

PROFESSIONAL STANDARDS of CARE FOR  
LICENSED MIDWIVES  
4 CONTACT HOURS

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the Florida Board of Nursing, Provider # 50-2502**

**PURPOSE OF THE COURSE:**

The purpose of this course is to provide the learner with information about standards of care and how these standards of care protect the safety of the patient as well as uphold their basic rights to the provision of competent care.

The content of the course includes the purposes of standards of care, state practice acts, standards of care and core competencies as related to midwifery, common departures from standards of care, the relationship of standards of care to the legal/ ethical aspects of practice, quality assurance, performance levels and education. Additional content includes evidence based practice guidelines for midwifery practice as well as how standards of care, practice standards and guidelines can be accessed and applied into all aspects of care.

**OBJECTIVES:**

At the conclusion of this course, the learner will be able to:

1. Define standards of care and how these standards of care relate to laws, ethical principles, quality assurance, performance levels and educational programs, such as core curriculums.
2. Discuss a number of standards of care, including those from the American College of Nurse-Midwives, the Midwives Alliance of North America and the American Nurses Association as related to midwifery practice.

3. Access and utilize standards of care and practice guidelines in one's practice while avoiding some commonly occurring departures from established standards of care.

## **INTRODUCTION**

Professions, including the healthcare professions, have standards of practice. *Standards of practice* establish minimum practice guidelines and expectations. They reflect the standard in terms of what should be done and how it should be done. They establish and document what is considered acceptable practice within the profession.

Legally and ethically, professionals are accountable for practicing in a way that is consistent with established standards of practice. It is critically important, therefore, that all healthcare professionals are familiar with these standards and that they apply these standards into their daily practice. Healthcare professionals and healthcare agencies place themselves in grave positions of liability when departures from established standards of care occur. Patient care, professional licenses, corporate and personal financial security can very well be in jeopardy with departures from established standards of care.

## **PROFESSION ASSOCIATIONS' STANDARDS OF PRACTICE**

Standards of practice are in place for nurses, physicians, respiratory therapists, psychologists, midwives, administrators, and others. The terms "standards of care" and "standards of practice" are often used interchangeably in the literature.

Standards of care and practice are objectively stated, minimal practice expectations. Practice standards are typically general and not highly specific and prescriptive of processes. They tend to be objectively stated outcome expectations, rather than process steps. Standards of practice are updated and added to as the professional body of knowledge grows and/or changes.

Professional organizations and associations for midwives and other professionals have and use standards of practice. Some examples include the standards of care, or practice, as put forth by the American Nurses Association (ANA), the American College of Nurse-Midwives and the Midwives Alliance of North America.

The American College of Nurse-Midwives defines the practice of a certified nurse-midwife and a certified midwife as below.

"A certified nurse-midwife (CNM) is an individual educated in the two disciplines of nursing and midwifery, who possesses evidence of certification according to the requirements of the American College of Nurse-Midwives." (American College of Nurse-Midwives, 2004).

"A certified midwife (CM) is an individual educated in the discipline of midwifery, who possesses evidence of certification according to the requirements of the American College of Nurse-Midwives." (American College of Nurse-Midwives, 2004).

The American College of Nurse-Midwives (2003), a national professional association for midwives, has established professional standards for the practice of midwifery. Their *Standards for the Practice of Midwifery* are below.

"Midwifery practice as conducted by certified nurse-midwives (CNMs) and certified midwives (CMs) is the independent management of women's health care, focusing particularly on pregnancy, childbirth, the post partum period, care of the newborn, and the family planning and gynecologic needs of women. The CNM and CM practice within a health care system that provides for consultation, collaborative management, or referral, as indicated by the health status of the client. CNMs and CMs practice in accord with the Standards for the Practice of Midwifery, as defined by the American College of Nurse-Midwives (ACNM).

### **STANDARD I**

#### *MIDWIFERY CARE IS PROVIDED BY QUALIFIED PRACTITIONERS*

The midwife:

1. Is certified by the ACNM designated certifying agent.
2. Shows evidence of continuing competency as required by the ACNM designated certifying agent.
3. Is in compliance with the legal requirements of the jurisdiction where the midwifery practice occurs.

### **STANDARD II**

#### *MIDWIFERY CARE OCCURS IN A SAFE ENVIRONMENT WITHIN THE CONTEXT OF THE FAMILY, COMMUNITY, AND A SYSTEM OF HEALTH CARE.*

The midwife:

1. Demonstrates knowledge of and utilizes federal and state regulations that apply to the practice environment and infection control.
2. Demonstrates a safe mechanism for obtaining medical consultation, collaboration, and referral.
3. Uses community services as needed.
4. Demonstrates knowledge of the medical, psychosocial, economic, cultural, and family factors that affect care.
5. Demonstrates appropriate techniques for emergency management including arrangements for emergency transportation.
6. Promotes involvement of support persons in the practice setting.

### **STANDARD III**

*MIDWIFERY CARE SUPPORTS INDIVIDUAL RIGHTS AND SELF-DETERMINATION WITHIN BOUNDARIES OF SAFETY*

The midwife:

1. Practices in accord with the Philosophy and the Code of Ethics of the American College of Nurse-Midwives.
2. Provides clients with a description of the scope of midwifery services and information regarding the client's rights and responsibilities.
3. Provides clients with information regarding, and/or referral to, other providers and services when requested or when care required is not within the midwife's scope of practice.
4. Provides clients with information regarding health care decisions and the state of the science regarding these choices to allow for informed decision-making.

### **STANDARD IV**

*MIDWIFERY CARE IS COMPRISED OF KNOWLEDGE, SKILLS, AND JUDGMENTS THAT FOSTER THE DELIVERY OF SAFE, SATISFYING, AND CULTURALLY COMPETENT CARE.*

The midwife:

1. Collects and assesses client care data, develops and implements an individualized plan of management, and evaluates outcome of care.
2. Demonstrates the clinical skills and judgments described in the ACNM Core Competencies for Basic Midwifery Practice.

3. Practices in accord with the ACNM Standards for the Practice of Midwifery.
4. Practices in accord with service/practice guidelines that meet the requirements of the particular institution or practice setting.

### **STANDARD V**

*MIDWIFERY CARE IS BASED UPON KNOWLEDGE, SKILLS, AND JUDGMENTS WHICH ARE REFLECTED IN WRITTEN PRACTICE GUIDELINES*

The midwife:

1. Describes the parameters of service for independent and collaborative midwifery management and transfer of care when needed.
2. Establishes practice guidelines for each specialty area which may include, but is not limited to, primary health care of women, care of the childbearing family, and newborn care.
3. Includes the following information in each specialty area:
  - a) Client selection criteria
  - b) Parameters and methods for assessing health status
  - c) Parameters for risk assessment
  - d) Parameters for consultation, collaboration, and referral
  - e) Appropriate interventions including treatment, medication, and/or devices.

### **STANDARD VI**

*MIDWIFERY CARE IS DOCUMENTED IN A FORMAT THAT IS ACCESSIBLE AND COMPLETE.*

The midwife:

1. Uses records that facilitate communication of information to clients, consultants, and institutions.
2. Provides prompt and complete documentation of evaluation, course of management, and outcome of care.
3. Promotes a documentation system that provides for confidentiality and transmissibility of health records.
4. Maintains confidentiality in verbal and written communications.

### **STANDARD VII**

*MIDWIFERY CARE IS EVALUATED ACCORDING TO AN ESTABLISHED PROGRAM FOR QUALITY MANAGEMENT THAT INCLUDES A PLAN TO*

## *IDENTIFY AND RESOLVE PROBLEMS.*

The midwife:

1. Participates in a program of quality management for the evaluation of practice within the setting in which it occurs.
2. Provides for a systematic collection of practice data as part of a program of quality management.
3. Seeks consultation to review problems, including peer review of care.
4. Acts to resolve problems identified.

## **STANDARD VIII**

*MIDWIFERY PRACTICE MAY BE EXPANDED BEYOND THE ACNM CORE COMPETENCIES TO INCORPORATE NEW PROCEDURES THAT IMPROVE CARE FOR WOMEN AND THEIR FAMILIES.*

The midwife:

1. Identifies the need for a new procedure taking into consideration consumer demand, standards for safe practice, and availability of other qualified personnel.
2. Ensures that there are no institutional, state, or federal statutes, regulations, or bylaws that would constrain the midwife from incorporation of the procedure into practice.
3. Demonstrates knowledge and competency, including:
  - a) Knowledge of risks, benefits, and client selection criteria.
  - b) Process for acquisition of required skills.
  - c) Identification and management of complications.
  - d) Process to evaluate outcomes and maintain competency.
4. Identifies a mechanism for obtaining medical consultation, collaboration, and referral related to this procedure.
5. Reports the incorporation of this procedure to the ACNM.”  
(American College of Nurse-Midwives, 2003).

The American Nurses Association (ANA) has also developed and published six (6) standards of practice and nine (9) standards of professional performance for all nurses, including nurse midwives.

The ANA’s six standards of nursing practice address:

- Assessment,
- Diagnosis,
- Outcomes identification,

- Planning,
- Implementation and
- Evaluation.

The ANA's standards of professional performance are as below:

- Education,
- Professional practice evaluation,
- Quality of practice,
- Collaboration,
- Collegiality,
- Research,
- Leadership,
- Resource utilization, and
- Ethics (American Nurses Association, 2004).

### **CORE COMPETENCIES FOR MIDWIFERY PRACTICE**

The Midwives Alliance of North America (1994) has established core, basic competencies relating to this specialty practice. These core competencies also reflect minimal standards of practice and the scope of practice for licensed or certified midwives, as follows:

#### **"I. Guiding Principles of Practice:**

The midwife provides care according to the following principles:

- A. Midwives work in partnership with women and their chosen support community throughout the caregiving relationship.
- B. Midwives respect the dignity, rights, and the ability of the women they serve to act responsibly throughout the caregiving relationship.
- C. Midwives work as autonomous practitioners, collaborating with other health and social service providers when necessary
- D. Midwives understand that physical, emotional, psycho-social and spiritual factors synergistically comprise the health of individuals and affect the childbearing process.

E. Midwives understand that female physiology and childbearing are normal processes, and work to optimize the well-being of mothers and their developing babies as the foundation of caregiving.

F. Midwives understand that the childbearing experience is primarily a personal, social and community event.

G. Midwives recognize that a woman is the only direct care provider for herself and her unborn baby; thus the most important determinant of a healthy pregnancy is the mother herself.

H. Midwives recognize the empowerment inherent in the childbearing experience and strive to support women to make informed decisions and take responsibility for their own well-being.

I. Midwives strive to insure vaginal birth and provide guidance and support when appropriate to facilitate the spontaneous process of pregnancy, labor, and birth, utilizing medical intervention only as necessary.

J. Midwives synthesize clinical observations, theoretical knowledge, intuitive assessment and spiritual awareness as components of a competent decision making process.

K. Midwives value continuity of care throughout the childbearing cycle and strive to maintain continuous care within realistic limits.

L. Midwives understand that the parameters of "normal" vary widely and recognize that each pregnancy and birth are unique.

## **II. General Knowledge and Skills:**

The midwife provides care incorporating certain concepts,

skills, and knowledge from a variety of health and social sciences, including, but not limited to:

- A. Communication, counseling, and teaching skills.
- B. Human anatomy and physiology relevant to childbearing.
- C. Community standards of care for women and their developing infants during the childbearing cycle, including midwifery and bio-technical medical standards and the rationale for and limitations of such standards.
- D. Health and social resources in her community.
- E. Significance of and methods for documentation of care through the childbearing cycle.
- F. Informed decision making.
- G. The principles and appropriate application of clean and aseptic technique and universal precautions.
- H. Human sexuality, including indication of common problems and indications for counseling.
- I. Ethical considerations relevant to reproductive health.
- J. The grieving process.
- K. Knowledge of cultural variations.
- L. Knowledge of common medical terms.
- M. The ability to develop, implement and evaluate an individualized plan for midwifery care.

N. Woman-centered care, including the relationship between the mother, infant, and their larger support community.

O. Knowledge and application of various health care modalities as they apply to the childbearing cycle.

### **III. Care During Pregnancy:**

The midwife provides health care, support, and information to women throughout pregnancy. She determines the need for consultation or referral as appropriate. The midwife uses a foundation of knowledge and/or skill which includes the following:

A. Identification, evaluation, and support of maternal and fetal well-being throughout the process of pregnancy.

B. Education and counseling for the childbearing cycle.

C. Preexisting conditions in a woman's health history which are likely to influence her well-being when she becomes pregnant.

D. Nutritional requirements of pregnant women and methods of nutritional assessment and counseling.

E. Changes in emotional, psycho-social and sexual variations that may occur during pregnancy.

F. Environmental and occupational hazards for pregnant women.

G. Methods of diagnosing pregnancy.

H. Basic understanding of genetic factors which may indicate the need for counseling, testing, or referral.

- I. Basic understanding of the growth and development of the unborn baby.
- J. Indications for, risks, and benefits of bio-technical screening methods and diagnostic tests used during pregnancy.
- K. Anatomy, physiology, and evaluation of the soft and bony structures of the pelvis.
- L. Palpation skills for evaluation of the fetus and uterus.
- M. The causes, assessment and treatment of the common discomforts of pregnancy.
- N. Identification of, implications of, and appropriate treatment for various infections, disease conditions and other problems which may affect pregnancy.
- O. Special needs of the Rh- woman.

#### **IV. Care During Labor, Birth, and Immediately Thereafter:**

The midwife provides health care, support, and information to women throughout labor, birth, and the hours immediately thereafter. She determines the need for consultation or referral as appropriate. The midwife uses a foundation of knowledge and/or skill which includes the following:

- A. The normal process of labor and birth.
- B. Parameters and methods for evaluating maternal and fetal well-being during labor, birth, and immediately thereafter, including relevant historical data.
- C. Assessment of the birthing environment, assuring that it is clean, safe and supportive, and that appropriate equipment and supplies are on hand.

D. Emotional responses and their impact during labor, birth, and immediately thereafter.

E. Comfort and support measures during labor, birth, and immediately thereafter.

F. Fetal and maternal anatomy and their interactions as relevant to assessing fetal position and the progress of labor.

G. Techniques to assist and support the spontaneous vaginal birth of the baby and placenta.

H. Fluid and nutritional requirements during labor, birth, and immediately thereafter.

I. Assessment of and support for maternal rest and sleep as appropriate during the process of labor, birth, and immediately thereafter.

J. Causes of, evaluation of, and appropriate treatment for variations which occur during the course of labor, birth, and immediately thereafter.

K. Emergency measures and transport for critical problems arising during labor, birth, or immediately thereafter.

L. Understanding of and appropriate support for the newborn's transition during the first minutes and hours following birth.

M. Familiarity with current bio-technical interventions and technologies which may be commonly used in a medical setting.

N. Evaluation and care of the perineum and surrounding tissues.

## **V. Postpartum Care:**

The midwife provides health care, support, and information to women throughout the postpartum period. She

determines the need for consultation or referral as appropriate. The midwife uses a foundation of knowledge and/or skill which includes but is not limited to the following:

- A. Anatomy and physiology of the mother during the postpartum period.
- B. Lactation support and appropriate breast care including evaluation of, identification of, and treatments for problems with nursing.
- C. Parameters and methods for evaluating and promoting maternal well-being during the postpartum period.
- D. Causes of, evaluation of, and treatment for maternal discomforts during the postpartum period.
- E. Emotional, psycho-social, and sexual variations during the postpartum period.
- F. Maternal nutritional requirements during the postpartum period including methods of nutritional evaluation and counseling.
- G. Causes of, evaluation of, and treatments for problems arising during the postpartum period.
- H. Support, information, and referral for family planning methods as the individual woman desires.

#### **VI. Newborn Care:**

The entry-level midwife provides health care to the newborn during the postpartum period and support and information to parents regarding newborn care. She determines the need for consultation or referral as appropriate. The midwife uses a foundation of knowledge and/or skill which includes the following:

- A. Anatomy, physiology, and support of the newborn's adjustment during the first days and weeks of life.
- B. Parameters and methods for evaluating newborn wellness including relevant historical data and gestational age.
- C. Nutritional needs of the newborn.
- D. Community standards and state laws regarding indications for, administration of, and the risks and benefits of prophylactic biotechnical treatments and screening tests commonly used during the neonatal period.
- E. Causes of, assessment of, appropriate treatment, and emergency measures for neonatal problems and abnormalities.

**VII. Professional, Legal and Other Aspects:**

The entry-level midwife assumes responsibility for practicing in accord with the principles outlined in this document. The midwife uses a foundation of knowledge and/or skill which includes the following:

- A. MANA's documents concerning the art and practice of Midwifery.
- B. The purpose and goal of MANA and local (state or provincial) midwifery associations.
- C. The principles of data collection as relevant to midwifery practice.
- D. Laws governing the practice of midwifery in her local jurisdiction.
- E. Various sites, styles, and modes of practice within the larger midwifery community.
- F. A basic understanding of maternal/child health care delivery systems in her local jurisdiction.

G. Awareness of the need for midwives to share their knowledge and experience.

### **VIII. Woman Care & Family Planning:**

Depending upon education and training, the entry-level midwife may provide family planning and well-woman care. The practicing midwife may also choose to meet the following core competencies with additional training. In either case, the midwife provides care, support, and information to women regarding their overall reproductive health, using a foundation of knowledge and/or skill which includes the following:

- A. Understanding of the normal life cycle of women.
- B. Evaluation of the woman's well-being including relevant historical data.
- C. Causes of, evaluation of, and treatments for problems associated with the female reproductive system and breasts.
- D. Information on, provision of, or referral for various methods on contraception.
- E. Issues involved in decision-making regarding unwanted pregnancies and resources for counseling and referral." (Midwives Alliance of North America, 1994).

Similarly, the American College of Nurse-Midwives (2002) has also established minimal basic core competencies that reflect standards of practice for midwives. These core competencies are as follows:

"The core competencies for basic midwifery practice describe the fundamental knowledge, skills, and behaviors expected of a new practitioner. Accordingly, they serve as guidelines for educators, students, health care professionals, consumers, employers, and policy-makers and constitute the basic requisites for graduates of all nurse-midwifery and midwifery education programs accredited/preaccredited

by The American College of Nurse-Midwives (ACNM) Division of Accreditation (DOA)\*.

Midwifery practice is based on the Core Competencies for Basic Midwifery Practice, The Standards for the Practice of Nurse-Midwifery and the Code of Ethics promulgated by the American College of Nurse-Midwives. Certified nurse-midwives (CNMs) and certified midwives (CMs) who have been certified by the ACNM or the ACNM Certification Council, Inc. (ACC) assume responsibility and accountability for their practice as primary health care providers.

Midwifery education is based on an understanding of health sciences theory and clinical preparation that shapes knowledge, judgment, and skills deemed necessary to provide primary health care management to women and newborns. Midwives provide health care that incorporates appropriate medical consultation, collaborative management, or referral. Each education program is encouraged to develop its own method of addressing health care issues beyond the scope of the current core competencies, and each graduate is responsible for complying with the laws of the jurisdiction where midwifery is practiced and the ACNM Guidelines for Incorporation of New Procedures into Practice.

The ACNM defines the midwife's role in primary health care based on the Institute of Medicine's report (1996)\*, the ACNM philosophy (1989), and the ACNM Board of Directors' Position Statement on Certified Nurse-Midwives and Certified Midwives as Primary Health Care Providers/Case Managers (1997). Primary health care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing the majority of health care needs, developing a sustained partnership with patients, and practicing within the context of family and community. As primary health care providers, CNMs and CMs assume responsibility for the provision of, and referral for, appropriate health care services that are within a defined scope of practice. The concepts, skills, and midwifery management process identified below comprise the foundation upon which practice guidelines and educational curricula are built. The core competencies are reviewed and revised regularly to incorporate changing trends in midwifery practice. This document must be adhered to in its entirety.

## I Hallmarks of Midwifery

The art and science of midwifery are characterized by these hallmarks:

1. Recognition of pregnancy, birth, and menopause as normal physiologic and developmental processes
2. Advocacy of non-intervention in the absence of complications
3. Incorporation of scientific evidence into clinical practice
4. Promotion of family-centered care
5. Empowerment of women as partners in health care
6. Facilitation of healthy family and interpersonal relationships
7. Promotion of continuity of care
8. Health promotion, disease prevention, and health education
9. Promotion of a public health care perspective
10. Care to vulnerable populations
11. Advocacy for informed choice, shared decision-making, and the right to self-determination
12. Cultural competence
13. Familiarity with common complementary and alternative therapies
14. Skillful communication, guidance, and counseling
15. Therapeutic value of human presence
16. Collaboration with other members of the health care team

## II Components of Midwifery Care:

### Professional Responsibilities of CNMs and CMs

The professional responsibilities of CNMs and CMs include, but are not limited to, these components:

1. Promotion of the hallmarks of midwifery

2. Knowledge of the history of midwifery
3. Knowledge of the legal basis for practice
4. Knowledge of national and international issues and trends in women's health and maternal/newborn care
5. Support of legislation and initiatives which promote high quality health care services
6. Knowledge of issues and trends in health care policy and systems
7. Commitment to the ACNM's Philosophy, Standards, and Code of Ethics
8. Ability to evaluate, apply, interpret, and collaborate in research
9. Participation in self-evaluation, peer review, continuing education, and other activities that ensure and validate quality practice
10. Development of leadership skills
11. Familiarity with practice management and finances

### III Components of Midwifery Care:

#### Midwifery Management Process

The midwifery management process includes:

1. Systematically compiling and updating a complete and relevant database for the comprehensive assessment of each client's health, including a thorough health history and physical examination
2. Identifying problems and formulating diagnoses based upon interpretation of the database
3. Identifying health care needs/problems in collaboration with the client
4. Providing information and support to enable clients to make informed decisions and to assume primary responsibility for their own health

5. Developing a comprehensive plan of care with the client
6. Assuming primary responsibility for the implementation of individualized plans
7. Obtaining consultation, planning, and implementing collaborative management; referral or transferring the care of the client as appropriate
8. Initiating management of specific complications, emergencies, and deviations from normal
9. Evaluating, with the client, the effectiveness of care and modifying the plan of care as appropriate.

#### IV Components of Midwifery Care:

##### Fundamentals

1. Anatomy and physiology, including fetal anatomy and physiology
2. Normal growth and development
3. Clinical genetics
4. Psychosocial, sexual and behavioral development
5. Basic epidemiology
6. Nutrition
7. Pharmacokinetics and pharmacotherapeutics
8. Principles of individual and group health education

#### V Components of Midwifery Care:

##### The Primary Health care of Women

1. Health Promotion and Disease Prevention  
Independently manages primary health screening and health promotion of women from the perimenarcheal through the postmenopausal periods

A. Applies knowledge of midwifery practice that includes, but is not limited to, the following:

1. Nationally defined goals and objectives for health promotion and disease prevention
2. Parameters for assessment of physical and mental health, including domestic violence, sexually transmitted infections, and substance, alcohol, and tobacco use
3. Nationally defined screening recommendations to promote health and detect/prevent disease
4. Management strategies and therapeutics to facilitate health and promote healthy behaviors

B. Applies knowledge of midwifery practice in the preconception period that includes, but is not limited to, the following:

1. Assessment of individual and family readiness for pregnancy, including emotional, psychosocial, and sexual factors
2. Impact of health, family and genetic history on pregnancy outcomes
3. Influence of environmental and occupational factors, health habits, and behavior on pregnancy planning
4. Health and laboratory screening to evaluate the potential for a healthy pregnancy

C. Applies knowledge of midwifery practice of gynecologic care that includes, but is not limited to, the following:

1. Human sexuality
2. Common screening and diagnostic tests
3. Parameters for differential diagnosis of common gynecologic problems, including sexually transmitted infections
4. Essentials of barrier, hormonal, mechanical, chemical, physiologic, and surgical conception control methods

5. Management strategies and therapeutics for common gynecologic problems and family planning needs

6. Management strategies and therapeutics for sexually transmitted infections that includes indicated partner evaluation, treatment, or referral

7. Counseling principles for sexual behaviors that promote health and prevent disease

8. Counseling, clinical interventions and/or referral for unplanned or undesired pregnancies, sexual concerns, infertility, and common gynecologic problems.

D. Applies knowledge of midwifery practice in the perimenopausal, postmenopausal and aging periods that includes, but is not limited to, the following:

1. Effects of menopause on physical and mental health

2. Identification of deviations from normal

3. Counseling and education for health maintenance and health promotion in the aging woman

4. Management strategies and therapeutics for alleviating the common discomforts that may accompany the perimenopausal period

2. Management of Common Health Problems

Independently manages, within the CNM's/CM's defined scope of practice, common health problems of women, utilizing consultation, collaboration, and/or referral to appropriate levels of health care services as indicated

A. Applies the knowledge of midwifery practice that includes, but is not limited to, the following:

1 Identification of deviations in the following areas:

a. Cardiovascular/hematologic

b. Dermatologic

c. Endocrine

d. Eye, ear, nose, and throat

e. Gastrointestinal

- f. Mental health
- g. Musculoskeletal
- h. Neurologic
- i. Respiratory
- j. Renal

2. Management strategies and therapeutics for the treatment of common health problems/deviations of essentially healthy women

## VI Components of Midwifery Care:

### The Childbearing Family

#### 1. Care of the Childbearing Woman

Independently manages the care of women during pregnancy, childbirth, and the postpartum period

A. Applies knowledge of midwifery practice in the antepartum period that includes, but is not limited to, the following:

1. Diagnosis of pregnancy
2. Genetics, placental physiology, embryology, and fetal development
3. Epidemiology of maternal and perinatal morbidity and mortality
4. Influence of environmental and occupational factors, health habits, and maternal behaviors on pregnancy outcomes
5. Emotional and psychosexual changes during pregnancy
6. Health risks, including but not limited to, domestic violence, sexually transmitted infections, substance, alcohol, and tobacco use
7. Promotion of breastfeeding
8. Indicators of normal pregnancy and deviations from normal
9. Assessment of the progress of pregnancy and fetal well-being
10. Etiology and management of common discomforts of pregnancy

11. Management strategies and therapeutics that facilitate healthy pregnancy and outcome

12. Anticipatory guidance related to birth, breastfeeding, parenthood, and change in the family constellation

B. Applies knowledge of midwifery practice in the intrapartum period that includes, but is not limited to, the following:

1. Diagnosis and assessment of labor and its progress
2. Assessment of maternal and fetal status during labor
3. Indicators of deviations from normal, including complications and emergencies
4. Measures to support psychosocial needs during labor and delivery
5. Management strategies and therapeutics to facilitate normal labor progress
6. Techniques for (i) administration of local anesthesia (ii), spontaneous vaginal delivery, (iii) third stage management, and (iv) performance and repair of episiotomy and repair of lacerations
7. Techniques for management of emergency complications and abnormal intrapartum events

C. Applies knowledge of midwifery practice in the postpartum period that includes, but is not limited to, the following:

1. Postpartum self-care, newborn care and feeding, contraception, and family relationships
2. Management strategies and therapeutics to facilitate a healthy puerperium
3. Facilitation of the initiation and establishment of lactation
4. Deviations from normal and appropriate interventions including management of complications and emergencies
5. Management of discomforts of the puerperium

## 2. Newborn Care

Independently manages the care of the newborn during the first 28 days of life.

A. Applies knowledge of midwifery practice that includes, but is not limited to, the following:

1. Effect of maternal/fetal risk factors on the newborn
2. Bonding and attachment theory
3. Evaluation of the newborn: physical and behavioral assessment and gestational age assessment
4. Primary health screening and health promotion up to 28 days of life
5. Methods to facilitate adaptation to extrauterine life: (i) stabilization at birth, (ii) resuscitation, and (iii) emergency management
6. Facilitation of continuation of breastfeeding
7. Indications of deviation from normal and appropriate interventions
8. Management strategies to facilitate integration of the newborn into the family” (American College of Nurse-Midwives, 2002)

\*Committee on the Future of Primary Care, Institute of Medicine, National Research

## **THE RELATIONSHIP OF STANDARDS OF PRACTICE TO LAW, ETHICS, QUALITY ASSURANCE & PERFORMANCE LEVELS AND EDUCATION**

### *The Impact of Practice Standards on Legal Proceedings*

Standards of care can play a very important part in malpractice and negligence law suits. Departures from standards of practice can place individuals in a position of liability and legal risk.

*Negligence* is defined "committing an act which a person exercising ordinary care would not do under similar circumstances definition - or the failure to do what a person exercising ordinary care would do under similar circumstances." (Legal Definitions, 2005). Additionally, it is defined as "The quality or state of being negligent; lack of due diligence or care; omission of duty; habitual neglect; heedlessness...Synonym: Neglect, inattention, heedlessness, disregard, slight" (Webster's Dictionary, 1998)

*Malpractice* is defined as " Evil practice; illegal or immoral conduct; practice contrary to established rules; specifically, the treatment of a case by a surgeon or physician in a manner which is contrary to accepted rules and productive of unfavorable results" (Webster's Dictionary, 1998).

In terms of legal suits, anyone can sue for anything they wish. For example, any patient can sue you for malpractice or negligence. When you are the defendant in a suit, you should not be so concerned about the fact that the person sued but, instead, you should ask yourself, "Can they win the lawsuit?" and "Does the malpractice or negligence suit have merit?"

Using standards of care, or practice, can answer these questions. When a plaintiff in the court of law files a suit saying that you did not do something you should have done, or that you did something that you should not have done, or that you did something in the wrong way, the next logical questions are:

- Did you fail to do something that you should have done? If so, who says that you should have done it?
- Did you do something that you should not have done? If so, who says that you should not have done it?
- Did you do something incorrectly or in the wrong way? If so, who says that you did something in the wrong way?

The answer to the "Who says?" questions should be the law, the practice act, the standards of care and the policies and procedures of the facility in which the care or service was provided. The "Who says" should not be a matter of personal opinion. Malpractice and negligence suits are lost when the healthcare professional rendering the care or service has followed the law, their practice act, the established standards of care and the policies and procedures of the healthcare facility.

The healthcare provider wins a legal negligence or malpractice suit against them when they are able to prove that they did the right thing in the correct manner, as per some established standard of care. Plaintiffs lose their suits against healthcare professionals when they cannot prove that another "reasonable person" under the same conditions would have done a different thing and/or would have done something differently. They lose their case when their opinion of what should have been done is not supported in established standards of care or practice, and/or in the law, the practice act and/or the policies and procedures of the healthcare facility.

Four components must be proven by the plaintiff, the person filing the lawsuit, in order to support a malpractice suit against a defendant, that is the individual or facility that is being sued. The plaintiff has the burden of proof. The defendant is considered not guilty if the plaintiff is not able to prove the following four essential elements of a malpractice suit.

1. *duty*. The basic client-midwife, or client-healthcare professional, relationship must be established with the implicit or explicit client and healthcare professional consent. Once this is established, clients become legally entitled to competent care that is consistent with established standards of practice. These standards include, but are not limited to, the healthcare professional's practice act, elements of the patient's bill of rights, and professional standards of practice established by professional organizations and associations, as appropriate, and with the healthcare facility's policies and procedures.
2. *breach of duty*. A breach of duty is best described as a failure to render care or perform an act in a manner that conforms with established practice standards. There must be a violation of one or more applicable standards of practice for the case to succeed. It must be proven in the court of law that the person rendering the care or service has failed to render care in the same way that a "reasonable" and "prudent" person would have, under the same circumstances. The care rendered has fallen below the normally acceptable level of quality. A healthcare professional's actions are compared and measured against established standards of care in the court of law. At times geography and the environment of care come into legal consideration. For example, a health care provider in a small rural hospital, far from appropriate transfer facilities, may not be held legally accountable for the same level of care rendered to a severe burn

patient as they would be in a larger metropolitan hospital with a burn unit.

3. *damages, injury or harm*. Many unacceptable acts and actions in healthcare fall below accepted levels of quality, however, they do not constitute a malpractice case if they do not cause harm, injury and/or damages to the affected individual. Harm, damage and/or injury must be proven in order for a malpractice suit to be won.
4. *a casual relationship between the breach of duty and the damages, injury or harm*. This element requires that proximate cause exists, that is, the plaintiff must prove that the breach of duty has caused the damage, injury or harm. When the sub-quality practice has a causal relationship to the injury, the unacceptable practice is considered the proximate cause of the injury.

## **CASE STUDY**

Melissa V. is a licensed midwife in the State of Florida with 5 years of experience as a licensed midwife. At approximately 7pm, the physician asked her to bring the Armstrong baby to the special procedures room for a circumcision.

After the circumcision was done she discovered that the wrong neonate was circumcised. She had brought the Baker infant into the special procedures room and the circumcision was done on the Baker infant without the consent of the Mrs. Baker. Proper identification of the neonate had also not been done. Although there was contributory negligence on the part of both the licensed midwife and the pediatrician who did the circumcision, it was not immediately clear whether the hospital too was at fault. It was also not immediately known whether or not the hospital had adequate policies and procedures in place to prevent this kind of wrong patient surgery.

After the incident was reported, a root cause analysis team was chartered to investigate the contributory causes, including the root causes that lead to this incident. Their findings indicated that:

1. The hospital had properly and completely oriented and trained Melissa to the newborn nursery area, using the standards of care for neonate care.

2. Melissa was deemed competent to perform the role(s) she was assigned to perform in the newborn nursery. These competencies were documented and accessible to her supervisor.

3. The hospital's policies and procedures failed in their ability to prevent sentinel events, like this one. They were in need of improvement. Specifically, there was no policy or procedure for neonate identification and no policy or procedure for pre-operative checks.

4. The Baker family does not have their male babies circumcised for cultural reasons.

Now, you are the judge in this malpractice suit.

The Baker family has initiated a malpractice lawsuit against the Melissa, the licensed midwife, the pediatrician and Elsewhere General Hospital.

*Using the four basic elements of a malpractice case as the framework, consider the following questions:*

#### *Duty*

1. Did the licensed midwife have a duty to act in this infant's care? Was the licensed midwife-patient relationship established?

2. Did the pediatrician have a duty to act in this infant's care? Was the physician-patient relationship established?

3. Did the hospital have a duty to act in this infant's care? Was the hospital-patient relationship established?

#### *Breach of Duty*

1. Did the licensed midwife act in the same manner that another reasonable and prudent person would have done under the same circumstances? Did the licensed midwife perform her role in a manner that is consistent with an acceptable level of quality? Did the licensed midwife perform her role in a manner that is consistent with accepted standards of practice and care?

2. Did the pediatrician act in the same manner that another reasonable and prudent person would have done under the same circumstances?

Did the pediatrician perform their role in a manner that is consistent with an acceptable level of quality? Did the pediatrician perform their role in a manner that is consistent with accepted standards of practice and care?

3. Did the hospital act in the same manner that another reasonable and prudent healthcare facility would have done under the same circumstances? Did the hospital perform its role in a manner that is consistent with an acceptable level of quality? Did the hospital perform its role in a manner that is consistent with accepted standards?

#### *Damage and Harm*

1. Did the neonate get harmed?
2. Did the Baker family get harmed?

#### *Causal Relationship: Did the Breach of Duty Cause Harm or Damage?*

1. Did the licensed midwife's acts of omission and/or commission lead to the harm? Were her actions the proximate cause of the damages?
2. Did the pediatrician's acts of omission and/or commission lead to the harm? Were their actions the proximate cause of the damages?
3. Did the hospital's acts of omission and/or commission lead to the harm? Were its actions the proximate cause of the damages?

#### *The Impact of Practice Standards on Ethical Practice*

Accountants, attorneys, real estate brokers, and government employees have codes of ethics that they must adhere to. Accountants are held accountable for honesty and honest accounting practices; real estate brokers are held accountable for disclosures regarding problems and potential problems, such as asbestos, lead and sink hole risks; attorneys are ethically bound to maintain confidentiality and privileged communication regarding some matters; and government employees are ethically bound to avoid any conflicts of interest. Recently, corporate ethics has become a national focus of attention, especially after the Enron Corporation collapse and their faulty accounting systems.

The ultimate purpose of ethical codes in the healthcare industry is to protect the rights and safety of the healthcare consumer. Healthcare

professionals must act ethically and adhere to their own professional codes of ethics.

Ethics is a body of knowledge containing values that are held by individuals or groups. Ethics and ethical codes in healthcare reflect four basic ethical principles, or underlying themes, that serve to organize the body of medical ethics and medical ethical decision-making.

These four ethical principles are:

- Autonomy,
- Beneficence,
- Nonmaleficence, and
- Justice.

*Autonomy* is "the quality or state of being self-governing; especially : the right of self-government; self-directing freedom and especially moral independence; a self-governing state" (Merriam-Webster, 2001).

*Beneficence* is defined as "the quality or state of being beneficent" (Merriam-Webster, 2001).

*Nonmaleficence* is best described as doing no harm. The Hippocratic Oath is an excellent example of how, historically, ethics and ethical principles have been in the healthcare profession throughout the ages.

*Justice* is defined as "the maintenance or administration of what is just especially by the impartial adjustment of conflicting claims or the assignment of merited rewards or punishments; the administration of law; especially : the establishment or determination of rights according to the rules of law or equity; the quality of being just, impartial, or fair; the principle or ideal of just dealing or right action; conformity to this principle or ideal; the quality of conforming to law; conformity to truth, fact, or reason; correctness "(Merriam-Webster,2001).

### *Autonomy*

The word autonomy is derived from the Greek word for self-rule. In reference to healthcare, autonomy is strongly linked to the client's right to decision-making and self-determination. All competent adults have the basic freedom to choose and make choices.

Patients and residents have a right to informed consent and informed refusal. They have the basic right to autonomous, knowledgeable decision-making and the ability to make choices, whether or not the healthcare provider(s) agrees with them or not.

Adults have the right to make decisions when they are of majority age, that is, at least 18 years of age, and they are deemed mentally competent to do so. Minors, on the other hand, are not legally able to make a decision about what care they will or not receive until they reach the age of 18 or they become a legally emancipated minor. Parents generally make legal decisions for minors. In some cases, a court appointed guardian makes these decisions, in the absence of a parent.

The adult consumer of healthcare services, or their surrogate, proxy, decision maker, has the right to consent to care and they also have the right to refuse any aspect of care or a treatment. These autonomous decisions are based on the individual's own unique values and beliefs; they are not based on what the healthcare provider feels is best for them. Self determination and autonomous decision-making must be ethically upheld by all healthcare professionals at all times.

### *Beneficence*

Simply stated, beneficence is doing good. Beneficence is doing the ethically correct thing. It reflects an individual's intentional acts, not errors and mistakes. Beneficence aims to promote the well being of others, not self. These intentional acts take into serious consideration the welfare of others. It is the welfare of others that is of greatest importance to healthcare professionals.

Beneficence challenges and ethical dilemmas in healthcare occur when it is not totally clear about what is truly good for a particular patient. Patient and resident needs are generally complex and approaches to care are numerous and varied. Many dilemmas arise because of these complexities and other factors.

The multidisciplinary healthcare team sometimes has difficulty arriving at a plan of care that is best for the patient and even then, not all members of the team may be in agreement about what course of treatment or care is best. Additionally, the autonomous decisions of the patient may make the "best" treatment options not feasible because the patient, resident or surrogate, proxy, decision maker has expressed the fact that they do not want a particular treatment or

intervention. Lastly, the team and patient or resident may collectively agree to what is best, but this option is not available or accessible to them and/or the option may not be legally permissible. For example, euthanasia is not legally permitted in our country. Any patient requests for euthanasia, therefore, cannot be supported because it is illegal. The healthcare team cannot agree to, or support, this option despite their own personal beliefs that euthanasia should be a legally acceptable and that this is the "best" option, especially when a patient or resident is using their right to self determination by expressing a desire for it.

### *Nonmaleficence*

Nonmaleficence literally means, "do not harm". Maleficence is defined as "doing harm". Nonmaleficence and beneficence are closely related, particularly in healthcare ethics, because many treatments and procedures have both benefits (beneficence) and risks for harm. Some of these risks can cause patient harm and pain (maleficence).

For example, a client under our care may choose to have parenteral nutrition to correct a nutritional deficit. Prior to consenting, the individual was correctly and completely informed about parenteral nutrition, its benefits and its risks, including those associated with infection. Alternatives to parenteral nutrition were also discussed with the patient, or proxy decision maker, as appropriate. If this patient chooses to have the parenteral nutrition and gets an infection as a result of it (maleficence), it is not considered unethical because the patient autonomously decided to have the parenteral nutrition after they were advised of the risks associated with this treatment and because the harm, or infection, was not done intentionally by the nurses and other healthcare professionals.

### *Justice*

The principle of justice entails fairness, impartiality, and justness. Challenges in the area of justice are numerous in the healthcare industry, particularly because fair and impartial access to care is sometimes not possible due to the constraints associated with healthcare dollars and the allocation of limited resources. These kinds situations are generally highly complex and difficult to resolve using justice alone as the ethical framework for decision-making.

Other healthcare situations, however, are easily addressed in terms of the principle of justice. Providing the same level of care and the same

level of quality for all those in our care, without discrimination, is straightforward and quite simple to ethically accomplish.

### *The Impact of Practice Standards on Quality and Performance*

Licensed midwives, and other healthcare professionals, are expected to provide high quality care and services that are consistent with established standards of practice generic to all licensed midwives in all settings and for their area of specialty. Healthcare professionals enter into a social contract with the patients that they provide care to. It, then, is their responsibility to fulfill this contract. Standards of care are one way for an individual, or a group (department) or the entire healthcare facility to objectively measure how well they are doing in terms of quality and performance.

Measurement capability is generally built into professional standards of care. For example, the American College of Nurse-Midwives (2003) has measurement capability built into their standards of practice. Standard II states:

*"MIDWIFERY CARE OCCURS IN A SAFE ENVIRONMENT WITHIN THE CONTEXT OF THE FAMILY, COMMUNITY, AND A SYSTEM OF HEALTH CARE.*

The midwife:

1. Demonstrates knowledge of and utilizes federal and state regulations that apply to the practice environment and infection control.
2. Demonstrates a safe mechanism for obtaining medical consultation, collaboration, and referral.
3. Uses community services as needed.
4. Demonstrates knowledge of the medical, psychosocial, economic, cultural, and family factors that affect care.
5. Demonstrates appropriate techniques for emergency management including arrangements for emergency transportation.
6. Promotes involvement of support persons in the practice setting." (American College of Nurse-Midwives, 2003).

All of the six criteria above are objective and measurable.

### *The Impact of Practice Standards on Education and Core Curriculum*

Basic entry-level education into the profession, inservice education and continuing education must be based on established standards of care. The Baker scenario above demonstrates how the hospital used established standards of care as the basis of their newborn nursery competency assessment and validation mechanisms.

Standards of care are the best framework to employ for education and training. These standards are valid and reliable; and they are not based on opinion or tradition, most are based on research.

### **STANDARDS OF CARE & EVIDENCE BASED PRACTICE GUIDELINES**

Recently, evidence based, or research based, practice guidelines have emerged onto the healthcare scene. The National Guideline Clearinghouse™ (NGC) collects and disperses these guidelines. Their clinical practice guidelines are “systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.” (National Guideline Clearinghouse, 2005).

According to the National Guideline Clearinghouse, all of the following criteria must be met in order for a clinical practice guideline to be included in NGC:

1. “The clinical practice guideline contains systematically developed statements that include recommendations, strategies, or information that assists physicians and/or other health care practitioners and patients make decisions about appropriate health care for specific clinical circumstances.
2. The clinical practice guideline was produced under the auspices of medical specialty associations; relevant professional societies, public or private organizations, government agencies at the Federal, State, or local level; or health care organizations or plans. A clinical practice guideline developed and issued by an individual not officially sponsored or supported by one of the above types of organizations does not meet the inclusion criteria for NGC.
3. Corroborating documentation can be produced and verified that a systematic literature search and review of existing scientific evidence published in peer reviewed journals was performed during the guideline development. A guideline is not excluded from NGC if corroborating documentation can be produced and

- verified detailing specific gaps in scientific evidence for some of the guideline's recommendations.
4. The full text guideline is available upon request in print or electronic format (for free or for a fee), in the English language. The guideline is current and the most recent version produced. Documented evidence can be produced or verified that the guideline was developed, reviewed, or revised within the last five years." (National Guideline Clearinghouse, 2005)

## **COMMONLY OCCURRING DEPARTURES FROM STANDARD OF CARE**

Some of the most commonly occurring departures from standards of care in healthcare include:

### *Legal Departures*

- Performing outside of one's scope of practice
- Delegating aspects of care to unlicensed personnel that are outside of their scope of practice
- Abandoning patients
- Altering a medical record

### *Ethical Departures*

- Failing to maintain the client's basic rights, such as the rights to dignity, privacy and confidentiality
- Rendering care with disregard for the patient and the quality of what is being done
- Not providing the same level of care to private payers as is provided to those on public assistance
- Neglected to report and follow up on unsafe, inadequate staffing issues
- Carrying out an inappropriate doctor's order

### *Practice Departures*

- Administration of the wrong medication to a patient as a result of a failure to perform each of the "rights of medication administration"
- Failing to provide appropriate techniques for emergency management including arrangements for emergency transportation.

## **LOCATING AND UTILIZING PROFESSIONAL STANDARDS OF PRACTICE**

### *Professional Standards Of Care From National Organizations and Associations*

The National Guideline Clearinghouse, which is an initiative of the Agency for Healthcare Research and Quality (AHRQ), is one of the best resources available on the web to locate evidenced based practice guidelines.

The National Guideline Clearinghouse permits the user to search by organization, by disease or condition and by treatment or intervention. Their website is <http://www.guideline.gov/>

Some of the organizations represented on this website include, among the many:

- Agency for Health Care Policy and Research
- Agency for Healthcare Research and Quality
- Agency for Health Care Policy and Research
- Agency for Healthcare Research and Quality
- American Medical Association
- American Medical Directors Association
- American College of Nurse Practitioners
- American College of Obstetricians and Gynecologists
- American College of Physicians
- American College of Preventive Medicine
- American College of Radiology

### *Professional Standards of Care That Address Specific Diseases and Conditions*

Some of the evidence based practice guidelines that address specific diseases and conditions, which can be found at the National Guideline Clearinghouse website, include:

- Cardiovascular Diseases
- Congenital, Hereditary, and Neonatal Diseases and Abnormalities
- Endocrine System Diseases
- Female Genital Diseases and Pregnancy Complications

### *Professional Standards of Care That Address Specific Treatments and Interventions*

- Catheterization
- Complementary Therapies
- Contraception
- Emergency Treatment
- Fetal Therapies

### *Some Professional Standards of Care For Nurses*

- [Neonatal Nursing: Scope and Standards of Practice](#) (04SSNN)
- [Nursing: Scope and Standards of Practice](#) (03SSNP)
- [Pediatrics Package](#) (SPN23))
- [Scope and Standards of Pediatric Nursing Practice](#) (PNP23)
- [Scope and Standards of Pediatric Oncology Nursing](#) (PONP20)

## **SUMMARY**

*Standards of practice* establish minimum practice guidelines and expectations. They establish and document what is considered acceptable practice within the profession. Legally and ethically, professionals are accountable for practicing in a way that is consistent with established standards of practice. It is critically important, therefore, that all healthcare professionals are familiar with these standards and that they apply these standards into their daily practice.

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