College of Midwives of Alberta

Standards of Practice

For

Midwives in Alberta

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Introduction

The **College of Midwives of Alberta (CMA)** is responsible under the ***Health Professions Act* RSA2000 (*the Act*)** for regulating the profession of midwifery in Alberta. The **CMA's** mandate is to govern its registrants in a manner that protects and serves the public interest. Regulation is a privilege that recognizes the maturity of the profession and honors the knowledge and skills possessed by its registrants. Midwifery is accorded this privilege on the basis that midwives will uphold the *Standards* and reputation of the profession, protect, and promote the best interests of **clients** and the public, and collectively act in a manner that allows the public to have confidence in the profession. ***Regulation*** requires that each midwife participate in the **CMA** regulatory process.

The **CMA** adopts and amends *Standards of Practice* for midwives in Alberta under the authority of Section 133 of ***the Act*.** A midwife must always act in accordance with ***the Act*,** the ***Midwives Profession Regulation, Alta Reg 237/2018 (the Regulation),*** the *Standards of Practice* for Midwives in Alberta (*the Standards*), ***the Alberta Competencies for Midwives*** **(*the Competencies*)** and the *Code of Ethics* that govern the midwifery profession in Alberta. These documents work together to form overarching powers and responsibilities through specific powers and responsibilities.

Purpose

It is the responsibility of the midwife to comply with all federal and provincial legislation as applicable. This includes ***the Act*** and its ***Regulations*** from which the *Standards* originate. The *Standards* set out the minimum *standards* for professional behavior and ethical conduct expected of all midwives registered with the **CMA.** They are mandatory in nature. All midwives involved in **client** care hold the role of a trusted **Regulated Health Care Provider**. The *Standards* represent criteria against which the practice of all midwives is measured by the **CMA**, the public, **clients**, employers, colleagues, and midwives themselves.

Midwifery education programs also use the *Standards* as a base for educating students to an entry to practice level. The *Standards*, along with the ***Competencies*, *the Act*, *Regulation*,** and the *Code of Ethics* set the expectations for the knowledge, skills, judgement, and attitude required of midwives to practice safely, ethically, and competently. These *Standards*, under the overarching authority of ***the Act*** and **the *Regulation*,** serve as a legal reference for reasonable and prudent practice.

It is the responsibility of the midwife to understand the *Standards*, the **Competencies** and the *Code of Ethics* and apply them to their practice, specific to their setting and role. Since midwives provide care in both community and institutional settings, the midwife must also be aware of and work in accordance with any documents that guide care set by locations in which they practice, including institutions, employers, and contractors, if they do not contravene the *Standards*.

Contravention of the *Standards* is **unprofessional conduct** and may lead to professional sanction under ***the Act.***

The Principles

The **CMA** developed the *Standards* using a model of governance referred to as *Principle-based Standards. Principle-based Standards* provide the midwife with a basis for approaching any situation. The **CMA** expects midwives to use the *Principle-based Standards***,** along with the knowledge and skills acquired and maintained through their initial and continuing education and experience to provide quality midwifery care in any situation.

The *Standards* are organized under four (4) principles. Some *standards* relate to more than one Principle. For organizational purposes these *Standards* are placed under the principle that is most relevant.

Principle 1: PROFESSIONAL KNOWLEDGE AND PRACTICE

Midwives are responsible for their own midwifery practice, continuously acquiring and implementing knowledge and skills to provide safe, ethical, and **competent** midwifery care.

Professional knowledge and practice focuses on developing and maintaining the knowledge and clinical skills necessary to provide care to **clients** at the entry-to-practice level of competence. Midwives must be committed to an ongoing process of learning, self-assessment, evaluation and identifying ways to best meet **client** needs. Midwives must exercise good clinical and professional judgment to provide quality care.

Principle 2: PERSON-CENTERED CARE

Midwives use person-centered care to deliver quality midwifery care. Person-centered care focuses on the **client** and their life context. Working with individuals in partnership, person- centered care offers quality care provided with compassion, respect, and trust. Person-centered care recognizes the central

role the **client** has in their own health care, and responds to their unique needs, cultural values, and preferences in all aspects of care.

Principle 3: CONTINUITY OF CARE

The goal of continuous midwifery care is to achieve quality care for the **client** by establishing a continuous caring relationship and an ongoing partnership with the midwife/midwives built on respect, understanding, support, and trust. Continuity of care is both a principle of care and a process concerned with quality of care over time. Continuity of care is an important means towards the goal of person-centered care.

Principle 4: INTEGRITY

Midwives have the professional and ethical obligation to conduct themselves in a way that demonstrates trustworthiness and integrity of the profession**.** Midwives must consistently uphold the *Standards*, the *Code of Ethics* and *the* ***Competencies*** in the best interests of their **clients** and the public.

Integrity is a fundamental quality of any person who seeks to practice as a registrant in the midwifery profession. Every midwife has a duty to provide quality care, and to practice with the best interests of **clients** and the public as paramount. Integrity requires midwives willingly and consistently do what is right, ethically and in the best interest of the **client,** while upholding the reputation and values of the profession.

Definitions

The following definitions are the terms used in the *Standards*. They are highlighted in bold when they are used.

Abandon: When a midwife discontinues **client** care without the request of the **client** and without arranging a suitable alternative care provider.

Act: The *Health Professions Act*, RSA 2000, c H-7.

Additional competencies: Competencies outside of the list of entry to practice competencies and require additional education and approval from the **CMA.**

Additional precautions: measures used when Infection Prevention and Control routine practices alone may not prevent transmission of an infectious agent.

Advanced authorization: Approval by the **CMA** Registrar or the Registration Committee authorizing a midwife to engage in one or more of the **restricted activities** set out in section 17 of the ***Regulation*.**

Alberta Electronic Health Record (ABEHR): An integrated electronic health information system established to provide and share access to health information in a secure environment, an example Netcare.

Basic (entry-to-practice) competencies: The entry-to-practice competencies expected of midwives, upon completion of their midwifery education program to provide safe, ethical, **competent** care in both institutional and community settings, as set out in the https://albertamidwives.org/uploaded/web/policies%20and%20statements/Alberta%20Competencies%20for%20Midwives.pdfCompetencies. These core competencies are also the minimum competencies required for ongoing registration with the **CMA.**

Bias: A conscious and/or unconscious tendency, inclination, or prejudice toward or against something or someone.

Biological Indicator (**BI**): A test system containing viable bacterial spores providing a defined resistance to a specified **sterilization** process.

Boundaries: An accepted social, physical and/or psychological space between people that clarifies their respective roles and expectations. Professional **boundaries** are critical for establishing and maintaining an appropriate **therapeutic relationship** between the midwife and the **client.**

Cleaning: The removal of contamination from an item to render it visually free of soil and quantified as below specified levels of the substance to be measured.

Client: A person or persons who contracts with the midwife or group of midwives for the professional service of midwifery care. **Client** also includes the newborn infant of the person who enters the contract for midwifery services.

Chemical Indicator (**CI**): A test system that reveals a change in one or more predefined process variables based on a chemical or physical change resulting from exposure to the process.

Collaboration: The process of working together with the **client**, other midwives, and other members of the health care team to provide person-centered care.

College (or CMA): The College of Midwives of Alberta.

Common risk: The most probable potentials for harm, regardless of the level of significance, that a reasonable person would want to consider when making a decision about undergoing a treatment or procedure.

The Competencies: *The Alberta Competencies for Midwives.*

Complaints process: The process by which the **CMA** addresses complaints as described on the **CMA** website.

Conflict of interest (COI): A situation in which a midwife has personal, occupational, or financial interests that may influence or appear to influence the objectivity, transparency, fairness and/or impartiality of decisions or recommendations about **client** care. A **conflict of interest** exists even if no unethical or improper acts result.

Confidentiality: The duty to keep all **client** information private as required by the *Alberta Health Information Act 2000*, the *Freedom of Information and Protection of Privacy Act 2000* and the *Personal Information Protection Act 2019. Acts*

Consultation: The process by which a midwife requests an opinion and advice regarding their **client's** care from another health care provider but remains the **client's most responsible provider (MRP).**

Contemporaneous documentation: The completion of the **client** care record notes at the time of the event or as close to it as prudently possible.

Continuing competence: The ongoing ability to apply the knowledge, skills, judgement, and personal

attributes to practice safely and ethically in a designated role and setting.

Controlled drugs and substances: A **drug** or substance included in Schedule I, II, III, IV or V of the *Controlled Drug and Substances Act* (2019) which may be ordered or prescribed only by professionals authorized under this legislation; and a listed substance which the midwife may only prescribe, possess or conduct an activity with in accordance with the *Benzodiazepines and Other Targeted Substances **Regulations***, Part G of the *Food and Drug Regulations* or the *Narcotic Control Regulations* if they are permitted to prescribe that substance in their practice under the laws of the province in which they are registered and entitled to practice.

Critical medical device: A **medical device** that enters sterile tissues, including the vascular system.

Cultural safety: A process based on respectful engagement, free from racism and discrimination, that recognizes and strives to address power imbalances inherent in the healthcare system.

Custodian: A health care provider designated under the *HIA* who collects, uses, or discloses health care information.

Decontamination / **decontaminated**: The process of **cleaning**, by use of physical and/or chemical means, to remove, inactivate, or destroy pathogenic micro-organisms, in order to render an object safe for handling.

Direct Supervision: The **supervisor** is to be physically present at the workplace, assessing and always observing when the supervised midwife is providing clinical care.

Disinfectant: Chemical(s) used for **disinfection**, including high-level **disinfectant** (HLD), intermediate-level **disinfectant** (ILD), and low-level **disinfectant** (LLD).

Disinfection / **disinfect** / **disinfected**: The process to inactivate viable micro-organisms to a level previously specified as being appropriate for a defined purpose. (See definitions for high- level **disinfection**, intermediate-level **disinfection**, and low-level **disinfection**).

Drug: Therapeutic agent; any substance, other than food, used in the prevention, diagnosis, alleviation, treatment, or cure of disease or condition.

Drug identification number (**DIN**): A **drug identification number** (**DIN**) is an eight (8) digit numerical code assigned to each drug product marketed under the Food and Drugs Act and Regulations.

Early postpartum: The time period from the birth of a baby to seven days after birth.

Effective communication skills: Use of communication techniques which incorporate **cultural safety**

that support a common understanding of ideas, desires and observations between midwife and **client** or midwife and other care providers.

Emergency measures: Evidence-informed actions and communication within the **scope of practice** of midwifery, which have the potential to physiologically stabilize and/or support the **client** during a crisis, including but not limited to IV fluids, maintaining airway, breathing, circulation resuscitation, and communicating with emergency services or resources.

Evidence-informed: actions or information based on successful strategies shown to improve **client** outcomes and derived from a combination of critically appraised sources, including but not limited to **client** perspectives, research, national guidelines, consensus statements, expert opinion, and **quality improvement** data.

Family: A person or persons whom the **client** identifies as part of their immediate support system.

Fitness to practice: All the qualities and capabilities of an individual relevant to their capacity to practice safely as a midwife.

Hand hygiene: Hand washing, hand antisepsis or other actions taken to maintain healthy hands and fingernails.

Health Record: Paper or electronic record specific to the care of a midwifery **client**.

High level disinfection: A process capable of killing vegetative bacteria, mycobacteria (including Mycobacterium tuberculosis), fungi, and lipid and nonlipid viruses, as well as some, but not necessarily high numbers of, bacterial spores.

Intermediate level disinfection: A process capable of killing vegetative bacteria, mycobacteria (including Mycobacterium tuberculosis), fungi, and lipid and nonlipid viruses. Reference:.

Indirect supervision: The **supervisor** is always readily available to the supervised midwife for consultation or assistance when the supervised midwife is providing clinical care,

Installation qualification (**IQ**): The process of obtaining and documenting evidence that equipment has been provided and installed according to its specification.

Low level disinfection: A process capable of killing most vegetative bacteria and some fungi, as well as enveloped (lipid) viruses (e.g., influenza, hepatitis B and C, and HIV). **Low level disinfection** does not kill mycobacteria, non-enveloped viruses, or bacterial spores.

Manufacturer's instructions for use (**MIFU**): The validated, written directions provided by the

manufacturer or distributor of a **medical device** or product, that contains the necessary information for the safe and effective use of the **medical device** or product.

Note: The term **MIFU** may also be used to refer to written instructions for use developed internally or by a commercial reprocessor, that have been validated by an approved laboratory.

Material risk: Any significant potential for harm that a reasonable person would want to consider when making a decision about undergoing a treatment or procedure.

Medical device: Any instrument, apparatus, appliance, material, or other article, whether used alone or in combination, including the software necessary for its proper application, intended by the manufacturer to be used for a human being for any of the following purposes:

- diagnosis, prevention, monitoring, treatment, or alleviation of disease;
- diagnosis, monitoring, treatment, or alleviation of, or compensation for, an injury or handicap;
- investigation, replacement, or modification of the anatomy, or of a physiologic process; or
- control of conception,

and that does not achieve its principal intended purpose in or on the human body by pharmacological, immunological, or metabolic means, but that can be assisted in its function by such means.

Note: Under the Medical Devices Regulations, Health Canada licenses high-level **disinfectants** and sterilants used in the **reprocessing** of **medical devices** as **medical devices**. However, in the context of these *Standards*, the term "**medical device**" does not include high-level **disinfectants** and sterilants

Medical device license (**MDL**): A license issued to a manufacturer by Health Canada, for a specific **medical device**.

Medical device reprocessing (**MDR**) area: Any area where the **reprocessing** of reusable **critical** and **semi-critical medical devices occurs**.

Mentor: An experienced or knowledgeable person who provides support and guidance to a less experienced or less knowledgeable person, specifically related to the CMA New Registrant Program, where the CMA-approved Mentor oversees, directs and evaluates the practice of a new graduate for a specified period of time**.**

Most responsible provider (MRP): The **primary care provider** who holds overall responsibility for leading and coordinating the delivery and organization of **client** care at a specific moment in time.

Non-critical medical device: A **medical device**, which either touches only intact skin but not mucous membranes, or does not touch the **client**.

Normal pregnancy or birth: A pregnancy or birth that does not have complications that pose a

significant risk to the wellbeing of the pregnant person or fetus, which is able to be managed by the midwife independently or in **consultation** with an appropriate physician.

Obstetrics: Care that specializes in the care of **clients** during pregnancy, childbirth, and the **postpartum** period

One-way workflow: The practice of ensuring that **reprocessing** work flows in one direction from the dirtiest to the cleanest.

Operational qualification (**OQ**): The process of obtaining and documenting evidence that installed equipment operates within predetermined limits when used in accordance with its operational procedures.

Packaging: (verb) - A step in the **sterilization** process in which a **medical device** is enclosed in materials or a container designed to:

a) allow the penetration and removal of the sterilant during **sterilization**; and
b) protect the **medical device** from contamination and other damage following **sterilization** and until the time of use.

Performance qualification (**PQ**): The process of obtaining and documenting evidence that the equipment, as installed and operated according to operational procedures, consistently performs according to predetermined criteria and thereby yields product meeting its specification.

Personal protective equipment (**PPE**): Equipment or clothing worn by a person for protection from health or safety hazards associated with conditions at a work site.

Point of Care Risk Assessment (**PCRA**): an individual assessment of each client's potential risk of transmission of microorganisms. This must be performed by all health care providers and other staff who come into contact with them. Based on that risk assessment and a risk assessment of the task, one may determine appropriate intervention and interaction strategies (eg. **hand hygiene**, waste management, use of **PPE** to reduce the risk of transmission)

Postpartum: The time from the delivery of the placenta and membranes until the return of the person's reproductive tract to its non-pregnant condition, usually around 6-8weeks after birth.

Preceptor: A **regulated health care provider** approved by the midwifery education program or **CMA** responsible for overseeing the performance of an individual undertaking a period of student clinical practice. The **preceptor** instructs, monitors, supports, and provides student feedback and reports on student progress.

Primary care provider (PCP**):** A **Regulated Health Care Provider** who is the initial access to the health care system. **PCP**s diagnose and manage a health condition; provide non-emergent treatment of a

health issue or injury, and offer health care or wellness advice and programs. Depending on the circumstances, a **PCP** may provide **emergency measures** as indicated, within their knowledge and skills, until more expert health care can be obtained.

Primary responsibility: See **most responsible provider**.

Process challenge device (**PCD**): An item providing a defined resistance to a **cleaning**, **disinfection**, or **sterilization** process and used to assess performance of the process.

Quality improvement: A systematic, formal approach to the analysis of practice performance and efforts to improve performance.

Regulated health care provider: A regulated member of a **college** under ***the Act***.

The Regulation: *The Midwives Profession Regulation, Alta Reg 237/2018*.

Reprocessing / **reprocess** / **reprocessed**: The **cleaning**, **disinfection**, and/or **sterilization** of a potentially contaminated **medical device** so that it is safe and effective for use on a client.

Restricted activities: Activities performed as part of providing a health service that requires specific professional competence to be carried out safely. **Restricted activities** authorized for midwives are listed in sections 16 and 17 of the ***Regulation***.

Reusable medical device: A device that has been designed by the manufacturer, through the selection of materials and/or components, to be **reprocessed** and reused.

Scope of practice: The activities a midwife is authorized to perform, as set out in legislation, including *Schedule 13* of ***the Act***, and the ***Regulation***, and as described by the *Standards of Practice*, ***the Competencies*** and subject to any limits or conditions imposed in accordance with ***the Act***.

Semi-critical medical device: A **medical device** that comes into contact with mucous membranes or non-intact skin, but does not penetrate them.

Single-use medical device: **Critical** and **semi-critical medical devices** labelled by their manufacturers to be used only once. The manufacturer may use terms, including but not limited to the following, to designate a device for single-use only:

- disposable;
- consumable;
- not for re-use or do not re-use;
- discard after single-use;

- do not use twice; or

a symbol such as: ②

Shared care: An approach to care of a **client** that involves more than one type of health care provider, who share joint responsibility in relation to aspects of that **client's** care. The provision of health services by two or more health care providers who work collaboratively with **clients** to deliver coordinated, high quality health service. **Shared care** requires processes outlining clear expectations for each providers responsibilities and accountabilities.

Social Media: Websites and applications that allow users to connect and socialize online. Users may create content and share ideas, thoughts, and information. This includes (but is not limited to) platforms, such as Facebook, Instagram, Twitter, TikTok and **Social Media** Chat Apps, blogging sites.

Sterilization / **sterilize** / **sterilized**: The validated process used to render a product free from viable microorganisms.

Supervision: The act of overseeing, directing, instructing, and evaluating learners or candidates.

Supervisor: A person who oversees, directs, evaluates, and may instruct people who are being evaluated (i.e., Internationally educated midwives), working under restrictions or who are enrolled in a **CMA** recognized midwifery education program.

Supportive care: When there is a transfer of responsibility from midwife to physician (either temporarily or permanently) and the midwife is no longer the **MRP**, the midwife continues to provide at least some aspects of care for the **client** within their **scope of practice.** This can range from care that highlights clarifying communication, emotional and physical support, anticipatory guidance, and **client** advocacy to managing labour or birth under a physician's **supervision**.

Therapeutic Relationship: A planned, goal directed, interpersonal process occurring between the midwife and **client** that is established for the advancement of **client** values, interests, and the promotion of **client** health and well-being.

Transfer of Care: The transfer of responsibility for care from one **most responsible provider** to another, for some, or all, of the duration of the **client's** care.

Unprofessional Conduct: Means one or more of the following, whether or not it is disgraceful or dishonorable *(HPA s.1(pp)(i-xii)):*

1. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services.

2. Contravention of the ***Health Professions Act* RSA2000 (the Act)** *, The* ***Regulation****, Standards of Practice* for Midwives in Alberta, *Alberta Competencies for Midwives*, and/or the **CMA** *Code of Ethics.*

3. Contravention of another enactment that applies to the profession.

Unregulated Health Care Provider: A person offering health services who is not required to be regulated by a health professions **college** under ***the Act*** in order to provide these services.

Vaccine: A unique class of pharmaceutical products that meet the statutory definition of both a **drug** and a biological product. A **vaccine** is a biological preparation that improves immunity to a particular disease.

Validation / **validated**: A confirmation process, through the provision of objective evidence, that the requirements for a specific intended use or application have been fulfilled.

Virtual care: Midwifery care that uses electronic communication technology. Examples include: texting, photos, phone calls, virtual platforms, video, or other electronic means.

Standards of Practice

Principle 1: Professional Knowledge and Practice

Standard of Practice 1: Professional Knowledge and Practice

A midwife must demonstrate professional knowledge and practice as follows:

1A: General

1. Know, understand, and adhere to current relevant legislation that apply to midwifery practice including but not limited to ***the Act,*** the ***Regulation,*** the *Standards*, the *Code of Ethics* and ***the Competencies*****.**
2. Take responsibility and accountability for the care they provide.
3. Carry out **restricted activities** set out in sections 16 and 17 of the ***Regulation*** in a **competent**, professional manner.
4. Carry out additional **restricted activities** and **advanced authorizations** set out in section 17 of *the **Regulation*** only after obtaining authorization from the Registrar
5. Confine their activities to those they are **competent** and authorized to perform.
6. Provide **client** care, including interventional treatment, to the **client** based on current, critically appraised, **evidence- informed** information and consistent with the *Standards of Practice.*
7. Integrate Infection Prevention and Control Routine Practices into all **client** encounters, according to *Standard of Practice 24: Infection Prevention and Control.*
8. **Communicate effectively** and respectfully with **clients**, their families, other midwives, and all members of the health care team, to enhance **client** care and outcomes.
9. Actively address **client** concerns and complaints regarding their care promptly, fairly, and transparently. Record in the **client's health record** according to ***Standard of Practice 2: Client Records and Record Keeping.***
10. Report any changes in personal **fitness to practice** to the **CMA** within a reasonable period of time after the midwife becomes aware in accordance with section 14 of the ***Regulation.***

11. Comply with required and relevant provincial and national mandatory reporting obligations.

12. Provide information to **clients** about regulated midwifery in Alberta, including **scope of practice** and the **complaints process** through the **CMA.**

13. Take the following actions when a midwife is also a member of another regulated profession and integrates knowledge and skills from the other profession into the **client's** care (for example, midwife and naturopath):

    a. Inform **clients** if any part of a proposed service or treatment is outside the scope of midwifery practice

    b. Conduct a separate informed decision-making discussion with the **client** if any part of a proposed service or treatment will be administered outside the scope of midwifery practice

    c. Ensure **clients** know they may refuse to receive care from a midwife in their capacity as another regulated professional.

14. Accurately document and maintain **health records** of all **client** encounters (aspects of care) that clearly identifies the professional capacity under which care is provided.

15. Maintain current contact information in their **CMA** profile.

1B: Clinical Care

1. Maintain and carry required supplies and equipment necessary for care in community settings as set out by the **CMA** and published on the **CMA** website.

2. Not **abandon** a **client** in the course of labour and birth once the midwife is present unless the midwife perceives that they are in imminent danger in which case:

    a. After removing self from danger, the midwife must call appropriate emergency services.

3. Transfer care to another midwife or physician if the midwife is no longer either physically or mentally able to provide safe, **competent** care for the **client.**

4. Ensure that every midwifery birth and immediate **postpartum**, regardless of location or setting, is attended by appropriate personnel, with appropriate requirements for equipment and supplies.

Standard of Practice 2: Client Records and Record Keeping

The Health Information Act (HIA), Section 64, requires registered midwives, as **custodians** of **client health records**, to submit a Privacy Impact Statement (PIA) to the Office of Information and Privacy Commissioner (OIPC) for review.

To demonstrate compliance with this *standard* for documentation and access the midwife must:

1. Ensure that all clinically related encounters, in person or via **virtual care** with the **client** are recorded in the **health record**. This includes important communication with other care providers, **family** members and substitute decision makers.
2. Record the date clearly identifying the year, month, and day. Timed entries will utilize the 24-hour clock format.
3. Midwives will utilize the standardized Alberta Health midwifery/obstetrical care forms or Electronic Health Recording when available. Ensure recording on health care records is:
    a. Clearly legible
    b. Identifiable, containing a signature or audit trail that identifies the author and their professional designation. Any student or care provider under **supervision** must be identified as such
    c. Accurate and objective
    d. **Contemporaneous** and chronological.
4. Label entries out of chronological order as “late entry” with the date and time of the actual recording and reason for delayed documentation indicated.
5. Use abbreviations, symbols, acronyms only when defined or described in *Standards of Practice* approved by the **CMA** or in a legend on an approved record or when written out in full with abbreviation in brackets at the first entry on each by the midwife on the record.
6. Correct errors on paper chart by crossing out the error with a single stroke, write “error” or

"wrong chart" and include the midwife's initials. Correct errors on electronic chart by adding correction statement with date and time of correction without deleting the error.

7. Have paper Alberta Health forms available for use in the event that electronic charting is temporarily unavailable.
8. Comply with the ***HIA Part 2*****,** to provide access for a **client**'s individual **health record**.
9. Comply with the ***HIA Part 2*****,** in **client**s request for amendment or correction to their personal **health record**.
10. Ensure all computers, including laptops can only be accessed through password protection. All midwives and staff will have individual login identification. Screens will be guarded from public view.

Content of Health Records

The record of each encounter must contain:

1. Date of encounter and, if applicable, time
2. Clear identification of the **client** and the midwife
3. Reason for encounter
4. Relevant history
5. Assessment including physical findings if applicable
6. Diagnosis
7. Any informed decision-making discussion, treatment, and/or advice provided
8. Plan for follow up

Storage of Health Records

1. Maintain all records in a confidential, secure manner always in accordance with the *HIA.*

2. Secure electronic records with a password, in a manner that is secure, permanent, and unalterable.

3. Always maintain possession of the **health records** in the event that a midwife carries **health records** to home visits. If this is not possible, the records shall be secured in a place where they will not be easily viewed and accessed. (i.e.: in the locked trunk of a vehicle).

4. Store permanent **health records** in secure storage for a minimum of 10 years from the date of the last entry, or if the **client** was less than eighteen years old at the time of the last entry. Ten years from the date the **client** became or would have become eighteen. Fetal monitor strips will be retained for 30 years. All records involved in a **CMA complaints process** will be retained for 30 years.

5. All electronic records will be securely stored. Electronic records will be backed up and stored in a secure place separate from where the original record is stored. If a midwife leaves a group practice, the original **health record** remains with the group practice. A copy of the record may be provided to the midwife. Practice owners are **custodians** of all records from their practice.

6. If a midwife leaves a group practice, the original **health record** remains with the group practice. A copy of the record may be provided to the midwife. Practice owners are **custodians** of all records from their practice.

7. If the midwife is in independent practice and moves or ceases to practice midwifery, a copy of the **health records** is to be retained. The original record may be transferred into the care of another registered midwife, given to the **client,** or placed with a secure storage service**. Ensure the client is aware of the location of their record.**

8. When a midwifery practice closes or an independent midwife ceases to practice midwifery or moves, they will inform the **CMA** of the location and deposition of their **health records.**

9. Cross-cut shred paper records containing any **client** information being destroyed once retention schedule has been met. Electronic records will be destroyed in accordance with the *HIA.*

10. Maintain appointment records for each clinical encounter with the name of the **client** receiving service and the name of the midwife for at least 2 years.

Standard of Practice 3: Continuing Competence

THIS SPACE IS RESERVED FOR NEW STANDARDS PENDING UPDATES AND COMPLANCE WITH BILL 46.

Standard of Practice 4: Use of Protected Professional Titles

Midwives may only use the title or titles, designated for the category of their registration as follows, according to the ***Midwives Profession Regulation.***

1. Regulated members on the General Register, Provisional Register and Courtesy Registers may use the following titles and initials:

    a. Midwife

    b. Registered Midwife

    c. R.M.

Standard of Practice 5: **Supervision**

5A: **Supervision** of Internationally Educated Midwives

To be approved to act in a **supervisory** role a midwife must:

1. Meet the qualification criteria for **supervisors** as determined by the Council of the **CMA** and be approved by the Registrar of the **CMA** in order to supervise midwives requiring **supervision** or precept midwifery students in clinical placements.

2. Be authorized by the **CMA** to perform **restricted activities, additional competencies** and **advanced authorizations** if expected to supervise these activities.

3. Not delegate professional responsibility, including but not limited to, a **restricted activity** to a person who does not have the competence to fulfill the professional responsibility.

When acting as a **supervisor** for a midwife who requires **supervision** a midwife must:

1. Operationalize a learning plan using the deficiencies and requirements identified by the **CMA** and review the plan with the supervised midwife and all involved **supervisors** prior to the beginning of the **supervision** period.

2. Provide ongoing and appropriate assessment, **supervision**, evaluation and mentoring to midwives requiring **supervision**.

3. Take reasonable steps, such as **direct supervision**, individual case review and remediation of

identified problems to ensure that the supervised midwife is practicing safely.

4. Identify and report to the **CMA** any further gaps in knowledge and skill not previously recognized. Add these additional gaps to the supervised midwife's conditions and reflect the appropriate learning required using the **Supervisor's** Report.

5. Report to the Registrar of the **CMA**, if at any time during the **supervision** period the supervised midwife displays **unprofessional conduct** or if the supervised midwife is not practicing in accordance with the **supervision** plan.

6. Submit all required reports to the **CMA** Registrar in a timely manner.

The supervised midwife must:

1. Submit the completed and signed ***Supervision Agreement and Conflict Declaration form*** to the **CMA**.

2. Review the identified learning objectives from **CMA** with the **supervisor**(s).

3. Attend regular meetings with the primary **supervisor** to discuss reports, update objectives and review progress.

4. Submit to the **CMA** Registrar, accurate and timely reports in accordance with requirements set out in the learning plan.

5. Contact the **supervisor** if practicing under **indirect supervision** when:

    a. A midwifery **client** is in active labour

    b. A midwifery **client** is in urgent need of **consultation** or **transfer of care**

    c. There is any deviation from the expected condition.

6. Explain to **clients** the nature, terms, and duration of their **supervision** and the implications to the **client's** care.

7. Submit all required reports to the **CMA** Registrar in a timely manner.

5B. Precepting of Clinical Placements for Midwifery Students

When acting as a **preceptor** for a midwifery student a midwife must:

1. Meet the qualification criteria for **preceptors** as determined by the Council of the **CMA** and be approved by the Registrar of the **CMA.**
2. Be approved by the **student's** education program as evidenced by a practicum agreement.
3. Be oriented and trained by the **Midwifery Education Program (MEP)** to supervise and evaluate **students**, according to a plan and criteria set by the appropriate **Midwifery Education Program** and the **CMA**.
4. Be authorized to perform any required **restricted activity** in order supervise that **restricted activity**.
5. Remain accountable for the care their students provide.
6. Offer the student full scope midwifery care opportunities unless otherwise deemed appropriate by the **MEP** and **CMA**.
7. Assist the **student** in obtaining their own login username for Electronic **health records** within their midwifery practice.
8. Verify the accuracy of information and co-sign all entries made by the **student** into the **client's health record.**
9. Submit a ***Conflict of Interest Declaration*** to their **Midwifery Education Program.**

To participate in a precepted learning situation the midwifery student must:

1. Be registered as a student with the **CMA**.
2. Not receive payment for any activity that is required for course credit.
3. Be enrolled in a midwifery undergraduate/graduate program or a midwifery bridging program approved by the **CMA**.
4. Adhere to the criteria and requirements of the **CMA**.
5. Obtain **client** consent to be involved with them.

Standard of Practice 6: Mentoring of New Registrants

When acting as a **mentor** for a graduate during the first year of general registration a midwife must:

1. Meet the qualification criteria for **mentors** as determined by the Council of the **CMA** and be approved by the Registrar of the **CMA** in order to **mentor** new graduate midwives.
2. Be authorized by the **CMA** to perform **restricted activities, additional competencies** and **advanced authorizations** if expected to facilitate these activities.
3. Complete and submit to the **CMA** the ***Conflict of Interest Declaration*****.**
4. Work on a 1:1 basis with the New Registrant for at least one year (12 months).
5. Complete and sign the **Mentor** Midwife portion of the New Registrant Program Application Form and send it electronically to the **CMA**.
6. Be available to the New Registrant in person or by phone 24/7 for support and advice. In the event that the **CMA** approved **Mentor** Midwife is unavailable (vacation or days off), the New Registrant and **Mentor** Midwife will **designate and communicate to CMA** the name of an Alternate **Mentor** Midwife to be available to the New Registrant during that time.
7. In the first month that the New Registrant starts work, support the orientation and mentorship of the New Registrant to the Midwifery Practice, hospital, and community environments.
8. Participate in monthly Chart Reviews with the new graduate.
9. Complete required forms at the conclusion of the New Registrant Program.

To demonstrate compliance to this standard the New Graduate midwife must:

1. Work within an established midwifery practice
2. Have a **mentor** who has been approved to serve by the Registrar or Registration Committee
3. Participate in monthly chart reviews with a regulated member who is registered on the general register, and who has been registered on the general register for at least one year
4. Meet any practice requirements set by the **CMA** Council.

5. Start work and/or volunteering at a Midwifery Practice only when the following conditions are met:

    a. Written confirmation from the **CMA** of a complete initial registration

    b. A Practice Permit has been issued, and a confirmation that the RM protected title or designation has been conferred to the New Registrant

    c. Possess liability insurance acceptable to the **CMA**

    d. Upon completion of all of the New Registrant Program requirements and completion of one year (12 months) in the New Registrant Program provide the **CMA** with the required forms.

Standard of Practice 7: Prescription and Administration of Drugs

The Midwives Profession Regulation, Alta Reg 237/2018 , section 16 and 17 authorizes General and Courtesy register midwives to prescribe Schedule I **drugs** incidental to the practice of midwifery. Midwifery Students, New Registrants and supervised international educated midwives will prescribe schedule one **drugs** with the approval of their **preceptors**, **mentors,** and **supervisors.**

In order to utilize **drugs** safely, the midwife must:

1. Successfully complete:

    a. A minimum 40 hour/3 credit course in pharmacology as part of their education program, or

    b. Successfully complete a continuing education course acceptable to the Council of the **CMA**.

2. Have the necessary knowledge and skills and use their best judgement to prescribe or administer **drugs** in a safe, appropriate, and ethical manner.

3. Only prescribe or administer a **drug** authorized by legislation, including, *HPA*, ***Controlled Drug and Substances Act*** , *Food and Drug Act* and ***The Midwives Profession Regulation, Alta Reg 237/2018*** and justified within the midwifery **scope of practice.**

4. Not prescribe uterotonic **drugs** for the purpose of induction or augmentation of labour, oral contraceptives, contraceptive devices, or **controlled substances** until granted **advanced authorization** by the Registrar or Competence Committee.

5. Limit prescribing of **drugs** to conditions that the midwife can diagnose in a **client** with whom a **therapeutic relationship** has been established and for which they can provide the necessary counselling, informed choice decision making and ongoing management of care.

6. Not self-prescribe.

7. Not prescribe for their own **family** member(s) or close friend(s), except to intervene in an emergency situation when there is no other authorized prescriber readily available.

8. Maintain current knowledge of the **drugs** authorized by legislation for use within the midwifery **scope of practice.**

9. Maintain complete and accurate records of all **drugs** prescribed or administered according to ***Standard of Practice 2: Client Records and Record Keeping.***

10. Ensure that a prescription is legible and includes the following elements of a complete prescription:

    a. Name and address of the **client**

    b. Date of issue

    c. Name of **drug** or ingredient(s) and strength, if applicable

    d. Dosage form, if applicable, quantity of the **drug** to be dispensed

    e. Route of administration, if applicable

    f. Directions for use

    g. Number of refills authorized and interval between each refill, if applicable

    h. Prescriber's name, permit number and phone number, and prescriber's signature.

11. Fax prescriptions will include all of the above elements. When faxed, measures must be in place to ensure security of transmission.

12. Write prescriptions for **controlled substances**, on a Tracked Prescription Program pad where appropriate, and in a manner that is difficult to alter.

13. Follow hospital protocols, record keeping and security procedures for all prescribing, administering, or disposing of **controlled substances** within the institution. Participate in drug error management programs in licensed midwife practice operations and provincial **drug**

error management programs as appropriate.

14. Participate in Canadian Adverse **Drug** Reaction Reporting Program.

15. Integrate infection prevention and control routine practices into all **client** encounters.

Standard of Practice 8: Prescribing, Acquisition, Transport and Administration of Vaccines:

To demonstrate compliance with this **standard** the midwife must:

1. Follow the ***Alberta Immunization Regulation Alta Reg 182/2018*** (a regulation under *the Public Health Act)* and the ***Alberta Immunization Policy*** *(*Alberta Health*).*

2. Follow prescribing requirements set out in ***Standard of Practice 7: Prescription and Administration of Drugs.***

3. Restrict the prescribing and ordering of **vaccines** *to* Hepatitis B **vaccine**s, measles, mumps and rubella **vaccine**s, Influenza **vaccine**s (inactivated), Tetanus-diphtheria acellular pertussis **vaccine** (Tdap) and COVID-19 **vaccine**s.

4. Have the necessary knowledge and skills to safely order and administer **vaccines**.

5. Have knowledge of and follow ***Alberta Vaccine Storage and Handling Policy for Provincially Funded Vaccine*** (Alberta Health) requirements for the storage, handling and transporting of **vaccines.**

6. Document each immunization encounter in accordance with jurisdictional health information processes.

7. Report all immunization encounters electronically to Alberta Health's Chief Medical Officer (CMO) as per the Alberta Health (2020) ***Immunization Data Submission and Response Guidelines*** within 7 (seven) days of the encounter.

8. Report adverse events following immunization (*AEFI)* using the **AEFI Immunization process** to Alberta Health Services within 3 (three) days of being informed that an adverse event following immunization has occurred, even if the midwife did not provide the immunization.

Manage any cold chain break according to the process set out in ***Alberta Vaccine Storage and Handling Policy for Provincially Funded Vaccine*** (Alberta Health).

Standard of Practice 9: Ordering, Performing and Interpreting Diagnostic Tests

Placeholder for Standard of Practice 9

Standard of Practice 24: Infection Prevention and Control

24A: Routine Practices

Registered Midwives are expected to ensure and promote effective **Infection Prevention and Control** (**IPAC**). Interventions and activities are implemented to minimize and eliminate the potential spread of infection in midwifery practice settings. New and evolving infectious diseases, new research leading to best practices, and advancing technology are constantly changing the practice of **IPAC**.

Standard 24A sets out the specific CMA requirements all midwifery registrants must adhere to in order to prevent the potential spread of infection between themselves, clients and staff in all practice settings.

1. A midwife must apply appropriate **IPAC** practices when providing care in accordance with applicable CMA *standards*, best practices, and facility requirements and the Public Health Agency of Canada document: *https://www.canada.ca/en/public-health/services/infectious-diseases/nosocomial-occupational-infections/routine-practices-additional-precautions-preventing-transmission-infection-healthcare-settings.html* when providing care to all clients at all times (to prevent cross-contamination), which includes but are not limited to:

    a. Perform **Point of Care Risk Assessment** (**PCRA**) for each client encounter
    b. Perform **hand hygiene** correctly:
        i. before contact with a client
        ii. before performing an aseptic technique
        iii. after contact with a client
        iv. after contact with objects in the immediate vicinity of the client
        v. after removing gloves
        vi. after contact with blood, body fluids or a moving from a contaminated body site to a clean body site during client care

    c. Use **personal protective equipment** (**PPE**)

    d. Practice and engage in proper respiratory hygiene

    e. Environmental **cleaning** of client care spaces

    f. Use aseptic technique when performing invasive procedures or handling injectable products

    g. Assess and implement additional precautions as necessary

    h. Follow guidelines for management and **decontamination** of blood borne fluid exposures and needle stick injuries

Single-Use and **Reusable Medical Device**s Standards

The College of Midwives of Alberta (CMA) sets out *Standards* for the use of single-use **medical devices** and the **reprocessing** of **reusable medical devices**, for all midwifery care areas, including community birth settings.
These *standards* apply to all midwives when using **single use** and **reusable medical devices**.

These requirements are in addition to the Alberta Health 2019 Reusable and Single Use Medical Devices (RSUMD) Standards adhered to by all AHS contracted settings. This includes all midwifery practices in Alberta.

The Spaulding Classification System

Spaulding, E.H. 1971. The role of chemical **disinfection** in the prevention of nosocomial infections in Proceedings of the International Conference on Nosocomial Infections, 1970. Eds. Brachman, P.S. and Eickoff, T.C. Chicago: American Hospital Association: 254–274.

The Spaulding classification system is used to inform the designation of level of risk of infection from a used instrument and the appropriate level of **reprocessing** required. It divides **medical devices** into three categories based on the potential risk of infection: **critical medical devices**, **semi-critical medical devices**, and **non-critical medical devices**. The Spaulding classification system establishes the minimum level of **reprocessing** needed to ensure **medical devices** are safe for use between clients.

STERILIZATION		**INTERMEDIATE OR LOW LEVEL DISINFECTION**
*Devices below must be cleaned, and then **sterilized***		
Critical medical devices	**Semi-critical medical devices**	**Non-critical medical devices and equipment**
i.e, devices that entire sterile tissues, including the vascular system. Examples of **critical medical devices** include but are not limited to: • surgical **medical devices** • biopsy forceps and brushes	i.e., devices that make contact with intact mucous membrane or non-intact skin. Examples of **semi-critical medical devices** include but are not limited to: • respiratory equipment • vaginal specula • ultrasound transducer probes that come into contact with	i.e., devices and equipment that make contact with intact skin or do not make direct contact. Examples of **non-critical medical devices** include but are not limited to: • stethoscopes • blood pressure cuffs

STERILIZATION		INTERMEDIATE OR LOW LEVEL DISINFECTION
*Devices below must be cleaned, and then **sterilized***		
	mucous membrane (e.g., vaginal probes, transesophageal echocardiogram probes) • pessary and diaphragm fitting rings	

24B: Single Use Medical Devices

1. **Single-use medical devices** shall only be used on a single client for a single procedure and then must be discarded.

2. A **single-use medical device** shall not be used beyond the expiry date specified by the manufacturer.

3. A sterile **single-use medical device** shall be maintained as sterile until point of use.

4. Opened but unused **medical devices** must be discarded.

5. Prior to using a **single-use medical device** that was purchased in an unsterile state, that single-use **medical device** shall be inspected and processed according to the validated **Manufacturer's Instructions for use** (**MIFU**).

6. A **single use medical device** shall be disposed of according to **MIFU** recommendations.

24C: Reusable Medical Devices

Reprocessing of **Reusable Medical Devices**

Environment and Structural Requirements for a **Medical Device Reprocessing** (**MDR**) Area

1. The **MDR** area shall be a designated area, separate from client care areas, and activity in the

area shall be restricted when **reprocessing reusable medical devices**.

2. All **MDR** areas shall:
   a. At minimum have spatial separation of clean and dirty areas and a one-way workflow pattern established to prevent cross-contamination. Ideally clean and dirty areas will be physically separated

   b. At minimum have a dedicated sink for **cleaning** equipment and a dedicated basin. A dedicated basin must be large enough to fully submerge the equipment being rinsed

   c. Have **hand hygiene** stations (either **hand hygiene** sinks or alcohol-based hand rub (ABHR) dispensers that have a Health Canada **Drug Information Number** (**DIN**) or a Natural Product Number (NPN) and contain 60% to 90% alcohol) at all entrances to, and exits from the **MDR** area and readily available within the **MDR** area:

      i. Designated **hand hygiene** sinks shall have properly functioning soap dispenser and paper towel dispensers
      ii. Designated **hand hygiene** sinks shall be used for **hand hygiene** only.

   e. Have work surfaces that can be cleaned:

      i. All work surfaces and surrounding areas shall be intact, cut resistant and seamless and be composed on non-porous, non-shedding material capable of withstanding frequent **cleaning**.

   f. Restrict access to the **MDR** area during **reprocessing** activities and until the area has been appropriately cleaned

   g. Use **one way work flow**

   h. Have adequate lighting for the tasks being performed in all work areas; and

   i. Use a water source which meets the equipment manufacturers' specifications for water and steam quality

Storage

   j. Areas where clean, **disinfected** and sterile **medical devices** are stored shall:

      i. Be dedicated to the storage of clean, **disinfected**, or sterile items

      ii. Be designed to have adequate space to prevent crushing or damage to **packaging**

iii. Have sufficient lighting to allow easy reading of labels and to determine the condition of **packaging**; and

iv. Be cleaned following an established schedule.

Procurement of **Reusable Medical Devices** and **Reprocessing** Equipment and Supplies

1. The decision to trial or purchase **reusable medical devices**, **reprocessing** equipment and supplies or reusable surgical textiles may include consultation with appropriate MDR and IPAC personnel.

2. Prior to trialing or purchasing a medical device including **medical device reprocessing** equipment, the midwife shall confirm that the device has a valid **medical device licence** (**MDL**) issued under the Government of Canada's *Medical Devices Regulations*.

   Note: The **Medical Devices** Active Licencing Listing (MDALL) contains product-specific information on all **medical devices** that are currently licenced for sale in Canada, or have been licenced in the past. This system has been designed to help health care workers who are contemplating the purchase of a Class II, III, or IV **medical device** to verify that the manufacture has an active **medical device licence**. Since **medical device licence's** can be suspended by Health Canada, cancelled during the annual renewal of licence's by Health Canada, or discontinued by the manufacturer, it is important to conduct this verification each time the purchase of a **medical device** is considered. MDALL can be accessed on Health Canada's website at *https://health-products.canada.ca/mdall-limh/*

   a. The midwife shall not trial or purchase a **reusable medical device** if the device does not have a valid **medical device** licence.

3. **Non-critical medical devices** intended for use between clients shall be purchased with validated **MIFU** for **reprocessing** when available, and when not available, a standard operating procedure for **disinfection** shall be developed in consultation with **IPAC** and **MDR** consultants as needed.

4. Prior to trialing or purchasing a reusable **critical** or **semi-critical medical device**, the midwife shall confirm that there is written confirmation that the **MIFU** for **reprocessing** have been validated according to Health Canada's requirements.
   a. The midwife will not purchase or trial a reusable critical or semi-critical medical device if there I no written confirmation that the MIFU for reprocessing has been validated.

   Note: Additional information about **MIFU** and the requirements Health Canada expects manufacturers to meet with respect to **validation** of **MIFU** can be found in Health Canada's "Guidance Document: Information to Be Provided by Manufacturers for the **Reprocessing** and **Sterilization** of **Reusable Medical Devices**." The document is available on the Health Canada

website at *https://www.canada.ca/en/health-canada/services/drugs-health-products/medical-devices/application-information/guidance-documents/guidance-document-information-manufacturers-sterilization-reusable-medical-devices.html*

5. Prior to trialing or purchasing a reusable **critical** or **semi-critical medical device**, personnel accountable for **MDR** shall review the written, validated **MIFU** to determine:

    a. That the recommended **reprocessing** procedures are specific to the **medical device** and the instructions are clear, complete, adequate, and in accordance with the level of **reprocessing** required for the **medical device**'s intended use

    b. That there are instructions for disassembly, **cleaning**, type of **sterilization** or level of **disinfection** required, cycle parameters and maintenance

    c. If there is a limit to the number of times the **medical device** can be **reprocessed** or if **reprocessing** will contribute to degradation of the **medical device**; and

    d. That the recommended **reprocessing** procedures can be achieved, given the midwifery practice's **reprocessing** resources.

6. In the event that the **MIFU** does not contain the information required the midwife shall contact the manufacturer for clarification or additional information.

    Note: Health care settings that are not able to obtain the relevant information should report this to Health Canada at:
    a. 1-800-267-9675;
    b. mdpr@hc-sc.gc.ca; or
    c. https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/dhp-mps/alt_formats/pdf/pubs/medeff/guide/2011-devices-materiaux/2011-devices-materiaux-eng.pdf

7. Before purchasing **reprocessing** equipment the midwife shall:

    a. Obtain technical and safety data, specifications and other information specific to the equipment for required utilities and connection (e.g. electrical, steam, water, plumbing, air supply and ventilation; and

    b. Ensure the minimum service space requirements set out by the manufacturer can be met.

General **Reprocessing** Requirements

1. **Reusable medical devices** that have been used shall be reprocessed.

a. Contaminated **reusable medical devices** that have not undergone **reprocessing** shall be clearly identified.

2. **Reusable medical devices** that come from an opened or compromised package shall be reprocessed prior to use.

3. Newly purchased reusable **critical** and **semi-critical medical devices** shall be reprocessed before initial use unless they are packaged and sterilized by the manufacturer.

4. **Cleaning** accessories shall be inspected before use to ensure they are not damaged. Damaged **cleaning** accessories shall not be used.

5. Reusable **cleaning** accessories shall be reprocessed after use in accordance with the **MIFU**, inspected for damage, and stored in a clean, dry place.

6. Single-use **cleaning** accessories shall be discarded following use.

Pre-**cleaning** and Transportation of Contaminated **Reusable Medical Devices**

1. Personnel shall pre-clean used **reusable medical devices** immediately after use and prior to transportation to the **reprocessing** area.

   a. At the point of use, single-use sharps shall be removed from **reusable medical devices** and disposed of in a puncture-resistant sharps container

   b. Organic matter shall not be allowed to dry on **reusable medical devices**. **Reusable medical devices** shall be cleaned with an enzymatic cleaner, thoroughly rinsed and dried before transport.

2. Contaminated items shall be transported in fully-enclosed, leak-proof containers that protect **reusable medical devices** from damage, and allow for effective **decontamination** or appropriate disposal after use.

   a. Sterile or clean **reusable medical devices** and soiled **reusable medical devices** shall be kept separated and transported in a manner that prevents cross-contamination

   b. All containers containing contaminated **medical devices** shall be so identified.

3. Contaminated **reusable medical devices** shall be transported to the **MDR** area in such a way so as not to contaminate the surrounding environment.

   a. Contaminated **reusable medical devices** shall follow transportation routes that minimize exposure to high-traffic and client-care areas and avoid areas designated for the storage of

clean or sterile **medical devices** and supplies.

Preparation and **Cleaning** of **Reusable Medical Devices**

1. **Cleaning**

    a. Each **medical device** shall be thoroughly cleaned prior to **disinfection** or **sterilization**

    b. **Cleaning** methods shall be consistent with the **medical device**'s **MIFU** and appropriate for the type of **medical device** and the amount of soil to be removed

    c. When manual **cleaning**, the **medical device**'s **MIFU** for **reprocessing** shall be followed, including any specifications for detergent type, water type, or water temperature and **cleaning** methods

    d. Immersible **medical devices** shall be completely submerged during **cleaning** to prevent the generation of aerosols.

2. **Rinsing and Drying**

    a. Chemical residues and loosened soil shall be completely rinsed from the **medical device** prior to **disinfection** or **sterilization**

    b. **Reusable medical devices** shall be dried prior to **disinfection** or **sterilization** with a clean, lint-free, or low-lint soft-absorbent towel

    c. **Medical devices** shall be visually inspected for cleanliness, damage, integrity, and functionality prior to **disinfection**, **sterilization**, or subsequent use

        i. Cleaned **medical devices** that are visibly soiled shall be cleaned again

        ii. **Medical devices** that are damaged or in poor working condition shall be removed from service, labelled, and segregated from usable **medical devices**. Such **medical devices** shall either be repaired or disposed of in accordance with the practice policies.

Disinfection of **Reusable Medical Devices**

1. **Disinfection** of **reusable medical devices** shall follow the **MIFU** for the **disinfection** process,

equipment, and products.

2. Only chemical **disinfectants** that have a Health Canada **DIN** or a **MDL** issued by Health Canada, shall be used in health care settings for the **disinfection** of **reusable medical devices**.

3. A liquid chemical **disinfectant** shall not be used beyond its:

    a. Expiry date; and

    b. In-use life.

4. Reusable liquid chemical **disinfectant** solutions shall be:

    a. Clearly identified and include the expiry date

    b. Stored in containers that are cleaned, **disinfected**, and dried prior to changing the solution; and

    c. Kept covered with a tight-fitting lid, except when introducing or removing a **medical device** to or from the solution.

Non-Critical Medical Devices

Note: In most cases, **non-critical reusable medical devices** can be **disinfected** at the point of use.

1. **Non-critical reusable medical devices** shall be disinfected between client use using an **intermediate-level disinfectant** (**ILD**) or **low-level disinfectant** (**LLD**)

    a. **ILD** or **LLD** wipes shall be moist enough to thoroughly wet the surface for the indicated contact time and a new wipe shall be used if the area to be **disinfected** cannot be completely wetted with a single wipe.

Semi-Critical Medical Devices

1. If a **reusable semi-critical medical device** cannot be **sterilized**, then it shall not be reused and must be disposed of as a single use medical device

Sterilization of **Reusable Medical Devices**

1. A **reusable critical medical device** shall be **sterilized** between client use.

2. **Sterilization** of **reusable medical devices** shall take place in accordance with:

    a. The **MIFU** of the device; and

    b. The **MIFU** for the **sterilization** process, equipment, and products.

Qualification and Requalification

1. **Installation qualification** of **sterilization** equipment (including large chamber and table top steam sterilizers) shall be performed and documented according to the manufacturer's specifications.

2. **Operational qualification** of **sterilization** equipment (including large chamber and table top steam sterilizers) shall be performed at installation.

3. **Operational requalification** shall take place at least annually and following a major sterilizer repair, sterilizer relocation, an unexplained sterility failure, and, for steam sterilizers, following any disruption to steam supply or change to steam pressures.

4. **Operational qualification** and requalification testing shall include a verification of each cycle used by the health care setting, according to the **MIFU** for testing.

5. **Operational qualification** and requalification testing shall be conducted by:

    a. Running three consecutive cycles using a process challenge device (PCD) with biological indicators. For table-top steam sterilizers, testing will take place in a fully loaded chamber.
    b. Additionally, in dynamic air removal sterilizers that use pre-vacuum cycles, ensuring that the sterilizer:
        i. meets the requirements of an air removal test and leak-rate test; and
        ii. is tested with three consecutive air removal tests (e.g., Bowie-Dick) in an otherwise empty sterilizer

6. **Performance qualification** shall be performed to ensure setting-specific packages and loads can be sterilized with the equipment and processes used in the health care setting.

    a. **Performance qualification** shall use products (e.g., instrument sets) and sterilizer loads used by the health care setting. The products and loads shall:

        i. Be assembled according to the sterilizer **MIFU**; and

        ii. Adhere to any limitations of validated **medical devices**, materials, weights.

    b. **Performance qualification** shall be performed when there are new materials, processes, or

conditions that could affect **sterilization**.

Packages and Labels

1. **Packaging** of **reusable medical devices** for **sterilization** shall take place in accordance with the **MIFU** of the device, the **sterilization** equipment, and the **sterilization packaging** manufacturer, using a validated sterile barrier system (e.g., pouches or wrappers).

2. Packages shall be labelled with sterilizer load identification information, including the load number and the **sterilization** date.

    a. For pouches, a label shall be placed on the transparent portion of the **packaging**

    b. For wrapped packages, writing shall be on the closure tape, not directly on the wrappers

    c. Labelling shall be done with a water resistant, heat resistant, soft-tipped, non-toxic marker which does not bleed through the tape onto the wrapper.

Loading and Unloading

1. Packages shall be placed in the sterilizer chamber in a manner that facilitates air removal, sterilizing agent penetration, sterilant evacuation, and, in the case of steam **sterilization**, drying.

    a. Wrapped items shall not contact the interior walls of the sterilizer chamber, as contact can damage the wrapper

    b. Pouches and wrapped packages shall not be stacked or compressed

    c. Between packages there shall be adequate space to ensure effective sterilizing agent penetration, evacuation, and drying.

2. Sterile packages shall be cooled to room temperature and dry before handling.

3. Before removal from the **MDR** area, packages shall be inspected for:

    a. Package integrity

    b. Dryness

    c. Presence of a label

    d. The correct change in an external **chemical indicator**

e. An intact seal, if used; and

f. Evidence of potential contamination.

4. If a package does not meet the inspection criteria, the contents shall not be used.

Sterility Assurance

1. **Sterilization** indicators shall be used only for the sterilizer type and **sterilization** cycle for which they were designed and validated and shall be used according to the sterilizer and indicator **MIFUs.**

   a. **Sterilization** indicators shall not be used beyond their expiry date and shall be stored according to the **MIFU.**

   1. Routine monitoring shall include assessment of:
      a. physical parameters of each sterilizer cycle (e.g., sterilization time, temperature, pressure,) which shall be verified before the load is released by: checking the sterilizer's displays, and manually recording in a log specifically for that purpose, at intervals during each cycle; or examination of the sterilizer printout or electronic record on completion of each cycle

      b. chemical indicator ;
      Note: If the sterilizer is not equipped with a printer, then a Type 5 chemical indicator must be in each package.
      c. the results of a biological indicator, if present.

2. Documentation of sterility assurance shall include a log as set out in 2a or a printout or electronic cycle parameter record if available, a load contents record, and associated chemical or biological indicator test results for each cycle, if present.

3. In the event of a failed indicator test or any other issue noted upon inspection, the service shall have processes in place to recall and reprocess the affected medical devices.

Chemical Indicators

1. Both internal and external **chemical indicators** shall be included with each package prepared for **sterilization**.

   a. The internal **chemical indicator** shall be placed in the area of the package that is least susceptible to **sterilizing** agent penetration

b. Notwithstanding a, if an internal **chemical indicator** is clearly visible from the outside of a package (e.g., through a plastic wrapper), an external **chemical indicator** is not required.
c. Use a Type 5 chemical indicator in each package.

Air Removal Test (i.e., Bowie-Dick/Dart)

1. For dynamic air removal-type sterilizers (pre-vacuum cycles), an air removal test shall be performed every day the sterilizer is used.

Biological Indicators

1. A **biological indicator** contained within a **process challenge device** (**PCD**) shall be used to test the sterilizer for each type of cycle used and at the shortest exposure time, within a full load. This test shall be done at least daily when the sterilizer is in use.

   Note: A **PCD** should present a challenge to the process that is equal to or greater than the challenge posed by the most difficult item that is routinely sterilized. A biological test pack is an example of a **PCD**. A **PCD** can be commercially manufactured or prepared in-house.

2. If a steam sterilizer will be used for multiple types of cycles, each type of cycle used shall be tested daily when being used.

3. At the conclusion of a **sterilization** cycle and before the load is removed, the operator shall confirm that the required parameters and all phases of the **sterilization** cycle including aeration (if required) have been met.

Storage

1. Reprocessed critical and **semi-critical medical devices** shall be protected from contamination by:

   a. Rotating stock via first-in, first-out

   b. Keeping items clean, dry, and protected
   c. Keeping items well-separated from soiled items and soiled areas via barriers and/or distance.
   d. Transport items in a manner that maintains their cleanliness/sterility

e. Ensuring they are not stored on the floor or a window sill, under sinks or near water sources, in open corridors or client rooms, or in the same area as hazardous materials.

Education and Training

1. The practice lead or person responsible for **MDR** in the midwifery practice shall ensure all personnel involved in the **reprocessing** of **critical** and **semi-critical medical devices** are appropriately educated and trained for the **reprocessing** duties/tasks that they perform.

    a. Persons who reprocess critical and **semi-critical medical devices** may be **medical device reprocessing** technicians from CMA approved programs or persons who have received training in **medical device reprocessing** at a level approved by the College of Midwives of Alberta (CMA)

    b. Personnel who reprocess critical and **semi-critical medical devices**, but are not **medical device reprocessing** technicians from approved courses, shall receive training in a formal **medical device reprocessing** training program recognized by the CMA, or comprehensive in-house training, and shall successfully complete competency testing.

        i. Comprehensive in-house training shall, at a minimum, set out principles that align with these *Standards*

        ii. Personnel who have not been fully trained and/or competency tested shall not reprocess critical and s**emi- critical medical devices** unless under the **direct supervision** of fully trained and/or competency tested personnel.

    c. The practice lead or person responsible for **MDR** within the midwifery practice shall maintain records of education, training, orientation, and competency assessment for new and existing personnel, as appropriate for the **MDR** duties/tasks performed according to requirements set out by the CMA.

Quality Management Systems

1. The midwifery practice shall have clear accountability and lines of responsibility for:

    a. All routine practices

    b. All aspects of **MDR, including how third 3rd party contractors process their devices**; and

    c. The appropriate use of **single-use medical devices**.

2. The midwifery practice shall have written policies and these Standards of Practice on-site and available to personnel for all aspects of **MDR**.

    a. The midwifery practice's **medical device reprocessing** policies shall include but not be limited to:

        i. All steps in the **reprocessing** of reusable **medical devices**, based on **MIFU**

        ii. The installation, operational, and **performance qualification** and requalification requirements of **reprocessing** equipment and products, based on **MIFU**

        iii. Regular inspection and preventative maintenance requirements for **reusable medical devices** and equipment, based on **MIFU**

        iv. Actions to be taken following a failed sterility indicator or unexplained parameter change, based on **MIFU**

        v. Recall procedures.

3. The midwifery practice shall have a written policy regarding **single-use medical devices** that is consistent with these *standards* available to all users.

4. The midwifery practice shall have policies in place that include but are not limited to:

    a. Required occupational health and safety activities with use of appropriate **PPE** when performing **MDR,** and when using single use medical devices

    b. **IPAC** routine practices

    c. Transportation and distribution of single use and reusable devices and products

    d. Regular monitoring and review of **MDR** logs and processes by a designated person other than the person performing the **MDR**

    e. Storage of items, including environmental conditions and requirements related to identification and labeling, to maintain sterility of packages and sterile medical devices over time and until point of use, based on MIFU

    f. The practices and procedures required to maintain sterility.

5. The midwifery practice shall conduct a regularly scheduled review of all written policies and revise when necessary.

6. The midwifery practice shall have a process for assessing risk when a breach or lack of compliance

with these *standards* occurs and shall report as appropriate.

Documentation

1. The midwifery practice shall retain records of **reprocessing** for a period of 5 years. These records shall include, but not be limited to, the following:

    a. Preventative maintenance of **medical devices reprocessing** equipment

    b. Results of installation, operational, **performance qualification** and requalification, and routine testing of **reprocessing** equipment and products.

2. The **MIFU** for **medical devices**, equipment, and supplies shall be received and maintained in printed form (e.g., in binders, manuals, or monographs) or in electronic format and be readily accessible to those needing access and shall be updated as required.

Principle 2: Person Centered Care

Standard of Practice 10: Person-Centered Care

To demonstrate **person-centered care**, a midwife must:

1. Create an environment of **cultural safety,** free from racism and discrimination, respecting the **client's** preferences and privacy needs.
2. Ensure the intake process for their midwifery service is fair, equitable, and transparent**.**
3. Utilize **effective communication skills** appropriate to the **client** and their **family**.
4. Respect **clients** as the primary decision-makers in their own care.
5. Follow the ***Standard of Practice 11: Informed Decision Making*** in all aspects of midwifery care.
6. Provide **clients** with a choice of birth place, including hospital and community, according to the ***Standard of Practice 11: Informed Decision Making.***
7. Respect the **client's** right to care during labour, birth and the **early postpartum** period in the setting chosen by the **client,** when safe and within the scope of midwifery practice.
8. Respect the **client's** right to choose or maintain their preferred midwifery care provider unless the preferred midwife is unavailable due to capacity or geographic circumstances.

Standard of Practice 11: Informed Decision Making

To support **clients** to make informed decisions in all aspects of care a midwife must:

1. Provide current, objective, critically appraised, **evidence-informed** information about all options so **clients** are fully informed when making decisions about their care.
2. Provide information on the potential natural course and outcome without treatment if conditions arise where treatment is advised.
3. Provide **clients** with the potential benefits, **common** and **material risks** and all alternatives to procedures, tests and **drugs** including not doing them.
4. Make recommendations for informed decision making based on risk benefit analysis.

5. Allow **clients** adequate time to make an informed decision, having regard to the circumstances.
6. Do not use any type of coercion to influence decision-making.
7. Inform and support the **client** in their right to accept or refuse any aspect of care without prejudice.
8. Make efforts to understand and appreciate what is motivating the **client's** decision.
9. Document the discussion and any decisions according to the ***Standard of Practice 2: Client Records and Record Keeping.***

Standard of Practice 12: Client Requests for Care Against Midwifery Recommendations

A Midwife must respect the health care choices of a **client**, including when a **client** requests care against the recommendation of the midwife.

Nothing in this *standard* requires a midwife to perform any procedure or do anything that the midwife is not qualified to do, that is contrary to the ethical practice of midwifery, or that is contrary to the midwife's judgement of safe care.

To comply with this standard a midwife must:

1. Ensure that an informed decision-making discussion with the **client** is facilitated when a **client** initially requests care outside of the midwifery **scope of practice** or the *Standards* or care that in the assessment of the midwife poses a significant risk to the pregnant person or fetus/baby. Document in accordance with the ***Standard of Practice 11: Informed Decision Making*** **and** ***Standard of Practice 2: Client Records and Record Keeping.***
2. Offer a consult to another appropriate obstetrical care provider for a second opinion and document in the **health record**.
3. Seek advice and support from another appropriate obstetrical provider, while maintaining **client confidentiality**, if the **client** declines to participate in a **consultation.** Share any recommendations obtained with the **client** and document in the **health record** according to the ***Standard of Practice 2: Client Records and Record Keeping.***
4. If the **client** refuses consent to the above recommendations, and in circumstances where it is possible for the **client** to obtain care from another more appropriate care provider,

a. Clearly communicate to the **client** that the midwife is no longer the most appropriate **Regulated Health Care Provider** to provide **primary care**

b. Discuss the opportunity for the midwife to continue to provide **supportive care** after the **transfer of care** as appropriate

c. Document the discussion and response in the **client** record according to **the *Standard of Practice 2: Client Records and Record Keeping.***

5. Where the **client** continues to request care from the midwife outside of the midwife's **scope of practice,** the *Standards*, or contrary to the midwife's judgement of safe care, the midwife must choose one of the following options, and must document the discussion and the **client** response in the **health record** according to the ***Standard of Practice 2: Client Records and Record Keeping:***

a. Inform the client that the midwife will be unable to care for the client due to the request for care being outside of the midwife's scope of practice, competency and/or the midwife's judgement of safe care and facilitate a referral to another qualified obstetrical provider according to the Standard of Practice 14: Terminating the Midwife-Client Relationship. The steps outlined in this Standard must *occur prior to the onset of labour, or*

b. Continue to provide antepartum, intrapartum and/or **postpartum** care within the midwifery scope of practice and competencies according to the *Standard of Practice 13: Informed Refusal.*, while not endorsing the client's decision, and not withstanding *Standard of Practice 17:Medical* Transfer of Care, Midwives choosing this option should inform the appropriate persons/consultants regarding the situation. Seek consultation and support from other appropriate maternity care providers.

Standard of Practice 13: Informed Refusal

To demonstrate respect for and acceptance of informed refusal of a recommendation the midwife must:

1. Ensure that the ***Standard of Practice 11: Informed Decision Making*** has been followed and documented.

2. Assure the **client** that the midwife will continue to provide courteous, professional care in the case of declining a recommendation.

3. Follow ***Standard of Practice 12: Request for Care Against Midwifery Recommendation*** if the request involves conditions that carry significant risk to the well- being of the pregnant person or fetus/baby.

4. Inform the **client** that they may change their mind at any time.

5. Document all discussions, actions, **client** responses and outcomes according to ***Standard of Practice 2: Client Records and Record Keeping.***

Standard of Practice 14: Terminating the Midwife-**Client** Relationship

In the situation where all avenues of resolution have been explored and a midwife determines that they can no longer accept the role of care provider to a **client**, the midwife must:

1. Not terminate the relationship if immediate care is needed and another appropriate health care provider is not immediately available.

2. Inform the **client** in writing, as soon as the decision is made, by the most effective formats, that the midwife is terminating care and the rationale for the termination. Communicate the details of the plan for transfer of **primary care.**

3. Follow up with delivery of the document to the **client** by a form of assured delivery such as courier, certified or registered mail.

4. Maintain a copy of the document and proof of delivery in the **client's health record**.

Principle 3: Continuity of Care Provider

Standard of Practice 15: Continuity of Care

A midwife must facilitate continuity of care as follows:

1. Provide access and time for the **client** to develop a **therapeutic relationship** with the midwife (or midwives) who provide care.

2. Make every reasonable effort to ensure the **client** continues to have access to midwifery care throughout pregnancy, birth and **postpartum** or, if midwifery care is no longer available, ensure access to suitable alternate **primary care provider**.

3. Establish and maintain a care arrangement that is clear to the **client** when care is provided by a team of midwives by:

    a. Developing a plan of care coverage that ensures that clients always have access to a midwife or other health care provider and that this plan is communicated to the **client**

    b. Developing a plan of care that is consistently followed by all midwives sharing care

    c. Ensuring that the results from all tests, treatments, **consultations,** and referrals are followed-up and acted upon and documented in a timely manner when on duty

    d. Providing complete and accurate **client** information to the oncoming midwife at the time care is handed over

    e. Make every reasonable effort to ensure that a midwife known to the **client** is available to attend the labour and birth.

4. Make reasonable effort to continue in a **supportive care role** with **clients** when care is transferred to a physician.

5. Attempt to find another midwife within an accessible distance to provide care if midwife and **client** are unable to maintain a **therapeutic relationship.**

6. Provide **client** visit options of available midwives, timing, and venue, based on individual **client** needs.

Standard of Practice 16: Medical Consultation

To demonstrate compliance with the medical **consultation standard** the midwife must:

1. Use their professional knowledge and judgement to identify conditions which may benefit from medical management**.**

2. Use the informed decision-making process as set out in the ***Standard of Practice 11: Informed Decision Making*** with the **client** around the identified condition and the recommendation for a medical **consultation.**

3. Initiate medical **consultation**, with the **client's** consent, providing complete and accurate **client** information.

4. If the **client** declines medical **consultation**, follow ***Standard of Practice 13: Informed Refusal*.**

5. Record all **client** encounters in the **health record**, including discussions, decisions, and actions according to the ***Standard of Practice 2: Client Records and Record Keeping.***

Standard of Practice 17: Medical **Transfer of Care**

To show compliance with the Medical **transfer of care standard** the midwife must:

1. With the client's consent, transfer care to an appropriate physician when it is determined that management of a condition is beyond the knowledge, skills and/or scope of the midwife and an appropriate physician is available to accept that care. In which case the midwife must either:

    a. Transfer **primary responsibility** for care to the physician while remaining involved as a member of the healthcare team and provide **supportive care** to the **client** within the scope of midwifery practice, in **collaboration** with the physician, to the extent agreed to by the **client**, physician and midwife, ***or***

    b. Transfer aspects of care (**Shared Care**) to a physician while the midwife remains one of the **MRP**s.

2. Use the informed decision-making process to explain the recommendations to the **client** in a clear and respectful manner.

3. Document the **client's** response to the recommendations according to the ***Standard of Practice 2: Client Records and Record Keeping.***

4. Transfer **primary responsibility** for care to the physician if the **client** consents.

5. Provide complete and accurate **client** information to the receiving provider at the time care is transferred.

6. Clearly identify the **MRP** to the **client** and all health care providers involved in the **client's** care.

7. Document the **transfer of care** in the **health record** according to *the* ***Standard of Practice 2: Client Records and Record Keeping.***

8. Follow ***Standard of Practice 12: Client Request for Care Against Midwifery Recommendation*** if the **client** refuses transfer of care. Document the refusal in the **client's health record** according

to the ***Standard of Practice 2: Client Records and Record Keeping.***

Conditions Which Require **Transfer of Care**

Midwives must transfer care to an appropriate physician if one is available, if the following condition are identified:

1. Initial History and Physical Examination
    - Any pre-existing maternal medical condition that may adversely affect or be exacerbated by pregnancy that requires specialized medical care such as cardiac disease, renal disease, pre-existing insulin-treated diabetes mellitus
    - HIV positive status
2. Prenatal Care
    - Molar pregnancy
    - Multiple pregnancy greater than twins
    - Severe hypertension, diastolic blood pressure equal to or greater than 110mm/Hg and/or systolic blood pressure that is equal to or greater than 160mm/Hg
    - Gestational hypertension requiring medication, pre-eclampsia, eclampsia or HELLP syndrome
    - Placental abruption
    - Symptomatic placenta previa or documented complete placenta previa at 32 weeks
    - Cardiac or renal disease
    - Preterm Premature Rupture of Membrane (PPROM) less than 34 + 0 weeks
3. During Labour and Birth
    - Preterm labour less than 34+0 weeks
    - Fetal presentation that cannot be delivered vaginally
    - Multiple pregnancy greater than twins

- Prolapsed cord or cord presentation
- Placental abruption, placenta previa or vasa previa suspected or palpated
- Severe gestational hypertension requiring medication or pre-eclampsia, eclampsia or HELLP syndrome
- Suspected embolus
- Uterine rupture
- Uterine inversion
- Active genital herpes at onset of labour or rupture of membranes
- Placenta Accreta

4. **Postpartum** (**Client**)

- **Postpartum** Pre-eclampsia or HELLP Syndrome
- **Postpartum** psychosis
- Suspected or confirmed embolism

5. **Postpartum** (Newborn)

- Major congenital anomaly or other condition requiring immediate intervention
- Gestational age less than 34+0 weeks
- Respiratory distress unresponsive to therapy
- Hyperbilirubinemia unresponsive to phototherapy

Standard of Practice 18: **Shared Care**

To demonstrate compliance with the **shared care standard** the midwife must:

1. Be courteous and respectful in all interactions.
2. Maintain the principle of person-centered care in all actions and interactions.

3. Clearly establish and agree on health care provider roles and responsibilities for all aspects of care and document this in the **health record.**

4. Ensure the responsible provider for each aspect of care is clearly communicated to all persons involved including the **client** and all health care providers involved in the care.

5. Develop a plan of care that includes the goals of care and expectations for communication between health care providers.

6. Provide information to other health care providers in a clear, accurate and timely manner.

Standard of Practice 19: **Supportive Care**

To demonstrate compliance with this **standard** the midwife must:

1. Make every reasonable effort to continue to provide **supportive care** to the degree that is desired by the **client**, appropriate in the individual circumstances and within the scope of midwifery practice.

2. Make every reasonable effort to find another midwife to provide the **supportive care** if the midwife is unable to safely provide the care due to circumstances such as fatigue.

3. Make reasonable effort to develop a clear understanding with the **MRP** about what activities the midwife will or will not do, within the midwifery **scope of practice.**

4. Document the activities that the midwife will do and continue to document care provided according to the ***Standard of Practice 2: Client Records and Record Keeping***

Principle 4: Integrity

Standard of Practice 20: **Client** Protection – Sexual Abuse and Sexual Misconduct by Registered Midwives

Midwives must follow the standard for ***Client Protection – Sexual Abuse and Sexual Misconduct by Registered Midwives,*** approved 2019 as a stand-alone document.

Available on **CMA** web site here.

Standard of Practice 21: **Conflict of Interest**

To demonstrate compliance with this *Standard* a midwife must:

1. Make full, frank, and timely disclosure of any real, potential, or perceived **conflict of interest** to the **client**.
2. Document the details of the disclosure in the **client's health record** according to the ***Standard of Practice 2: Client Records and Record Keeping.***
3. Resolve any real, potential, or perceived **conflict of interest** in the best interests of the **client.**
4. Make arrangements for an alternate care provider if an identified **conflict of interest** cannot be resolved.
5. Not provide midwifery care for their own **family** member(s) or close friend(s), except to intervene in an emergency situation when there is no other appropriate care provider readily available.
6. Honor the **client** choice for the midwifery provider- must have a complete informed decision-making process around the **conflict of interest** and document the **client** choice in the **client's health record.**
7. Not seek or accept any benefit for a referral, service or product provided by themselves or other parties.
8. Not offer an inducement to another regulated professional conditional on providing a referral, service, or product to a **client.**
9. Refer to **CMA** *Code of Ethics,* regarding acting in a conflict-of-interest situation.

10. Document the **client** preferences and ultimate decision for care provider clearly in the **client's health record.**

Standard of Practice 22: Use of Communication Technology

Standard of Practice 22A: **Virtual Care**

Placeholder for Practice 22A

Standard of Practice 22B: **Social Media**

To demonstrate compliance with this **standard** the midwife must:

1. Comply with the *Code of Ethics*, the ***Standard of Practice 23:* Privacy of *Client Health Information Management and Maintenance,*** facility policies, and all applicable laws in any environment where a midwife interacts with or is visible to **clients** and the public.
2. Read, understand, and use the strictest privacy settings to maintain control over personal information on social internet platforms.
3. Use only secure confidential internet platforms for midwife/**client** interactions or when giving midwifery advice to individual **clients.**
4. Not have dual **social media** relationships (social and professional) with **clients.**
5. Never post **client** images or **client** information (including but not limited to names, clinical conditions, or area of residence) on the midwife's professional or personal **social media** without formal, documented permission. Protect personal **client** information acquired from legitimate health care related online sites during collection, use, disclosure, storage, and destruction.
6. Use a personal email account not related to the midwifery practice email address when using personal **social media**.
7. Clearly indicate when comments are made on **social media** in an official capacity on behalf of the **CMA**, their midwifery practice or professionally as a midwife, or alternatively, when comments are personal, or private views and opinions.
8. Align comments with the legislation, policies, bylaws, and position statements of the **CMA** If a midwife is posting content on behalf of **CMA**, their midwifery practice, or themselves as a midwife.
9. Be responsible for content that they post, respect brands, trademarks, and copyrights, and ensure their posts do not create a real or perceived **conflict of interest.**

Standard of Practice 23: Privacy of Client Health Information Management and Maintenance

To demonstrate compliance with this *standard* the midwife must:

1. Adhere to the ***Health Information Act (HIA), Personal Information Protection Act (PIPA),*** the

Health Information Regulation (HIR)**,** the ***Alberta Electronic Health Record Regulation***, the ***Health Information Act Designation Regulation***, the *Standards of Practice***,** *Code of Ethics*, and all applicable laws related to privacy and safety of **client** information for all **clients** under midwifery care.

2. Ensure that they understand the privacy requirements that apply to their practice.

3. Address the threats and risks to the security and integrity of the **client** health information that is collected, stored, transmitted, or destroyed, via paper and electronic means, through administrative, technical, and physical safeguards.

4. Take steps to prevent, protect against, and mitigate any negative effects on **client** health information (privacy breaches) as a result of unauthorized use, disclosure, copying, modification, disposal, theft, or loss.

5. Collect, use, or disclose only **client** health information that is essential for the intended purpose relevant and consistent with professional responsibilities, if the **client** consents, or if the collection, use, or disclosure is permitted or required by legislation.

6. As custodians, exercise the highest degree of anonymity legally possible with respect to the collection, use, and disclosure of health information.

7. Cooperate with Alberta Health as it carries out its' responsibility to audit and investigate accesses to the ***Alberta Electronic Health Record****.*

8. Notify the Commissioner of a privacy breach if the **custodian** determines "there is a risk of harm to an individual as a result of the loss or unauthorized access or disclosure" as soon as practicable (HIA, section 60.1(2)). The **custodian** is also required by *section 60.1(3) of HIA* to notify the Minister of Health and the affected individuals of the privacy breach.

9. Notify the CMA of any privacy breech, as above.