

Ontario Birth Centres: Facility Standards & Clinical Practice Parameters

For Midwife-Led Birth Centres

The College of Midwives of Ontario

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Preface

The care in a birth centre (BC) is midwife-led. In midwife-led care, the midwife is the most responsible professional in the planning, organization and delivery of care. The guiding principles of midwife-led care are the protection and promotion of normal birth, continuity of care and being cared for by a known and trusted midwife during labour. Overall, in a midwife-led model of care, there is an emphasis on the ability of women to experience birth with minimum intervention.

The care provided within BCs is consistent with the established philosophy of midwifery care in Ontario. The delivery of this care could include alternate practice arrangements for midwives with approval from the College of Midwives of Ontario (CMO).

The guiding principles of the Facility Standards and Clinical Practice Parameters (CPP) are as follows:

- Midwifery philosophy is maintained through full scope of midwifery practice and care
- BCs are not hospitals
- BC clients have received prenatal care from a midwife or midwifery practice group
- Midwives provide the same services in BCs as they provide in home settings
- Midwives in BCs provide services, in particular to vulnerable populations, in order to meet community needs and to make midwifery care outside hospital more accessible to women in Ontario
- BCs provide increased access to midwifery
- BCs provide an environment that is culturally safe with appropriate care
- BCs have a high volume of normal births providing a site for education and research
- BCs may offer complementary services (which are funded separately from core services) that meet the needs of the community

For details on the model of midwifery care see:

CMO Standard *The Midwifery Model of Care*

CMO Standard *Continuity of Care*

CMO Standard *Informed Choice*

CMO Standard *Consultation and Transfer of Care*

Using and Updating this Document

This document is comprised of two related but distinct components: facility standards and clinical practice parameters. The appendix (*Midwife-Led Birth Centres – Facility Standards and Clinical Practice Parameters: Legislation, Regulations, Standards, Guidelines and Required Protocols, Policies and Procedures*) applies to both components. This document has been written in a way that: intends to provide the larger, oversight requirements of BC operation and provision of care; and, allows users to review and use each component separately in their area of responsibility. This means that there is some intentional repetition between the facility standards and the clinical practice parameters.

These standards and parameters are subject to periodic review. Amendments in the form of replacement pages may be issued from time to time. Such pages will be posted to the CMO's website. A review of the parameters and standards is planned as part of the BC Pilot Project evaluation.

The College of Midwives of Ontario would like to acknowledge the work of the Winnipeg Birth Centre in developing policies and procedures and their generosity in sharing these with the CMO in the development of the CPPs.

Purpose of Facility Standards & Clinical Practice Parameters

The principle purposes of this document are to support midwives in implementing a Quality Management Program specific to BCs and to act as a guide for assessing the quality of client care provided in the centres.

Facility Standards & Clinical Practice Parameters: for Midwife-Led Birth Centres is a framework designed to assist midwives when providing care to women choosing to labour and give birth in a Birth Centre (BC).

Facility Standards and Clinical Practice Parameters (CPPs) are not intended to replace a midwife's clinical judgement. It is understood that the same standard of care that midwives provide in a home setting will be provided in the BC and that the tenets of continuity of care, informed choice, and choice of birth-place remain the foundation of the care delivered. All midwives working in a BC will follow one set of protocols, policies and procedures.

Role of the College of Midwives of Ontario

In developing CPPs, the College of Midwives of Ontario (CMO) worked to ensure that CPPs are:

- based on the appropriate mix of current, scientifically reliable information from research literature and clinical experience;
- implemented with procedures developed by consensus and consultation with the profession at large;
Note: *At the pilot phase, this consensus and consultation will include the professionals and communities leading and working with the pilot sites.*
- set exclusively from the quality of care perspective, as such, some of the conclusions reached could add to care costs;
- flexible enough to allow for a range of appropriate options including the need to take into account the variations in community need and resource realities from urban to rural areas;
- supportive and provide assistance to midwives and BC staff without restricting them to overly prescriptive or rigid formulas;
- updated regularly based on appropriate research studies and other learning;
- clearly stated to reduce uncertainty for midwives and improve their clinical decision making; and
- widely distributed to ensure that all midwives benefit from this knowledge.

Responsibilities of the College of Midwives of Ontario

Responsibilities of the CMO include:

- assessing the quality of care provided in BCs when requested by the Director of Independent Health Facilities (the Director). The CMO shall maintain a roster of midwives and other qualified persons to serve as assessors and inspectors as required;
- communicating with the Director about standards and issues that are conditions of BC funding;
- assessing each BC prior to it providing services to women;
- assessing service quality in facilities. The Better Outcomes Registry & Network (BORN) information system monitors individual and facility outcome performance; and
- providing education to BC staff so that they may continually improve the services they provide to clients.

The CMO works with BCs and their governing Board of Directors (Board) so that BCs can:

- develop a BC Quality Management Program that is based on the CPPs;
- monitor facility performance by conducting quality assessments;
- continually improve client services; and
- resolve issues and conduct reassessments as necessary.

Volume 1 Facility Standards

1 Organization and Administration

1.1 Client Services

1.1.1 General

Midwifery practice groups and midwives working in BCs shall be subject to regulation by the CMO for all of the care they provide both within and outside the BC.

A BC provides a comfortable, safe environment for women anticipating a normal labour and birth, and has provisions for client safety, privacy, and comfort. The BC has pre-arranged relationships with one or more hospitals for consultation with appropriate health care professionals and for transfer of care to hospital(s) with 24-hour obstetrical and neonatal care services.

1.1.2 Language

Every effort is made to provide services in both official languages, in accordance with the *French Language Services Act*, in those areas designated as being bilingual. This includes all written information and signs. Every effort is made in these areas to hire bilingual personnel.

1.1.3 Accessibility

BCs operate in accordance with the requirements of the *Accessibility for Ontarians with Disabilities Act*. This includes access to translation services and sign language interpretation.

1.1.4 Orientation

All clients using BCs are provided with orientation to the facility and services. Information, including admission criteria and continuation in the BC program of care, is provided in plain language, both in print and online.

1.1.5 Scope of Care

Midwives practising at the BC are required to abide by the College of Midwives of Ontario standards, which promote woman-centred decision-making, autonomy, and respect for choice. Midwives who provide care in the BC are responsible for prenatal care, intrapartum care, and postpartum care up to six weeks after the birth, regardless of location of birth.

The scope of practice of midwives in a BC shall be the same as in any other setting: the assessment and monitoring of women during pregnancy, labour, and the post-partum period and of their newborn babies; the provision of care during normal pregnancy, labour, and post-partum period; and the conducting of spontaneous, normal vaginal deliveries.

Because midwives are the only regulated health professionals caring for women at a BC, the following are examples of interventions and services that are NOT available and will form the basis of informed choice discussions with prospective clients. These examples are not considered part of normal pregnancy and childbirth and are not part of the BC or Ontario midwifery care regardless of where the midwifery services are provided:

- (a) pharmaceutical augmentation or induction of labour;
- (b) epidural, regional and/or general anaesthesia;
- (c) forceps or vacuum extractions;
- (d) caesarean section;
- (e) narcotic analgesia.

1.1.6 Practice Arrangements

If a midwifery practice group is to operate its clinic within the BC (i.e., if the BC is the only or the primary location of clinic services for that practice), space and resource requirements must be considered and appropriate policies and procedures must be in place to address any issues that may arise from this arrangement.

1.1.7 Unfunded Services

Complementary, unfunded services through individual contracts with the Ministry of Health and Long-Term Care may also be offered in the BC. Relationships with all organizations or groups with which the BC has formed an alliance in order to provide services shall be governed by agreements/contracts between the service provider(s) and the Ministry of Health and Long-Term Care. These agreements/contracts should ensure that core services are not compromised and that resources (space, equipment, supplies, personnel, funding, etc.) are protected.

1.2 Governance

1.2.1 General

The BC is a not-for-profit corporation with a governing Board and is separate from other health, hospital, or medical services. The BC Board plays a significant role in the guidance of the organization. In achieving its success, the Board governs and works as a team towards achieving goals. Exercising collective influence, Board members have no individual authority or power. The Board has a shared responsibility with the midwives and other staff working in the BC to ensure the care provided is safe, of high quality and meets the needs of the women who choose to give birth there.

How a Board governs affects an organization and impacts the service that it provides. Fully adopting best practices in governance helps the BC Board operate at an optimal level and achieve the goals of the organization.

Effective governance is responsive to the changing needs of the community being served, and to the professionals and staff providing services. Since each BC will be operating in a unique community, the Board may choose to adapt practices in the way that is most suitable to their community.

1.2.2 Partners and Stakeholders

The Board includes representation from all partner organisations or groups providing services in the BC.

Mechanisms exist to ensure meaningful input is sought from all key stakeholder organisations or groups.

1.2.3 Accountability

Accountability involves a formal relationship between parties where responsibility is conferred and accepted. It includes an obligation to report on the execution of that responsibility.

The BC Board has a formal accountability relationship with the Ministry of Health and Long-Term Care pursuant to the Terms of Funding.

In turn, the BC Leadership Team is accountable to the BC Board.

The BC has a complete accountability framework articulated in writing. It is based on:

- clear roles and responsibilities
- clear performance expectations
- balanced expectations and capacities
- credible and timely reporting
- reasonable review and adjustment

The BC Board has policies that provide the framework for organisational governance that adhere to the following minimum requirements:

- (a) The BC Board oversees the recruitment, hiring and performance of the Midwifery Program Director.
- (b) The BC Board oversees the recruitment, hiring and performance of the Administrative Director.
- (c) There is a conflict of interest policy that is reviewed prior to every meeting of the Board.
- (d) There is effective and complete documentation of all Board activities (e.g., meeting minutes, current policies and procedures, adequate financial reporting, etc.).
- (e) The BC Board effectively communicates information among its members, to groups with whom the BC has an alliance or partnership and to stakeholders.
- (f) The BC Board membership is well managed and encompasses the skills and competencies required to reflect the community it serves.
- (g) Individual members of the BC Board demonstrate high standards of professional conduct.
- (h) The BC Board regularly evaluates its performance and revises its structure or policies.
- (i) The BC carries liability insurance as required by the Director pursuant to the Funding Agreement.

1.3 Organization and Administration

The BC shall adhere to the following minimum administrative requirements:

- a) There is a written plan for the operation of the centre, including mechanisms for operation in the absence of the Administrative Director, which is consistently followed.
- b) There is evidence of consistent adherence to generally accepted accounting principles.
- c) There is a written organizational chart that delineates the current responsibilities, both clinical and administrative, within the BC.
- d) There is an orientation program and a continuing education program for all staff.
- e) All staff receive evaluations of their performance on a regular (i.e., annual or more often as needed) basis as defined by the BC Leadership Team.
- f) Fire and emergency drills are held regularly.
- g) There are mechanisms in place, which are consistently followed, for staff to review the results of quality management activities, plan corrective actions, and monitor effectiveness of action(s) taken.
- h) There are written agreements for contracted and/or purchased services obtained from individuals or other facilities. Agreements are reviewed regularly.
- i) Contracts for student health professional clinical placements are approved by the BC Leadership Team and the professional staff member(s) responsible for the provision of services to women/newborns.
- j) There is a plan for informing the community of the services provided in the BC.
- k) Policies relating to the organization and administration of the BC will be revisited on a regular basis.

2 Staffing a Birth Centre

2.1 Staff Requirements

2.1.1 General

2.1.1.1

Qualified health professionals provide care in BCs. The complement of midwives providing services at a Birth Centre (BC) is a viable number that can provide intrapartum backup and a workable call structure based on the model of care, which requires a Registered Midwife and a qualified second attendant dedicated to the care of each woman. A written staffing model (that includes job descriptions for both clinical and non-clinical staff) shall be in place and consistently followed to ensure that women will receive safe care 24 hours a day, 7 days a week, and 365 days a year.

2.1.1.2

There shall be sufficient ancillary and administrative personnel to ensure:

- (a) efficient administrative operation of the BC;
- (b) security and safety for all staff, clients and visitors;
- (c) availability of appropriate educational and support programs;
- (d) appropriate and timely cleaning and maintenance of the facility; and
- (e) access to any other services offered.

2.1.1.3

The BC complies with all relevant workplace health and safety and employment standards and laws.

All registered midwives are ethically obligated to know their personal serologic status with respect to HBV, HCV and HIV. Periodic testing is recommended for the midwife's health and to prevent exposing their clients to infection.

All providers have an ethical obligation to determine their serologic status following any direct exposure to blood or human tissue in the workplace, e.g. needle stick injury, and to follow any subsequent reporting requirements of Public Health.

2.1.2 Health Professionals

Health professionals providing services in the BC shall:

- (a) be currently registered with the relevant regulatory College in the province of Ontario or appropriate governing body;
- (b) meet the credentialing requirements as set out by the Board;
- (c) maintain and provide evidence acceptable to the Board of the knowledge and skills required to provide the services offered by the BC;
- (d) maintain and provide evidence of continuing education appropriate to the position;

- (e) have malpractice insurance coverage to a level acceptable to the appropriate regulatory body;
and
- (e) practice within their own scopes of practice but will maintain alignment with the principles of midwifery care in Ontario.

2.1.2.1

There will be adequate numbers of professional and support staff on duty and on-call 24 hours a day, 7 days a week, to meet the demands for services routinely provided, and in periods of high demand or emergency, to ensure the woman's/newborn's safety.

Health professionals who have and maintain current certification in maternal cardiopulmonary resuscitation (CPR), newborn resuscitation (NRP), and emergency skills (ES) are present at each birth.

2.1.3 Administrative Professionals and Support Staff

Administrative professionals, including a qualified Administrative Director with authority, responsibility and accountability for overall centre administration, will be on staff to support the effective operation of the BC. In order to ensure the safety of all clients, families, and staff using the building on a round-the-clock basis, security staff will also be retained.

2.2 Credentialing and Maintenance of Privileges

2.2.1 Credentialing

The BC Board of Directors credentials all midwives and other health professionals providing services and care in the BC. This process includes:

- (a) identified professional staff categories and duties;
- (b) an established credentialing process that involves obtaining information from the relevant health regulatory college for initial appointments and re-appointments, and which includes confirmation of current registration with the appropriate regulatory body;
- (c) the requirement that each professional signs a consent for their regulatory body to release to the BC registration information in a Letter of Professional Conduct or equivalent; and
- (d) a process for monitoring and reporting suspension and revocation of privileges in accordance with the Health Professions Procedural Code's mandatory reporting requirements.

2.2.2 Non-midwifery Professionals Providing Care in the Birth Centre

2.2.2.1

Other personnel may be utilized by the BC on a consultant basis to support choices, respond to a community need, or support full provision of care. A list of consultant personnel providing health services in the BC shall be maintained and each individual must be privileged and authorized by the BC.

2.2.2.2

A BC may engage with allied health professionals to provide services in the BC. Some may be involved on a collegial or consultative basis in the care of the midwife's clients. These health professionals are currently registered to practice their profession in Ontario and function within the scope of practice outlined by their College.

2.2.2.3 Alignment with Midwifery Philosophy

Health professionals will be accountable to their own regulatory bodies. Any professional providing care in the BC will do so in a way that is aligned with the midwifery philosophy, which is an evidence-based philosophy supporting normal labour and birth.

Appropriate interdisciplinary agreements will be in place to support effective collaboration.

3 Quality Management in the Birth Centre

3.1 Quality Advisor

3.1.1 General

As outlined in the *Independent Health Facilities Act* (IHFA) General O. Regulation 57/92, every BC shall appoint a Quality Advisor to provide advice to the BC Board with respect to the quality and standard of services provided in the BC. The Quality Advisor of a midwife-led BC shall be a Registered Midwife with no terms, conditions or limitations on her certificate of registration.

The BC shall have a designated Quality Advisor who is the Midwifery Program Director of the BC. The Quality Advisor chairs the Quality Advisory Committee of the BC as required by regulation under the IHFA.

There shall be a written agreement between the Quality Advisor and the BC.

3.1.2 Responsibilities

The Quality Advisor advises the BC Board with regard to the quality of services provided. The Quality Advisor is responsible for advising the Board on the professional aspects of the BC which include, but are not limited to, the following:

- (a) establishment and maintenance of a safe environment for professional and other staff and women/newborns;
- (b) supervision of all clinical and professional activities;
- (c) selection and appointment of staff and the annual review of privileges granted to each member of staff;
- (d) the accuracy and reliability of the appropriate equipment used in providing care and appropriate training of all staff who use equipment;
- (e) remote power supply monitoring and backup power available;
- (f) maintenance of all necessary clinical records with adherence to client confidentiality;
- (g) establishment of a Quality Management Program; and
- (h) completion of a CMO-approved assessment plan.

3.1.3 Reporting Requirements

Whenever the Quality Advisor has reasonable grounds to believe that any aspect of the services provided in the BC are not being provided in accordance with generally accepted professional standards or has reasonable grounds to believe that not all persons who provide services in the BC are qualified to do so, the Quality Advisor reports these concerns in writing to the Director, IHF forthwith.

3.1.4 Role

The Quality Advisor or her designate shall:

- (a) be physically present as the Midwifery Program Director at the BC on a regular basis, and be available for consultation at any time when services are provided. All interactions and consultations between the Quality Advisor and BC staff or Board shall be documented;

- (b) seek advice from other health care professionals where necessary to ensure that all aspects of the services provided through the BC are provided in accordance with generally accepted professional standards; and
- (c) consult with the Quality Advisory Committee at least quarterly and document the substance of the discussion, actions agreed upon, and the completion date for any actions agreed upon.

3.1.5

The Quality Advisor shall advise the Board and document advice concerning, but not limited to, the following:

- (a) the qualifications, selection and ongoing education of the professional and other staff working in the BC;
- (b) whether adequate and appropriate staffing, equipment and procedures are available to ensure client and staff safety in the BC;
- (c) testing being performed on a periodic basis to ensure the accuracy and reliability of the BC's equipment;
- (d) the proper design of consultation requests, performance protocols, documentation, and reports used at the BC; and
- (e) the facility's policies regarding the maintenance of all appropriate clinical records, including their maintenance for the required length of time.

3.2 Quality Advisory Committee

The BC shall have a Quality Advisory Committee (QAC) as required by the IHFA General Regulation. The QAC consists of representatives from the BC Board and health care professionals who provide services in or in connection with the BC.

The QAC, whose chair is the Quality Advisor, shall have a mechanism in place to regularly solicit input from consumers, relevant health professionals, appropriate agencies from the community, and professional and non-professional BC staff.

4 Facility Emergency Protocols

4.1 Emergency Protocols

The BC shall have and consistently follow appropriate written policies and safety procedures for emergencies, including but not limited to:

- (a) a pre-arranged relationship and an emergency plan with local emergency health services;
- (b) written emergency protocols (e.g., fire, pandemic planning) shall be available to all midwives and staff; and
- (c) fire and emergency drills shall be held regularly, according to best practices.

4.2 Emergency Transfer and Transfer of Woman/Newborn

The BC shall have and consistently follow appropriate written policies and procedures for the emergency transfer of a woman/newborn including the requirement that prior arrangements for the care of the woman/newborn be in collaboration with a receiving health facility in the event of an emergency. These prior arrangements include the following:

- (a) an agreement to follow the CMO Standard *Ambulance Transport*
- (b) the designation of who in the BC is responsible for contacting the receiving health facility, and who in the receiving facility is to receive the woman/newborn following transport;
- (c) the specific kind of documentation to be used to facilitate the transfer;
- (d) the role of the health professional in the receiving health facility; and
- (e) accommodation to allow students to continue their role in the care of clients in the event of a transfer.

4.3 Hospital Privileges

The BC shall have and follow appropriate written procedures to address situations where a BC health care professional:

- (a) has admitting privileges at the receiving health facility;
- (b) does not have admitting privileges in the receiving health facility; or
- (c) has had hospital privileges denied or revoked.

5 Health Records

Health records provide a format for continuity of care and documentation of legible, uniform, complete and accurate maternal and newborn information. Records are readily accessible to health care professionals and maintained in a system that protects confidentiality, provides for storage, retrieval, and prevention of loss.

An appropriate system for processing, maintaining, storing, retrieving and distributing health records shall be established, and consistently followed, as required by the General Regulation under the *Independent Health Facilities Act*, the *Regulated Health Professions Act*, relevant privacy legislation including the *Personal Health Information Protection Act*, the *Midwifery Act*, and the CMO Standard *Record Keeping*.

6 Facilities, Equipment and Supplies

6.1 General

A BC is equipped to provide a safe environment for an uncomplicated labour and birth. It is also equipped for the management of obstetrical emergencies in the midwifery scope and emergency transfers.

The physical facility of the BC is adequate to accommodate clients for the level of care required for uncomplicated labour and birth and the immediate postpartum care of healthy women and newborns. The CMO Standard *Consultation and Transfer of Care* shall be consistently followed. This means that women who require interventions outside the midwifery scope of practice or who require ongoing monitoring beyond what the midwife is able to provide in the BC will need to be transferred to hospital for continuing care. For this reason, the BC is not equipped for prolonged stays for clinical reasons, although it is equipped to be open 24 hours a day as needed to accommodate women labouring and giving birth at any time.

There is space for furnishings, equipment and supplies to comfortably accommodate the childbearing woman, families, staff, midwives and other health professionals, including students, providing services. The physical facility is adequate to ensure privacy for every client. Appropriate government bodies will review the specifications and safety where necessary (e.g. Public Health for kitchen areas and appliance suitability and safety). Records for any evaluations will be maintained and stored.

6.2 Physical Facility and Equipment

6.2.1

The facility meets all construction, fire, safety, and health codes as well as zoning regulations appropriate to a BC. The minimum requirements of the BC are that it complies with the following:

- (a) Canadian Standards Association (CSA) health care facilities requirements;
- (b) Ontario Building Code (OBC) for life safety issues including CSA and other building systems standards embedded within the OBC;
- (c) accessibility requirements in accordance with the *Accessibility for Ontarians with Disabilities Act*, to support client, family and staff needs;
- (d) *Occupational Health and Safety Act*; and
- (e) infection control guidelines and standards and Provincial Infectious Disease Advisory Council (PIDAC) best practices.

6.2.2

Taking into account all of the services being provided at the BC (i.e., both core function and any additional non-funded services) the specific considerations that must be made include, but are not limited to, the BC complying with:

- (a) Building Codes

- i. BC site complies with all applicable building codes, including fire and life safety requirements.
- (b) Electrical
- i. Electrical hazards are managed according to applicable codes.
 - ii. All electrical devices are certified.
 - iii. Emergency power supply can provide for safety of clients
- (c) Access
- i. Allows barrier free access in accordance with provincial legislation and municipal by-laws.
 - ii. Doors and corridors can safely accommodate stretchers and wheelchairs.
 - iii. Elevators and stairwells are equipped and maintained to enable evacuation/transport
- (d) Size
- i. BC size is adequate for all care to be provided safely, to accommodate volume of births, to ensure client comfort and privacy and to accommodate any unfunded services being provided.
- (e) Ventilation
- i. Ventilation must ensure client and staff comfort. Where applicable, ventilation and air circulation should be augmented to address care-related air-quality issues (e.g., use of nitrous oxide as analgesia for labour and postpartum).
- (f) Medical compressed gases and pipelines
 Medical compressed gases and pipelines must comply with:
- i. Canadian Standards Association standards;
 - ii. Specific applicable recommendations arising from provincial legislation; and
 - iii. A second supply of oxygen (normally a spare cylinder) with pressure gauge, regulator, and wrench shall be available.
- (g) Layout
 Layout facilitates safe client care and client flow.
- The following areas are physically separate, where appropriate:
- i. administration and client-waiting area;
 - ii. personal health information storage;
 - iii. birthing room, including washroom facilities;
 - iv. emergency exit(s);
 - v. clean utility area ;
 - vi. dirty utility room;
 - vii. non-sterile storage area;
 - viii. sterile area;
 - ix. staff rooms, including washroom facilities;
 - x. public washroom; and
 - xi. kitchen.
- (h) Safety
- i. Provisions are in place to ensure client, staff and public safety. This includes but is not limited to lighting as required for provision of care and movement in and around the BC.
- (i) Emergency Measures
 Provisions are in place to ensure:

- i. Safe evacuation of clients and staff in case of any emergency (i.e., stretchers, wheel-chairs, or other adequate methods of transport are available);
- ii. Easy access for an ambulance to transfer clients to a hospital; and
- iii. Ready access to resuscitation equipment (maternal and neonatal).

(j) Infection control

Provisions are in place to ensure that the BC can comply with all relevant infection control guidelines. This includes, but is not limited to such measures as:

- i. floors, walls, baths and furniture that can be cleaned to meet infection control requirements;
- ii. adequate hand-washing facilities and proper towel disposal;
- iii. laundry facilities suitable for linens and birth supplies and appropriate clean storage;
- iv. openings to the outside effectively protected against the entrance of insects or animals by self-closing doors, closed windows, screening, controlled air current, or other effective means;
- v. space that can accommodate required equipment and staff; and
- vi. appropriate measures to prevent and address infestation.

6.2.3

The facility maintains a record of periodic inspections by the Health Department, Fire Department, building inspectors and other officials concerned with public safety. The facility is also barrier free and accessible to emergency stretchers.

6.2.4

Smoking is not permitted in the facility.

6.2.5

The facility is neat and clean.

6.2.6

Additional space is available for services including, but not limited to:

- (a) business operations;
- (b) secure health records storage;
- (c) secure pharmacological storage;
- (d) waiting/reception rooms;
- (e) TTY telephones;
- (f) family room and play area for children;
- (g) client conference rooms;
- (h) family kitchen facilities;
- (i) toilet for individuals accompanying the woman;
- (j) bath and toilet facilities for all labouring women;
- (k) appropriate access to parking;
- (l) utility/work areas, storage areas;
- (m) adequate information technology (IT); and

(n) staff area, including hand washing, kitchen, bathing, and sleeping facilities.

6.2.7

Equipment and space is in, or available to the BC to provide for:

- (a) sound proofing between rooms;
- (b) internal communication system;
- (c) portable lighting and heating sources;
- (d) emergency lighting and heating sources;
- (e) hot water heaters with adequate water pressure;
- (f) hot water and tub facilities available to all labouring women;
- (g) sterilization facilities;
- (h) access to information and communication technology; and
- (i) laundry equipment.

7 Providing a Sanitary Environment

7.1 General

BCs follow best practices and standards established by the Provincial Infectious Diseases Advisory Committee (PIDAC) and the Canadian Standards Association (CSA) to ensure the following basic requirements:

- (a) The facility provides a sanitary environment.
- (b) The facility is clean and properly maintained.
- (c) Adequate toilet facilities are available for staff, visitors and clients.
- (d) Birthing rooms and any areas where a woman's assessment is carried out have facilities for hand washing.
- (e) The kitchen area is cleaned and maintained according to BC policies.

7.2 Infection Control Practices

BCs adhere to:

- (a) accepted standards of infection control practices pertinent to the care provided and the procedures performed at the BC as a means to protect both health care workers and clients at the BC; and
- (b) actions that minimize the risk of infection, including:
 - i. adhering to proper use of disinfectants;
 - ii. maintaining equipment properly;
 - iii. handling regulated waste according to accepted standards; and
 - iv. observing body fluid precautions.

7.3 Using Sterile Techniques

Operative procedures and invasive procedures are carried out using sterile techniques.

7.4 Disposing of Biomedical Waste

All biomedical waste is discarded in accordance with the current PIDAC Guidelines. All staff, including housekeeping, are trained in accordance with *Routine Practices and Additional Precautions In All Health Care Settings* (PIDAC, 2011).

8 Equipment and Supplies Management

8.1 Drugs and Other Substances

8.1.1

An appropriate drug inventory system shall be in place and consistently used. Periodic inspection, in accordance with best practices, is conducted to ensure restocking takes place and all out-dated drugs are replaced and properly discarded.

8.1.2

Sufficient supplies are available for the administration of medications and intravenous fluids as authorized in Ontario Regulation 884/93, *Designated Drugs*.

8.1.3

Medical gases that are within the midwifery scope to administer (i.e., oxygen and nitrous oxide) shall be available to all women delivering in the BC. The BC shall have appropriate equipment and physical facility standards to ensure the safe storage, administration, and removal of these gases.

8.2 Birth Equipment

8.2.1

All equipment is available, in a readily accessible manner, to allow health care professionals to respond to potential and actual emergency situations in the facility during the antepartum, intrapartum and postpartum periods.

8.2.2

Equipment necessary to care for women anticipating a normal labour and birth, and for newborns is on site in the BC. This includes, but is not limited to that required by the CMO Standard *Essential Equipment, Supplies and Medications*.

8.2.3

Equipment on site includes, but is not limited to, that which is necessary to perform the following procedures:

- (a) physical assessment of mother and baby;
- (b) drug administration
- (c) collection of laboratory specimens (blood, urine, cultures, and smears);
- (d) amniotomy (including detection of amniotic fluid via microscope);
- (e) episiotomy and episiotomy/laceration repair;
- (f) sharps disposal;
- (g) biomedical waste disposal;
- (h) sterilization of instruments;
- (i) resuscitation of mother and newborn including portable or wall suction and portable or wall oxygen; and

- (j) weighing the newborn

Portable lighting and portable heat sources shall be available as well as equipment and supplies as necessary to comply with best practices for infection prevention and control.

8.2.4 Equipment for Maternal and Newborn Emergencies

Suitable equipment for both maternal and newborn emergencies is required. Equipment includes, but is not limited to:

- (a) intravenous supplies;
- (b) medications used for maternal bleeding;
- (c) maternal and newborn resuscitation;
- (d) blood collection equipment;
- (e) appropriate equipment to administer oxygen and perform suction;
- (f) nitrous oxide; and
- (g) equipment packaged and readily available for maternal or newborn transport by ambulance.

8.2.5 Equipment for Non-Obstetrical Emergencies

Suitable equipment for non-obstetrical emergencies is also available at the birth centre for all visitors, clients and staff and includes, but is not limited to:

- (a) portable emergency resuscitation station;
- (b) defibrillator; and
- (c) epinephrine for anaphylaxis.

Volume 2 Clinical Practice Parameters

9 Planned Place of Birth

9.1 Risk Assessment

The risk criteria for determining eligibility for admission of a woman to and continuation in the Birth Centre (BC) program of care is established based on the CMO Standard *Consultation and Transfer of Care*.

An out of hospital birth is defined as a birth conducted by a primary care provider where other specialized medical care (obstetrical, paediatric, surgical and/or anaesthetic skills) is not provided on site. A BC is such a site.

The choice of birth place should be assessed individually and throughout the course of care for every midwifery client. This assessment may go beyond clinical indications to encompass psychological or other considerations.

Decisions about whether an out of hospital birth is suitable are based on the judgment of the care provider in collaboration with the informed choice of the client. The obligation to ensure that the client is fully informed of the risks, benefits and alternatives to giving birth in the BC rests with the midwife.

Care providers must take into account factors such as distance, weather conditions, availability of emergency support systems, family and environmental supports, and any relevant psychosocial factors when determining the appropriateness of a particular birth setting.

9.2 General Guide for BC Births

1. The woman is in good health;
2. The woman is experiencing an uncomplicated pregnancy;
3. The fetus is expected to be healthy at birth;
4. The woman and her care provider have a reasonable expectation of having an uncomplicated labour and birth;
5. The woman has received adequate prenatal care by a privileged BC provider;
6. The care provider is able to monitor the well-being of the mother and the fetus during the pregnancy and birth process using available clinical methods, skills, equipment and laboratory testing;
7. There are no impediments to instituting common emergency procedures if necessary, e.g., IV's, position changes, etc.;
8. There are no difficulties foreseen in transporting the mother/newborn with the usual emergency transport system;
9. The woman has a means of transporting herself and her newborn to and from the BC; and
10. The result of consultations, when required, is confirmation of healthy pregnancy or labour progress.

10 Transfer from the Birth Centre

10.1 General

There is an appropriate written plan developed in collaboration with all hospitals with which the BC has a relationship. In particular, the BC shall have prior arrangements in place for transfer of care between sites. A BC liaises with local hospitals, consultants and emergency services. Optimal safety is ensured with the maximum cooperation between all health care providers and services including hospital emergency services and BC midwives and staff.

10.2 Non-emergency Transports

The majority of transports from out of hospital births into hospital are in non-emergency situations. In non-emergencies, consultation and transfer of care may take place pursuant to the arrangements the attending midwife has with the hospitals at which she has admitting privileges. Non-emergency transports will generally not use emergency services.

10.3 Emergency Transports

In emergencies, the midwives at the BC shall make every effort to accommodate a rapid transfer of care to the closest hospital with obstetric and/or neonatal care.

10.4 Guidelines for Maternal/Newborn Transport

BC policies and procedures with all collaborating hospitals shall be agreed upon and documented. These will be in place for the emergency management and non-emergency transport of the woman/newborn. The BC will document and review transports in a timely manner.

Prior arrangements for the care of the woman/newborn shall be made with the receiving health facility in the event of an emergency. In those situations where the health and safety of the woman and/or newborn are at risk, the woman/newborn is offered transport by the most expeditious means to the receiving facility.

There is an appropriate written policy on maternal/newborn transport that is made available to staff and to all clients upon intake into care. If the woman refuses the transfer, the attending health professional should obtain written confirmation from the woman that she is refusing the transfer and if the woman refuses to provide such written confirmation, the attending health professional must document such refusal.

11 Equipment, Supplies, and Medication

BCs shall abide by the relevant CMO standards related to equipment, supplies, and medications. BCs shall have proper procedures that are consistently followed to ensure that equipment, supplies, and medication are appropriately stocked, safely stored and maintained, and readily accessible for the care of every woman and newborn.

Resources needed for any unfunded services offered in the BC will also be stocked, stored, maintained, and accessed in a way that ensures the comfort and safety of all women, staff, and the public.

See the following CMO documents for information on equipment and medications:

CMO Standard Essential Equipment, Supplies and Medications

Amended Ontario Regulation 884/93 Designated Drugs

CMO Standard Prescribing and Administering Drugs

12 Infection Control

In order to maintain a safe environment for women and newborns, as well as all staff at the BC, up to date knowledge and best practices in infection control shall be utilized at the BC. The following items form the basis of the policies and procedures relating to infection control in the BC.

Staff providing care at a BC will be responsible, at a minimum, for:

- (a) knowing what the current infection control guidelines are for the practice setting;
- (b) assessing risks and knowing how to apply infection control procedures;
- (c) adhering to current infection control programs;
- (d) educating and modelling infection control practices for others;
- (e) being aware of what infection control resources are available;
- (f) advocating for best practices in infection control;
- (g) ensuring ongoing quality of infection control practices;
- (h) utilizing the personal protective equipment that is made available to them by the BC including clothing to be worn only on-site while on duty at the BC; and
- (i) monitoring changes to infection control practices and updating practise accordingly.

BCs shall be prepared to dispose of placentas in accordance with best practices in infection control and to accommodate clients who wish to keep their placenta after giving birth. Placentas will be retained for evaluation and sent to pathology in cases where the newborn is suspected to be compromised.

13 Laboratory and Diagnostic Testing

Laboratory and other diagnostic testing will be done in accordance with the midwifery scope of practice and the CMO Standard *Laboratory Testing* and the *Laboratory and Specimen Collection Centre Licensing Act, 1990*.

Access to laboratory and diagnostic testing services shall be established with appropriate service providers and shall be available in a timely manner.

The BC shall develop appropriate detailed internal policies and protocols related to laboratory and diagnostic testing and results. The BC shall have policies and protocols developed with any hospitals providing obstetrical and newborn care, emergency transport services, and laboratory and diagnostic services.

14 Quality Management

14.1 Quality Management Program

A robust Quality Management Program is a planned, systematic and comprehensive strategy that permits internal and external review of the quality of care provided in order to provide safe and responsive care to women and newborns.

There is an appropriate established policy for evaluating the quality of direct care services to childbearing families, and the environment in which the services are provided, which includes a clear process to identify and resolve problems that arise between clients and providers as well as between providers. This process does not replace the client/practitioner complaints or the mandatory reporting processes and obligations under the RHPA but should be part of an internal policy and process that is utilised to address client and provider concerns in a proactive manner.

A BC will develop appropriate protocols for record keeping and data collection that meet the requirements set out by the CMO and MOHLTC. Analysis of data may lead to recommendations by the CMO or MOHLTC for changes to policy or clinical practice.

14.2 Assessment Protocols

A BC shall have appropriate protocols that include, but are not limited to, assessment of the following areas:

- (a) outcomes of maternal and newborn care;
- (b) client and community satisfaction;
- (c) provider satisfaction;
- (d) compliance with the BC's stated goals;
- (e) compliance with and effectiveness of midwives' practice protocols;
- (f) compliance with CMO standards of practice; and
- (g) compliance with and effectiveness of the BC's administration and organization protocols.

14.3 Clinical and Organizational Practice Protocols

BCs shall have appropriate clinical and organizational practice protocols that conform to the CMO's protocol requirements that are followed by all care providers. Clinical protocols shall allow midwives to use clinical judgement in providing safe, responsive care for their clients and shall:

- (a) allow for client decision making;
- (b) allow the midwife to work fully within the scope of midwifery care;
- (c) be based on current available scientific evidence and take into account health care practices in local and comparable communities;
- (d) be dated, reviewed, and updated at specific intervals; and
- (e) be developed by midwives practising at the BC and reviewed and approved by the BC's Board.

14.4 Woman/Newborn Care

The BC shall implement the following quality management activities related to direct woman/newborn care:

- (a) annual (at least) review of protocols, policies, and procedures related to maternal and newborn care;
- (b) evaluation of the process for determining eligibility for admission to and continuation in the BC program of care;
- (c) evaluation of the appropriateness of medications prescribed, dispensed, or administered in the BC;
- (d) performance evaluations of health professionals employed by or on the staff of the BC (peer review and self-evaluation);
- (e) regular meetings of health professionals to review the management of care of individual women/newborns and to make recommendations for improving plan of care;
- (f) regular review of transfers of women and newborns to hospital care to determine appropriateness and quality of the transfer;
- (g) regular review and evaluations of significant problems or complications of pregnancy, labour, and postpartum and the appropriateness of the clinical judgement of the health professional in obtaining consultation and attending to the problem;
- (h) regular review of all health records for legibility and completeness; and
- (i) evaluation of staff ability to manage emergency situations by unannounced periodic drills for woman and newborn emergencies.

14.5 Maintaining a Safe Environment

The BC shall implement the following quality management activities related to maintaining a safe environment:

- (a) routine testing of the efficiency and effectiveness of all equipment;
- (b) routine review of housekeeping procedures and infection control;
- (c) evaluation of maintenance policies and procedures and infection control procedures;
- (d) evaluation of maintenance policies and procedures for heat, ventilation, emergency lighting, waste disposal, water supply, and laundry and kitchen equipment; and
- (e) evaluation of staff on their ability to manage emergency situations by regularly holding fire, power failure, and natural disaster drills.

Staff members shall participate in the development and implementation of quality management activities, the review of information resulting from these activities, the planning to address any deficiencies identified, and the review of effectiveness of any corrective actions taken on the deficiencies.

14.6 Compliance with the Birth Centre's Stated Goals

A BC shall have a mission statement. Every year the BC Board will undertake a self-evaluation to assess how well it has met its stated goals and report the findings to the BC Board of Directors, staff, and stakeholders, including the CMO.

14.7 Clinical Care Provided

A BC shall collect data on the outcome of client care. This data will include but not necessarily be limited to the following:

(a) Outcomes

- i. number of spontaneous vaginal births;
- ii. number of newborns;
- iii. newborn birth weights;
- iv. newborn APGAR scores;
- v. number of newborns breastfed;
- vi. time spent in BC by client;
- vii. neonatal morbidity/mortality;
- viii. maternal morbidity/mortality; and
- ix. number and types of interventions needed including
 1. perineal repairs
 - a. lacerations and degree;
 - b. episiotomies;
 2. artificial rupture of membranes;
 3. medications (all medications in the *Designated Drugs* regulation);
 4. emergency procedures (including dystocia and post-partum hemorrhage management) , including neonatal resuscitation.

(b) Consultations with Physicians

- i. number;
- ii. reasons

(c) Transfers to Hospital

- i. number of women transferred out of BC to hospital;
 - a. number of non-emergency transports and number of emergency transfers
- ii. times of
 1. initiation of transfer;
 2. discharge time from BC;
 3. admission time to hospital; and
 4. transfer of care, if applicable;
- iii. reasons for transfers to hospital;
- iv. number of women transferred to hospital where care was transferred to a physician.
- v. rationale for consultation with physician;
- vi. name(s) of hospital(s);

- vii. outcomes of women transferred out of BC; and
- viii. outcomes of babies transferred out of BC.

14.8 Client and Community Involvement

A BC shall collect appropriate data in the areas of client and community involvement. This data will include, but not necessarily be limited to, the following:

- (a) number of women
 - i. attending orientation sessions;
 - ii. requesting care in BC;
 - iii. accepted in BC; and
 - iv. referred elsewhere and reasons for the referral;
- (b) demographic information about the client population.

14.9 Clinical Outcomes

Midwives will use clinical judgement in providing safe, responsive care for their clients in a BC. All midwives with practice privileges in the BC must abide by the same set of written practice protocols acceptable to the Board of Directors of the BC. See the CMO Standard *Practice Protocols*. These protocols shall outline the roles of the midwives throughout the care provided and include the following areas:

- (a) Labour and Birth
 - i. pre-labour rupture of membranes at term;
 - ii. nutrition in labour;
 - iii. fetal surveillance
 - 1. first stage of labour;
 - 2. second stage of labour; and
 - 3. third stage of labour;
 - iv. lack of progress during
 - 1. first stage of labour; and
 - 2. second stage of labour;
 - v. meconium stained amniotic fluid;
 - vi. artificial rupture of membranes;
 - vii. episiotomy;
 - viii. medications – administration;
 - ix. gases – administration;
 - x. vaginal birth after caesarean; and
 - xi. retained placenta.
- (b) Immediate Postpartum Protocols
 - i. immediate postpartum care of mother;
 - ii. immediate postpartum care of baby; and

- iii. medications
 - 1. eye prophylaxis; and
 - 2. vitamin K.

(c) Emergency Protocols

- i. abnormal fetal status;
- ii. antepartum hemorrhage;
- iii. prolapsed cord;
- iv. undiagnosed breech;
- v. undiagnosed twins;
- vi. shoulder dystocia;
- vii. postpartum hemorrhage;
- viii. neonatal resuscitation.

(d) Perinatal Death Protocol

- i. death and bereavement;
- ii. stillbirth;
- iii. antepartum intrauterine death.

14.10 Compliance with the College of Midwives of Ontario's Standards of Practice

14.10.1

Midwives work in teams and function as primary caregivers within their scope of practice and according to the Standards of Practice of the CMO. Each birth should be planned with the understanding that two midwives will be in attendance, except in those situations when a second birth attendant is approved by the CMO as alternate practice arrangements. This second birth attendant shall be competent and knowledgeable to attend birth and follow the midwifery model of care.

All midwives providing services in a BC:

- (a) are currently registered in good standing to practice their profession in Ontario and function within the scope of practice as outlined by the CMO in accordance with the CMO Registration Regulation, including
 - i. maintenance of CPR, NRP and ES qualification;
 - ii. maintenance of malpractice insurance; and
- (b) maintenance of active practice requirements according to the CMOs current requirements; and
- (c) have access to laboratory services in accordance with the CMO Standard *Laboratory Testing*; and
- (d) have access to consultation with appropriate specialists including physicians as per the CMO Standard *Consultation and Transfer of Care*.

14.10.2

Review of practice privileges in a BC shall take place annually and shall include an evaluation of each midwife and compliance with all requirements of the CMO's Standards of Practice, including the *Consultation and Transfer of Care*.

14.10.3

Midwives practising in the BC shall hold regular peer case reviews. All cases involving significant morbidity or mortality shall be the subject of peer case review. This obligation is separate and apart from any obligation to hold peer case reviews pursuant to the Quality Assurance Program of a regulator of any health professional. If a peer case review held by midwives practising in the BC is being done in compliance with the CMO's Quality Assurance Program, all midwives participating must agree to that prior to the peer review and all midwives must follow the Quality Assurance Program requirements for peer reviews.

14.11 Use of Unfunded Services

The BC shall evaluate any unfunded services offered in order to ensure the safety, comfort and satisfaction of all clients, families and staff. The evaluation should also evaluate the impact of unfunded services on core service provision.

15 Research Activities

When research is conducted by the BC or by employees or affiliates of the BC, or when the BC is used as a research site such that BC clients and/or staff are the subjects of research, qualified researchers must conduct the research. A qualified researcher is defined as having evidence of formal training and/or experience in the conduct of clinical, epidemiologic, or sociologic research.

Research shall be conducted:

- (a) in accordance with written research policies and procedures approved by the BC Board of Directors;
- (b) by staff trained to conduct such research;
- (c) in a manner that protects the client's health, choice, comfort, safety, and right to privacy
- (d) in a manner that protects the BC and its clients from unsafe practices; and
- (e) after review of the research plan and approval by an external Ethics Review Board.

16 Education

16.1 Clinical Placements

The education of midwifery students is central to the maintenance and growth of the profession. Opportunities shall be made available for student clinical placements in the BC with clinical preceptors. As well, the BC shall serve as a high-volume site of normal birth that may be beneficial for students of other health care disciplines to receive clinical education. The following list sets out the role of the BC in the education of future maternity care providers.

A BC provides:

- (a) opportunities for midwifery clinical educational placements;
- (b) opportunities for preceptor/mentor/supervisor education and continuing professional development;
- (c) opportunities for inter-professional clinical educational placements;
- (d) support from a referral hospital in which midwives have full-scope privileges;
- (e) protocols for student access to hospitals where he/she does not have a formal placement;
- (f) sufficient volume to support an education evaluation process; and
- (g) potential for education research projects in addition to the education evaluation research.

16.2 Continuing Education

The BC may also serve as a site for:

- (a) refresher clinical placements for health professionals needing higher volume placements in a normal birth setting;
- (b) continuing education and remediation for Registered Midwives; and
- (c) support for new registrant midwives with low birth numbers.