
 - Abnormal neurological signs including hypotonia.
- Respiratory distress.
- Excessive bruising other than a cephalhaematoma and/or generalized petechia.
- Failure to pass urine within 24 hours or meconium within 48 hours of birth.
- Feeding intolerance with vomiting or diarrhea.
- Less than 3 vessels in umbilical cord.
- Congenital anomalies.
- Persistent cyanosis or pallor
- Suspected pathological jaundice.
- Infection of umbilical stump site.
- Seizure like activity.
- Significant weight loss.
- Temperature above or below normal that is unresponsive to therapy.
- Conditions that cause concern in either the parents or the midwife.

2.4 Guidelines for Out-of-Hospital Birth

Midwives offer women a choice of birthplace. A midwifery client can choose to give birth in a hospital, a birth-centre or at home. Midwives are responsible for informing their clients regarding the benefits and risks of all birth-settings and for assisting them in choosing the most appropriate birth site for their individual circumstances.

2.4.1 Notifying Regional Health Authorities

Before acting as a principal midwife for out-of-hospital births in an area where she does not already hold admitting privileges, a midwife must notify the administration of the Regional Health Authority responsible for the area within which she intends to provide midwifery services.

2.4.2 Consideration in Determining an Appropriate Site for Birth

Before acting as a principal midwife for out-of-hospital births, a midwife must:

- a. use *The Guidelines for Medical Consultation* in Chapter 4.3.2. to identify conditions that exist or arise prior to the onset of labour, which require the midwife to advocate a medical consultation and a planned hospital birth, and
- b. take into account the availability of emergency support systems, distances, and other factors relating to the safety of the mother and child.

The final decision about the planned place of birth is based on the professional judgement of the midwife and the informed choice of the client.

If a clients' choice of birthplace contravenes the *Midwifery Standards of Practice*, the midwife must follow the *Policy for Care Outside Midwifery Standards of Practice* (See Appendix 6).

2.4.3 Emergency Support

In each area where a midwife offers services, the midwife must know about the availability of and how to access emergency services including local EMS and the nearest hospital capable of dealing with an obstetrical emergency.

Once the decision to attend an out-of-hospital birth has been made, the principal midwife must ensure that an appropriate emergency support system is in place for the birth including:

- (a) an emergency transport service that is available 24 hours a day and can respond within 30 minutes; and
- (b) a nearby hospital capable of dealing with an obstetrical emergency at which the midwife has admitting privileges or other standing arrangements in place that allow the hospital to know the midwife is regularly attending births within its catchment area; or
- (c) a nearby hospital capable of dealing with an obstetrical emergency which the midwife has notified that she will be conducting a home birth within its catchment area.

2.4.4 Out-of-Hospital Birth: Essential Equipment

A midwife who attends an out-of-hospital birth must have and must maintain equipment, supplies and drugs that may be required during labour, birth and the postpartum period, including but not limited to:

Amnihook Antiseptic solution Blood pressure cuff Blood tubes Cord clamps (sterile) Doppler/Fetoscope Epinephrine (1 in 10,000) Erythromycin eye ointment IV Solution and equipment Gloves (sterile) Lubricant (sterile) Mechanical suction equipment Neonatal intubation equipment Oral airways for adult and infant Oxytocic drugs	Resuscitation equipment for infant including self-inflating or anesthesia bag Scissors: (sterile) One pair blunt-ended for cord One pair for episiotomy Syringes and needles (sterile) Stethoscope Suturing equipment (sterile) and local anesthetic Thermometer Two hemostats (sterile) Urinalysis supplies Urinary catheter (sterile) Vitamin K.
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2.4.5 Conditions Requiring Transport From an Out-of-Hospital Setting

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

Although women choosing to birth at home or in a birth centre will have been screened, conditions may arise during labour, birth and the postpartum period which necessitate transport to a hospital. This section lists these conditions.

If any of the following conditions are present, the midwife must arrange for transport of the midwife's client to a hospital capable of dealing with the condition.

I. Conditions noted during labour and birth

- a) Severe gestational hypertension, proteinuria or other symptoms
- b) Active genital herpes at onset of labour
- c) Abnormal labour pattern unresponsive to therapy
- d) Abnormal presentation
- e) Unexplained sudden and severe pain
- f) Prolapsed cord
- g) Non-reassuring fetal heart rate patterns
- h) Excessive vaginal bleeding
- i) Retained placenta
- j) Unexplained fever or other signs of chorioamnionitis
- k) Any circumstance where the safety of the mother, child and/or midwife cannot be assured

II. Conditions noted postpartum

- a) Hemorrhage unresponsive to therapy
- b) Inversion of uterus
- c) Postpartum eclampsia

III. Conditions noted in the newborn within the first 48 hours

- a) Abnormal heart rate or pattern
- b) Respiratory distress
- c) Persistent cyanosis or pallor
- d) Suspected pathological jaundice
- e) Extensive bruising other than a cephalhaematoma and/or generalized petechia
- f) Significant congenital abnormalities
- g) Temperature above or below normal that is unresponsive to treatment
- h) Seizure-like activity
- i) Hypotonia
- j) Lethargy, with or without poor feeding

This list is not exhaustive. There may be other circumstances where the midwife or labouring woman believes transport to a hospital is advantageous