Ministry of Health
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Standards of Practice for Midwives

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These standards for practice provide a framework for Midwifery Practice. They also inform women, and others including consumers, those who regulate, educate, collaborate with and manage midwives on what to expect from a midwife's practice.

Uses may include:

- professional conduct matters
- the scope of practice
- bi-annual renewal of registration, and continuing professional development
- complaints and discipline
- assessment of midwives educated overseas seeking registration and employment in Bermuda
- assessment of midwives returning to work after breaks in service

These standards are to be read in conjunction with the Nursing and Midwifery Act 1997, and the Midwifery Code of Conduct, and Scope of practice. Reading the glossary in these standards is also important for understanding the definitions of key terms.

The Standards were developed in in consultation with the midwifery profession; and compare with standards in Australia, Canada, United States, United Kingdom, and International Confederation of Midwives (ICM).

Introduction

A midwife is a person who has successfully completed a midwifery education programme that is duly recognised in the country where it is located; who has acquired the requisite qualifications to be registered and / or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery. Adapted from the International Confederation of Midwives' (ICM 2011) definition and adopted by the Bermuda Nursing and Midwifery Council

Registered midwives will be expected to understand, promote and facilitate normal childbirth and identify complications that may arise in women and babies. They will know when to call for assistance and implement emergency measures, often in conjunction with other health professionals. It is important for midwives to promote health and wellbeing and to provide unbiased information and communicate effectively with a range of women and their families.

They must also meet Bermuda Nursing and Midwifery Council's (BNMC) requirements of good health and good character. In addition, Midwives must practice in line with the **code of conduct for midwives** and maintain these standards for competence throughout their careers to remain registered. Failing to consistently meet these standards can result in Council investigating a midwife's fitness to practice and whether they are suitable to remain on register. A midwife must always act in accordance with the law.

These guidelines are not a statutory instrument, and a midwife must use judgement to apply the principles to the unique circumstances of each case. Serious or persistent failure to follow this guidance will have consequences for your registration.

A midwife with less than (3) three years' experience may not be the lead midwife attending to home birth or birthing room.

Professional Conduct

Clients and the public can be confident that all registered midwives will:

Assume full responsibility and accountability for their practice as midwives.

Understand their scope of practice.

Midwives are lead carers to women experiencing normal childbirth and being able to support women throughout their pregnancy, labour, birth and postnatal period, in all settings including midwife-led units, birthing centres and the home.

Recognise and respond appropriately where safe and quality practice may be compromised, and consider and respond in a timely manner to the health and wellbeing of women and their families in relation to the capability for practice.

Practice within relevant legal parameters and professional standards, codes and guidelines.

Practically apply sound, evidence-based knowledge of facilitating childbirth and caring for the mother and neonate.

Participate in own continuing professional development to maintain the required knowledge and skill base for safe and effective practice.

Contribute to a culture that supports learning, teaching, knowledge transfer and critical reflection.

Use appropriate interpersonal skills to support women and their families; and when collaborating with other health professionals.

	Use skills in managing obstetric and neonatal emergencies, underpinned by appropriate knowledge. Engage in professional relationships within a context of collaboration, with other health practitioners and colleagues and are conducted with mutual trust, respect and cultural awareness. Ensure that any physical or mental health condition does not affect ability to provide safe and effective care. Recognize the limits imposed by fatigue, stress, or illness, and adjust practice to the extent that is necessary to provide safe and effective care.
Person-Centred Care	Person cantered care ensures services provided are safe, client catered, informed and evidence-based. Women participate in their care and make informed decisions. Women/clients and their families can expect all registered midwives to: Establish and maintain a professional relationships by engaging purposefully in kind, compassionate and respectful partnerships. Listen to clients and provide information that is evidence based and in ways they can understand to allow for informed decision-making. Support clients to be active participants in managing their own health and the health of their neonates. Advise clients about the nature of any proposed treatment, including the expected benefits, material risks and side effects, alternative courses of action, and likely consequences of not having that treatment. Ensure treatment is only provided with the client's informed and voluntary consent unless otherwise permitted by law. Protect the privacy of clients requiring and receiving care, ensuring confidentiality of any information gained in the course of the relationship and restricting the use of the information gathered for professional purposes only. Practice ethically, with respect for dignity, equity and justice without the discrimination that may be associated with race, age, disability, sexuality, gender identity, relationship status, power relations and/or social disadvantage.

Effective and competent practice	Midwives will use relevant and current, up to date, knowledge and skills in their practice by: Demonstrating the clinical skills and judgments described in the International Confederation for Midwives (ICM) Core Competencies for Basic Midwifery Practice. Maintaining written documentation of the parameters of service for independent and collaborative midwifery management and transfer of care when needed. Having accessible resources to provide evidence based clinical practice for each specialty area which may include, but is not limited to, primary health care of women, care of the childbearing family, and neonate care. Providing care for women who have suffered pregnancy loss. Ensuring that current research findings and other evidence are incorporated into practice team-working in the best interests of individual women. Recommend the use of products or services based on evidence and clinical judgment, and not commercial gain. Make referrals to other health care providers only based on the client's best interest and not financial gain. Respect the woman's right to make her own decision and seek a second opinion. Establish and maintain clear and appropriate professional boundaries. Engaging in continual personal professional education and development, relevant professional practice improvement and performance appraisal processes. Only providing care, or undertake any treatment, that you are trained to give, this includes the use of complementary or alternative therapies.
Fitness to Practice	Midwives can be referred to the Nursing and Midwifery Professions Complaints Committee where concern arise about their fitness to practice. Referrals can be made by an employer, a colleague, a member of the public, or anyone else. Midwives have a duty to self-refer if they believe their own fitness to practice may be impaired. Referrals for questions arising for fitness to practice may be made for allegations regarding matters such as: Misconduct – behaviour that falls short of what can be reasonably expected of a professional midwife. Such cases may relate to conduct in work, or outside of work.

Lack of competence – evidence of a lack of knowledge, skills or professional judgment that raises a question as to whether the midwife is capable of meeting the required standards for safe and effective practice.

Health – a question as to the midwife's ability to discharge their professional duties arising from a serious, long-term, untreated or unacknowledged health condition.

Convictions or cautions – where a midwife has received a criminal conviction or caution that calls into question their fitness to practice or has the potential to undermine public confidence in the midwifery profession.

Not having the necessary knowledge of English – evidence that a midwife does not have the necessary knowledge of English to practice safely and effectively in Bermuda.

Determinations of other regulatory bodies – where a midwife has had a finding of impairment made against them by another regulator of a health and social care profession, within or beyond Bermuda.

Financial Arrangements

Advising of Fees

Midwives must be honest in any financial arrangements with clients. The Client has the right to know how much services will cost and how much they will be charged before accepting treatment.

A midwife must avoid encouraging clients to give, lend, and bequeath money or gifts that will benefit her/him directly. This includes being involved with loans or investments schemes with client.

Declare any financial or commercial interests he/he has in any aspect of the client's care.

Declare any financial /professional interest she/he has in a product that may be used in the client's care.

A midwife must not let her/his professional judgement be influenced by any commercial considerations.

Regulatory Criteria for Education and Licensing	Initial Registration and return to Registration Midwives seeking registration in Bermuda require to have completed a programme of Midwifery that meets the International Confederation of Midwives (ICM) Global Standards for Midwifery Education (2013) and has attained/demonstrated, at a minimum, the current ICM Essential Competencies for Midwifery practice which are encompassed in this document. In essence the initial programme meets: A midwifery curriculum includes both theory and practice elements with a minimum of 40% theory and a minimum of 50% practice. Sequence and content of the midwifery curriculum enables the student to acquire essential competencies for midwifery practice in accord with ICM core documents. Provides documentation evidence of theory and practice competence Regulatory body standards leading to licensure or registration as a midwife in the country in which the programme was undertaken. Is a knowledgeable, practitioner who adheres to the ICM International Code of Ethics for Midwives, and standards of practice of the profession in his/her jurisdiction. Established scope of practice within the jurisdiction where legally recognized. The minimum length of a direct-entry midwifery education programme is three (3) years. The minimum length of a post-nursing/health care provider (post-registration) midwifery education programme is twelve (12) months. The use of evidence-based approaches to teaching and learning that promote adult learning and competency based education. Multidisciplinary content and learning experiences that complement the midwifery content.
Updating, Inactive Status and Restoration to The Register	Registration files must be updated according to the timelines set forth by the BNMC and should occur on a regular basis. For the purposes of general updating and renewal of registration, application and attestation of continual education are normative requirements. Restoration to the Register may be required due to a person voluntarily removing themselves, through inactivity in midwifery services, not meeting BNMC reregistration requirements or removal by the Council due to confirmed misconduct.

A midwife is considered to be inactive if there is failure to submit re-application of documents and fees required for re-registration within the re-licensure period.

a) Where the applicant has a current license from another jurisdiction and the Bermuda license is lapsed for 8 or more years, the applicant will be required to complete initial application process.

or

b) Where the applicant has a current license from another jurisdiction and the Bermuda license has lapsed for less than 8 years, renewal of registration will be in accordance with Renewal of Registration instructions.

or

c) Where the applicant does not hold a current license the applicant will be required to attend a Refresher Course and supervised practice hours. (See table 1, below for all re-registration required CEU hours and practice hours).

For all cases of inactivity, the Council must assess if the applicant is eligible for restoration to the register based on his/her:

- Character.
- Professional ability- experience, practice and knowledge so as to ensure competent practice.
- The reason for removal/ suspension and their conduct thereafter.
- Any other circumstances.

"Professional ability" is, in part, determined by the period of time the person was inactive and the reason for the period of inactivity. The Council will determine specific requirements on a case by case basis; ~~however~~, the table below indicates the general requirements for restoration to the active register for midwifery.

Table 1: Restoration to Active Midwifery Register Requirements where the applicant <u>does not hold an active license in another jurisdiction.</u>

No. of years inactive	Requirements	Explanation
2 years	• 24 hours CPD/CEU's	CPD/ CEU's are required for re-registration Nursing and Midwifery Act 1997 and Nursing Rules 2010. See Continuing Professional Development/ Education (a) (stated below). Required Practice hours (100) must be completed before registration.
2 - 5	• 30 hours of CPD/ CEU • 100 hours of supervised or Validated practice hours by a practicing midwife or physician • Police vetting Report	See Continuing Professional Development/ Education (b) (stated below). Required Practice hours (100) and CPD hours (30) must be completed before registration.
5 – less than 8 years	• 72 hours of CPD/CEU • 150 hours of supervised or validated practice hours by a practicing midwife or physician • Police vetting Report	The training can include: study, professional development seminar, webinar, workshop etc. and clinical practice as required by Council See Continuing Professional Development/ Education ((b)stated below). Required Practice hours (150) must be completed before registration.
8 years or more	• NEW application submission to BNMC to include (Non Residents). Active, un-encumbered Midwifery registration from another jurisdiction	

	• If residing in Bermuda Refresher course with practicum component • 200 hours of supervised /validated practice hours by a practicing midwife or physician • Police vetting Report	Refresher course and supervised practice hours must be completed before registration.

Continuing Professional Development/ Education

The Council has policy for continual professional development to ensure that after they are registered, midwives continue their professional education and maintain their competence to practice. A minimum recommendation for hours is 24 continuing education units (CPD/ CEU) with the following:

- 6 of the 24 hours dedicated to pharmacology relative to Midwifery practice
- 12 hours of the 24 hours must be directly related to core Midwifery subject matter

or

- 12 of the 30 hours dedicated to pharmacology relative to Midwifery practice
- 18 of the 30 hours must be directly related to core Midwifery subject matter

- Routine certification in Cardiopulmonary Resuscitation and Neonatal Resuscitation required. Will not be counted for the purpose of CPD/CEU Credits.
- Participation in skills-based simulation of obstetric emergency management of; shoulder dystocia, post-partum hemorrhage, undiagnosed breech delivery, is also highly encouraged.

Public Health Issue	Legislation	Report to:	When
Births, Still-Births, Deaths*	Registration (Births and Deaths) Acts 1949 Sections 6 and 11	Births: Registrar-General and Chief Medical Officer Deaths: Registrar-General (If the coroner indicates an inquest must be held, the medical practitioner does not need to notify the Registrar-General)	Births: Must notify of birth within 48 hours Deaths: The medical practitioner must send notice within 48 hours of the death or, if needed, after an examination of the body
Child Abuse*	Children Act 1998 Section 20	Director of Child and Family Services	As soon as it is suspected
Senior Abuse*	Senior Abuse Register Act 2008 Section 8	Registrar of Senior Abuse (the Acting Manager, National Office for Seniors and the Physically Challenged)	As soon as it is suspected along with the supporting evidence
Communicable and Reportable Diseases*	Public Health Act 1949 Section 68 (1) (b)	Government Medical Officer (orally or in writing); function delegated to the Epidemiology and Surveillance Unit in the Office of the Chief Medical Officer	As soon as aware or suspect a client has a communicable disease as per the Act
Communicable and reportable Diseases and select non-communicable	International Health Regulations 2005*	Communicable and reportable diseases: Office of the Chief Medical Officer who reports to the World Health Organization about	Timely notification as required

Public Health Issue	Legislation	Report to:	When
Chronic Diseases		smallpox, poliomyelitis due to wild-type poliovirus, human influenza caused by new subtypes and SARS or any other public health emergency of international concern Non-communicable chronic diseases: The Epidemiology and Surveillance Unit in the Office of the Chief Medical Officer about diabetes, heart disease, and select cancers	
Controlled Drugs*	Misuse of Drugs Act 1972 Section 20 (1)	Minister of Health, Seniors and Environment and the Bermuda Nursing and Midwifery Council	Upon request by the Minister or if concern is raised about extensive misuse of controlled drugs
Vaccinations (those given against communicable diseases)	For reporting to World Health Organization and Pan American Health Organization	Chief Medical Officer	At regular intervals
Gunshot Wounds	No current legislation	No legal obligation to report due to confidentiality. Police are usually aware due to public information and the nature of offence. There is reporting of non-accidental injuries to the Epidemiology and Surveillance Unit of Department of Health.	As soon as information received about the nature of the injury; weekly surveillance by the Department of Health
Impaired Driving	Motor Car Act 1951	Director of TCD Minister of Tourism Development & Transport (refers matter to the Medical Reference Committee)	As soon as reasonably possible

Occupational Safety/Accidents*	Occupational Safety & Health Act 1982 Section 3D Occupational; Safety & Health Regulations 2009 Section 26	Minister Employer (given notice of disease, illness, or injury) Chief Medical Officer/Government Medical Officer (giving notice of disease, illness or injury)	No time frame listed, but can be assumed that it is as soon as reasonably possible
*These are legal requirements that must be reported. All legislation is available online at www.bermudalaws.bm.			

Appendix 11

Client Records

Client record includes paper-based and electronic formats.

A. A client record should contain enough information for any physician or other regulated health professional to be sufficiently informed of the care being provided including:

   a) Clinical notes

   b) Lab and imaging reports

   c) Pathology reports

   d) Referral letters and consultation reports

B. A client record must contain or provide reference to the following minimum information:

   1. Client's name, address, phone number, date of birth, gender, and ID number
   2. Dates seen and identity of the physician /obstetrician attending to the client
   3. Documentation of pregnancy include relevant information
   4. Significant prior history
   5. Current medications, allergies and drug sensitivity
   6. Prescription record (when issued, the dose of medication, frequency of administration, duration the client is to take the medicine, whether there are refills)
   7. Relevant social history including alcohol or drug use or abuse
   8. Relevant family history
   9. Physical examination findings
   10. Diagnoses - Plan of care
   11. Investigations ordered and results obtained

12. Relevant information prenatal care intrapartum care, post-natal care and neonate care.

13. Date of Delivery.

14. Instructions and advice to the client including follow up care instructions

15. Reports sent or received regarding the client's medical care.

16. Consent signed by client or signed by legal guardian.

17. Referrals as needed.

C. In addition, a client record should be legible, written in English and with alterations and corrections to the client record clearly identified showing the identity of the person making the alteration and the date.

D. Client records should be stored for a minimum of ten (10) years2 following the date of last service or in the case of minors, ten years or until two years after the age of majority (18 years) – whichever is longer.

E. Independent practicing midwives are highly encouraged to seek Malpractice insurance.

[2] In the case of civil actions, the Limitation Act 1984 requires midwives to keep client records for six (6) years. (Council suggests D above) Malpractice insurance policies may stipulate longer storage requirements and midwives are encouraged to verify this information directly with their insurer

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