STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.
BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov

Nurse-Midwifery Advisory Committee Meeting

Sheraton Fairplex Hotel & Conference Center
601 W. McKinley Ave
Pomona, CA 91768
(909) 622-2220

AGENDA

September 7, 2017
Meeting to follow Board Meeting

Thursday, September 7, 2017 – Meeting to follow Board Meeting

10.0 Call to Order/Roll Call /Establishment of a Quorum

10.01 Vote on Whether to Approve Committee Meeting Minutes: April 5, 2017

10.1 Items to be Discussed and Considered; Possible Action

1. Updates on presentation to Board regarding CNM Scope of Practice
2. Advance Practice Nursing Survey 2017; Status of Survey
3. Advance Practice Committee Membership process
4. CNM Committee Meeting Frequency
5. CNM Committee Members' Term of Office
6. The adoption of the Core Competencies for Midwifery Practice and Standards of Midwifery Practice
7. Meeting Schedule for 2018

10.2 Public Comment for Items Not on the Agenda

10.3 Adjournment

NOTICE: All times are approximate. Meetings may be canceled without notice. For verification of meeting, call (916) 574-7600 or access the Board's Web Site www.rn.ca.gov under "Meetings." The meeting is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting the Administration Unit at (916) 574-7600 or email webmasterbrn@dca.ca.gov or send a written request to the Board of Registered Nursing Office at 1747 North Market Suite 150, Sacramento, CA 95834. (Hearing impaired: California Relay Service: TDD phone (800) 326-2297). Providing your request at least five (5) business days before the meeting will help to ensure the availability of the requested accommodation.

Board members who are not members of this committee may attend meetings as observers only, and may not participate or vote. Action may be taken on any item listed on this agenda, including information only items. Items may be taken out of order for convenience, to accommodate speakers, or maintain a quorum. The public will be provided an opportunity to comment on each agenda item at the time it is discussed; however, the committee may limit the time allowed to each speaker.

Nurse-Midwifery Advisory Committee Meeting
Board of Registered Nursing
Hearing Room
1747 North Market Blvd.
Sacramento, CA 95834
(916) 574-7600
Minutes
April 5, 2017

Present: BJ Snell, PhD, CNM, WHNP, MSN, FACNM; Lin Lee, RN, CNM; Karen Ruby Brown, MSN, CNM; Karen Roslie, CPPM
Absent: Naomi Stotland, MD
Guests: Joseph Morris RN, MSN, Ph.D., Janette Wackerly, RN, BSN, MBA; Betty Woods, RN, FNP, MSN; Trande Phillips, RN; Shannon Silberling Deputy Chief, Complaint Intake and Investigations Dept., Joseph Pacheco Deputy Chief of Enforcement, Complaint Intake and Investigations, Julie Campbell-Warnock, Research Program Specialist

Recorder: Nicoll Walton/Susan C. Engle DNP, PHN, RN

Agenda Item	Discussion	Action
10.0 Call to Order/Roll Call /Establishment of a Quorum:	The meeting was called to order by BJ Snell Quorum established If a member is not able to attend the Nurse Midwifery Advisory Committee meeting in the planned physical location, they need to submit the location where they plan to access the meeting electronically and the telephone number at least 15 days before the date of the meeting. Public participants may attend the meeting at any location.	
10.01 Vote on Whether to Approve Committee Meeting Minutes: September 16, 2016	Minutes were approved by the committee members with minor corrections that will be submitted in writing. Established quorum	Karen Ruby Brown to submit edits in writing

10.1 Items to be Discussed and Considered		
1. Creating and Presenting an Informational Session for BRN Related to Nurse-Midwifery Practice	Committee member shared that the Board understands nursing issues but may not have a lot of information about midwifery practice and midwifery education. The committee discussed items that they would want to have in the informational session. Each committee member provided input for the presentation content such as insight to how midwifery practice is in hospitals with physician co-management and the safety perspectives, midwives practice under scope of practice and not standardized procedures with the exception of specific SPs required by law, educational evolution aspects and perspectives, history of midwifery and California practice, issues related to CNMs and Licensed Midwives related to homebirths and practice settings such as birth centers and homes. Based on Committee member's discussion, staff provided a summary of the content for the informational session to the Board. Content to include co-management with physicians and residents in hospitals where nurse midwives work, history of midwifery practice in California, and consumer perspective. Committee member shared that the history, trends will include health policy component including scope of practice and licensed ~~nurse~~ midwives, differences and commonalities, and Dr. Stoddard's perspective with Physician and residents. Board member suggested that the presentation also include resident education. Staff recommended that the presentation include a question and answer period. Staff recommended a part one and a part two. Staff shared that the presentation ~~in~~ covering all aspects discussed will inform the Board that includes public members and Registered Nurses. Staff shared that the Board meetings are scheduled for September and November.	Janette Wackerly will provide the Board meeting dates. Karen Ruby Brown to develop PowerPoint presentation/s Committee to provide presentation need (i.e. Audiovisual equipment)
2. Feedback Received from Certified Nurse Midwifery Community Related to Expert Witness Participation	There was discussion between Committee members and staff regarding expert witness participation. In addition, there was discussion regarding standardized procedures and physician supervision. Staff informed the committee that the name has been changed from expert witness to Expert Practice Consultant. Committee member shared that in the past wording had been interpreted by experts was that the Board was asking the expert to find a violation which isn't true. Staff stated that the Board needs an unbiased opinion as to whether or not there was unprofessional conduct issue. Staff shared that they are engaging in a process with the AG ~~to~~ in the near future to have formalized training so that the consultant will know what their legal role is and how their product to the Board will be used and provide some direction to the Board. Committee	Joseph Pacheco to provide synopsis of changes

	requested that staff provide a synopsis of the changes were made to the materials sent to consultants and posted on the website so that the information can be shared with the midwifery community. Committee wanted to know how early the nurse midwife could be involved in a case as there are times when things seem to get down the pike so far that the case may not need to go that far and so having someone that can give input at an earlier timeframe as to whether this is appropriate scope of practice or not because there are some investigations that have continued to go on and on that are really within the midwifery scope of practice but no midwife has ever looked at the case until it gets way down the pike. Staff shared that all investigators were trained by the AG office. The training included a piece around midwifery. Staff: what evidence needs to be collected? Staff: How much is enough to identify early on in an investigation when it's ok to stop. Committee member asked if it would be okay to bring in an expert practice consultant (title changed from expert witness) at the 1st or 2nd step to do an initial look to see if it needs to go anywhere or to advise. Staff stated that it is possible; the main hurdle to that is we have had discussions the nurse expert get involved early in the process but resources is the number one issue. Staff reported that the Board does not have the money and the second resource that is lacking is people. Staff reported that there are not enough nurses to review the cases already and those are the ones that have been found already with potential violations and that it was suggested that all midwifery cases that are referred would go to an expert that would over tax the system and actually delay it even further because there are not enough experts currently. Committee member shared that resources might be freed up if cases that do not require the level of investigation to work numbers to make sense. Committee member asked if volunteers could do the 1st glance. Staff reported that due to confidential issues the practice expert consultant would need to be contracted through DCA. Committee member asked if the initial investigator was a nurse; staff responded that the initial investigation team were not nurses. Staff reported that 5 midwifery nurse cases were sent to the AG for disciplinary reasons. Committee member stated that it seems to be investigations for out of hospital births. Committee member shared that the expert needs to be familiar with out of hospital births. Committee member reported that many expert witnesses found that the cases they worked on was related to physician supervision issues and with physician supervision not being available that it put the expert in a bind of recognizing that the current practice does not fit the whole physician supervision model and with the administrative rulings and those kind of things so they are giving feedback to the Board that there is a big issue to have a nurse midwife trying to provide true expert witness when in fact what supervision is in 2017 is very different then what it was in 1974.	

	Staff asked the committee to provide clear cut practice guidelines; What is the standard of care in the field? What does the committee suggest to the Board? What is the NMW allowed to do? What is not allowed? What is the standard in birthing centers and home birth practice? Staff reported that the standard of practice is undefined. Committee member share that it may be undefined from the Board's perspective but it is clearly defined by the professional associations nationally and by the birth center associations. Committee member shared that there are standards and guidelines that a certified NMW is expected by their competency and national certification to be held too. Committee member stated that those standards are very clear; national certification is what keeps the NMW in the position to be tied to the standards. Staff shared that the Expert Practice consultant information was updated on the BRN webpage.	
3. Status of Survey for Advanced Practice Nursing 2017; Information Only	Staff provided an update on the survey for Advanced Practice Nursing 2017. A survey draft was sent to another group of nurse practitioners and nurse midwives to provide feedback. A copy of the final version of the survey was included in the meeting packet. The survey was beta tested by NPs/CNMs who did not see the questions. In an attempt to improve the response rate, the survey link was sent by UCSF in 2016 to 2500 NPs and CNMs. As of January 24th, 690 (28%) online responses were received. Statistics March 31st, show that there were 1435 (58%) eligible responses received with 612 (25%) received by mail and 823 (33%) responses received online as of March. A final post card reminder March 31st. The survey will remain open for another 3-4 weeks. UCSF will then provide an analysis and report to be available late 2017. Committee member asked for the breakdown of the CNM is the sample and the number of CNM responses.	Julie Campbell-Warnock to provide number of CNMs and NPs that received the survey.
4. Mission of Nurse Midwifery Advisory Committee and Reporting Relationship to the Board	Committee member asked if the recommendation made by the Sunset Review Committee to have the NMW Advisory Committee report directly to the Board. Committee member asked if the Board had discussed this matter. Staff reported that the committee should report recommendations to the Practice committee. Committee member shared that there are parts of the committee that deal with education, practice and credentialing. Staff stated that if there are separate issues, the committee can provide a report to the education committee. Staff discussed information about attendance at the Nursing Education & Workforce Advisory Committee (NEWAC). NEWAC meets twice a year. The next NEWAC meeting is in October. Education and practice issues are discussed at the NEWAC meeting with representation from a diverse group of participants such as the Hospital Association, ACNL, and Deans and Directors.	Janette Wackerly to provide information about participation and attendance at the NEWAC meetings.
10.2 Discussion and Consideration of	Committee chair asked members for input to prioritize 1-7 for future agenda items to allow the NMW committee and community to interact with different staff and to improve communication. Committee member discussed the need for legislation to look	

Items Related to the Practice of Midwifery; Possible Recommendations to the Full Board	at how the board could advise NMW committee until supervision is removed from the regulation. Committee discussed legal implications, advisements to be developed for episiotomies in the home.	
1. Discuss the Meeting Frequency and Disciplinary Issues Regarding Nurse-Midwives that Arose During the Sunset Review Process	Staff discussed that the committee will need to bring forward the agenda item to the nursing practice committee or the education/licensing committee. If the item is agendadized, a committee member would need to attend and present the agenda item at the respective meeting. Staff shared that the committee meeting are held 5 times per year generally before the Board meetings. The meetings will be held in northern California through June.	
2. Comparison of Midwifery in California of Certified Nurse Midwives and Licensed Midwives to Include Scope, Supervision, Education Preparation, and Predominant Location of Practice	Item not discussed, tabled until future meeting	
3. Issues Regarding Physician Supervision and Prior Administrative	Committee members and staff discussed the need to develop CNM advisories such as: supervision, episiotomies (Business and Professions Code 2746.5(2), NCSBN state practices, proposal: consultation, collaboration, referral principles. Committee members discussed CNMs and L~~N~~Ms in relation to disciplinary action 2761(a)(4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional	

Cases Related to Certified Nurse Midwifery and Licensed Midwife Practice	license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action. Dual license clearly defined before they start practicing as a L~~N~~M. Committee Members discussed that CNM need for standardized procedures for furnishing and episiotomy so that they are not practicing medicine without a license.	
4. Recommendation for Revision to Business and Professions Code Section 2746.52 to Add Performance of an Episiotomy as an 'Urgent/Emergency Event' in the Home Setting and Repair of Laceration in Home as a Patient Safety Issue	Committee members discussed issues related to episiotomies in hospitals, birth centers, and home births in reference to Business and Professions Code Section 2746.52) Committee members discussed implications for episiotomies and home births including patient safety (i.e. delay in repair, bleed) Committee members discussed the need to develop advisements such as the one that was developed for "vacuum" until language in law can include "home" for homebirths.	
5. Authority Conferred for Nurse Midwifery Scope of Practice in Business and Professions Code Section 2746.5 Regarding Whether Standardized Procedures are Necessary for Nurse Midwifery Practice	Item not discussed, tabled until future meeting	
6. Recommendation for Revision to Business and Professions Code	Item not discussed, tabled until future meeting	

Sections 2746 through 2746.8 Relating to Whether California Certified Nurse Midwifery Practice Should Be Based on Standards for Practice of Midwifery and Core Competencies for Basic Midwifery Practice		
7. Length of Time to Obtain Registered Nurse License and Nurse Midwifery Certification	Committee members shared that there are 3 Nurse Midwifery programs in California. The application process by endorsement from out of state and the length of time required for processing. Staff shared that there is a separate process for furnishing.	
10.3 Discuss Online License and Certificate Renewal Processes	Item not discussed	
10.4 Public Comment for Items Not on the Agenda	None	
Next Meeting	September 7, 2017	

Adjournment: The meeting was adjourned at 4:30pm

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BOARD OF REGISTERED NURSING
Certified Nurse-Midwifery Committee
Agenda Item Summary

AGENDA ITEM: 10.1
DATE: September 7, 2017

ACTION REQUESTED: Updates on Presentation to Board regarding CNM Scope of Practice

REQUESTED BY: BJ Snell

BACKGROUND: **Items to be discussed and considered: Possible Action**

NEXT STEPS: Place on Board agenda.

FISCAL IMPACT, IF ANY: **None**

PERSON(S) TO CONTACT:

Janette Wackerly, MBA, BSN, RN
Supervising Nursing Education Consultant
Janette.Wackerly@dca.ca.gov
(916) 574-7686

BOARD OF REGISTERED NURSING
Certified Nurse-Midwifery Committee
Agenda Item Summary

AGENDA ITEM: 10.1
DATE: September 7, 2017

ACTION REQUESTED: Advance Practice Nursing Survey: Status of Survey

REQUESTED BY: BJ Snell

BACKGROUND: **Items to be discussed and considered: Possible Action**

As provided in the previous update on April 5, 2017, the BRN has commissioned the University of California San Francisco (UCSF), Center for the Health Professions to complete a survey of California Nurse Practitioners (NPs) and Certified Nurse-Midwives (CNMs). UCSF provided the survey to the selected survey sample of 2,500 NPs and CNMs. The survey data collection closed in early May 2017. Responses were received from a total of 1,616 NPs and CNMs. Below is a breakdown of the survey distribution and responses:

	Active Licenses/ Residing in CA (Nov 2016)	Survey Sample		Survey Responses	Response Rate
		% of Pop	#		
Nurse Practitioner (NP)	19,768	10.1%	2,000	1,269	63.5%
Certified Nurse-Midwife (CNM)	582	43.0%	250	177	70.8%
Dual Certified (NP & CNM)	569	43.9%	250	170	68.0%
TOTAL	20,919	12.4%	2,500	1,616	64.6%

A report with descriptive information and findings is being completed by UCSF. Dr. Joanne Spetz from UCSF will attend the November 9, 2017 Board meeting to provide a presentation of the highlights of the data and when finalized the report will be posted to the BRN website. Expected completion is late 2017.

NEXT STEPS: Place on Board agenda.

FISCAL IMPACT, IF ANY: **None**

PERSON(S) TO CONTACT:

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BOARD OF REGISTERED NURSING
Certified Nurse-Midwifery Committee
Agenda Item Summary

AGENDA ITEM: 10.1
DATE: September 7, 2017

ACTION REQUESTED: Advance Practice Committee Membership Process

REQUESTED BY: BJ Snell

BACKGROUND: **THE BOARD MADE THE FOLLOWING MOTIONS ON SEPTEMBER 3, 2015**

Nurse-Midwifery Committee be composed of

- One direct practice nurse-midwife from northern California
- One direct practice nurse mid-wife from southern California
- One nurse-midwifery educator
- One public member who is a consumer of nurse-midwifery services; and
- One obstetrical practicing with experience working with nurse-midwives- total of five members on the Committee.

Nurse Midwifery Committee should have membership with staggered terms for two direct practice nurse mid-wives. One direct practice nurse-midwife would be a term of two years and one direct nurse-midwife would be a term of three years. The other three members would have staggered terms of two years.

Nurse-midwifery committee will meet twice a year.

NEXT STEPS: Place on Board agenda.

FISCAL IMPACT, IF ANY: **None**

PERSON(S) TO CONTACT:

Janette Wackerly, MBA, BSN, RN
Supervising Nursing Education Consultant
Janette.Wackerly@dca.ca.gov
(916) 574-7686

BOARD OF REGISTERED NURSING
Certified Nurse-Midwifery Committee
Agenda Item Summary

AGENDA ITEM: 10.1
DATE: September 7, 2017

ACTION REQUESTED: CNM Committee Meeting Frequency

REQUESTED BY: BJ Snell

BACKGROUND: **THE BOARD MADE THE FOLLOWING MOTIONS ON SEPTEMBER 3, 2015**

Nurse-Midwifery Committee be composed of

- One direct practice nurse-midwife from northern California
- One direct practice nurse mid-wife from southern California
- One nurse-midwifery educator
- One public member who is a consumer of nurse-midwifery services; and
- One obstetrical practicing with experience working with nurse-midwives- total of five members on the Committee.

Nurse Midwifery Committee should have membership with staggered terms for two direct practice nurse mid-wives. One direct practice nurse-midwife would be a term of two years and one direct nurse-midwife would be a term of three years. The other three members would have staggered terms of two years.

Nurse-midwifery committee will meet twice a year.

NEXT STEPS: Place on Board agenda.

FISCAL IMPACT, IF ANY: **None**

PERSON(S) TO CONTACT:

Janette Wackerly, MBA, BSN, RN
Supervising Nursing Education Consultant
Janette.Wackerly@dca.ca.gov
(916) 574-7686

BOARD OF REGISTERED NURSING
Certified Nurse-Midwifery Committee
Agenda Item Summary

AGENDA ITEM: 10.1
DATE: September 7, 2017

ACTION REQUESTED: CNM Committee Members Term of Office

REQUESTED BY: BJ Snell

BACKGROUND: **THE BOARD MADE THE FOLLOWING MOTIONS ON SEPTEMBER 3, 2015**

Nurse-Midwifery Committee be composed of

- One direct practice nurse-midwife from northern California
- One direct practice nurse mid-wife from southern California
- One nurse-midwifery educator
- One public member who is a consumer of nurse-midwifery services; and
- One obstetrical practicing with experience working with nurse-midwives- total of five members on the Committee.

Nurse Midwifery Committee should have membership with staggered terms for two direct practice nurse mid-wives. One direct practice nurse-midwife would be a term of two years and one direct nurse-midwife would be a term of three years. The other three members would have staggered terms of two years.

Nurse-midwifery committee will meet twice a year.

NEXT STEPS: Place on Board agenda.

FISCAL IMPACT, IF ANY: **None**

PERSON(S) TO CONTACT:

Janette Wackerly, MBA, BSN, RN
Supervising Nursing Education Consultant
Janette.Wackerly@dca.ca.gov
(916) 574-7686

BOARD OF REGISTERED NURSING

Certified Nurse-Midwifery Committee
Agenda Item Summary

AGENDA ITEM: 10.1
DATE: September 7, 2017

ACTION REQUESTED: The Adoption of the Core Competencies for Midwifery Practice and Standards of Midwifery Practice

REQUESTED BY: BJ Snell

BACKGROUND: **Items to be discussed and considered: Possible Action**

NEXT STEPS: Place on Board agenda.

FISCAL IMPACT, IF ANY: **None**

PERSON(S) TO CONTACT:

Janette Wackerly, MBA, BSN, RN
Supervising Nursing Education Consultant
Janette.Wackerly@dca.ca.gov
(916) 574-7686

Core Competencies for Basic Midwifery Practice

The *Core Competencies for Basic Midwifery Practice* include 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 Accreditation Commission for Midwifery Education (ACME), formerly 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 Midwifery*, the *Philosophy of the ACNM*, and the *Code of Ethics* promulgated by the ACNM. Certified nurse-midwives (CNMs) and certified midwives (CMs) who have been certified by the ACNM or the American Midwifery Certification Board (AMCB), formerly the ACNM Certification Council, Inc. (ACC), assume responsibility and accountability for their practice as primary health care providers for women and newborns.

The scope of midwifery practice may be expanded beyond the core competencies to incorporate additional skills and procedures that improve care for women and their families. Following basic midwifery education, midwives may choose to expand their practice following the guidelines outlined in Standard VIII of the *Standards for the Practice of Midwifery*.

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 *Standards for the Practice of Midwifery*.

ACNM defines the midwife's role in primary health care based on the Institute of Medicine's report, *Primary Care: America's Health Care in a New Era*,[1] the *Philosophy of the ACNM*,[2] and the ACNM position statement, "Midwives are Primary Care Providers and Leaders of Maternity Care Homes."[3] 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 to appropriate health care services, including prescribing, administering and dispensing of pharmacologic agents. The concepts, skills, and midwifery management processes identified

below form 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 and applies to all settings for midwifery care, including hospitals, ambulatory care settings, birth centers, and homes.

I. Hallmarks of Midwifery

The art and science of midwifery are characterized by the following hallmarks:

A. Recognition of menarche, pregnancy, birth, and menopause as normal physiologic and developmental processes
B. Advocacy of non-intervention in normal processes in the absence of complications
C. Incorporation of scientific evidence into clinical practice
D. Promotion of woman- and family-centered care
E. Empowerment of women as partners in health care
F. Facilitation of healthy family and interpersonal relationships
G. Promotion of continuity of care
H. Health promotion, disease prevention, and health education
I. Promotion of a public health care perspective
J. Care to vulnerable populations
K. Advocacy for informed choice, shared decision making, and the right to self-determination
L. Integration of cultural humility
M. Incorporation of evidence-based complementary and alternative therapies in education and practice
N. Skillful communication, guidance, and counseling
O. Therapeutic value of human presence
P. Collaboration with other members of the interprofessional 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 the following components:

A. Promotion of the hallmarks of midwifery
B. Knowledge of the history of midwifery
C. Knowledge of the legal basis for practice
D. Knowledge of national and international issues and trends in women's health and maternal/newborn care
E. Support of legislation and policy initiatives that promote quality health care
F. Knowledge of issues and trends in health care policy and systems
G. Knowledge of information systems and other technologies to improve the quality and safety of health care
H. Broad understanding of the bioethics related to the care of women, newborns, and families
I. Practice in accordance with the ACNM Philosophy, Standards, and Code of Ethics
J. Ability to evaluate, apply, interpret, and collaborate in research

K. Participation in self-evaluation, peer review, lifelong learning, and other activities that ensure and validate quality practice
L. Development of leadership skills
M. Knowledge of licensure, clinical privileges, and credentialing

N. Knowledge of practice management and finances
O. Promotion of the profession of midwifery, including participation in the professional organization at the local and national level
P. Support of the profession's growth through participation in midwifery education
Q. Knowledge of the structure and function of ACNM

III. Components of Midwifery Care: Midwifery Management Process

The midwifery management process is used for all areas of clinical care and consists of the following steps:

A. Investigate by obtaining all necessary data for the complete evaluation of the woman or newborn.
B. Identify problems or diagnoses and health care needs based on correct interpretation of the subjective and objective data.
C. Anticipate potential problems or diagnoses that may be expected based on the identified problems or diagnoses.
D. Evaluate the need for immediate intervention and/or consultation, collaborative management, or referral with other health care team members as dictated by the condition of the woman, fetus, or newborn.
E. In partnership with the woman, develop a comprehensive plan of care that is supported by a valid rationale, is based on the preceding steps, and includes therapeutics as indicated.
F. Assume responsibility for the safe and efficient implementation of a plan of care that includes the provision of treatments and interventions as indicated.
G. Evaluate the effectiveness of the care given, recycling appropriately through the management process for any aspect of care that has been ineffective.

IV. Components of Midwifery Care: Fundamentals

A. Anatomy and physiology, including pathophysiology
B. Normal growth and development
C. Psychosocial, sexual, and behavioral development
D. Basic epidemiology
E. Nutrition
F. Pharmacokinetics and pharmacotherapeutics
G. Principles of individual and group health education
H. Bioethics related to the care of women, newborns, and families
I. Clinical genetics and genomics

V. Components of Midwifery Care of Women

Independently manages primary health screening, health promotion, and care of women from the peri-menarcheal period through the lifespan using the midwifery management process. While the woman's life is a continuum, midwifery care of women can be divided into primary, preconception, gynecologic, antepartum, intrapartum, and post-pregnancy care.

A. Applies knowledge, skills, and abilities in primary care that include but are not limited to the following:

1. Nationally defined goals and objectives for health promotion and disease prevention
2. Parameters for assessment of physical, mental, and social health
3. Nationally defined screening and immunization recommendations to promote health and to detect and prevent disease
4. Management strategies and therapeutics to facilitate health and promote healthy behaviors
5. Identification of normal and deviations from normal in the following areas:
    a. Cardiovascular and hematologic
    b. Dermatologic
    c. Endocrine
    d. Eye, ear, nose, and throat
    e. Gastrointestinal
    f. Mental health
    g. Musculoskeletal
    h. Neurologic
    i. Respiratory
    j. Renal
6. Management strategies and therapeutics for the treatment of common health problems and deviations from normal of women, including infections, self-limited conditions, and mild and/or stable presentations of chronic conditions, utilizing consultation, collaboration, and/or referral to appropriate health car services as indicated.

B. Applies knowledge, skills, and abilities in the preconception period that include but are not limited to the following:

1. Individual and family readiness for pregnancy, including physical, emotional, psychosocial, and sexual factors including
    a. Non-modifiable factors such as family and genetic/genomic risk
    b. Modifiable factors such as environmental and occupational factors, nutrition, medications, and maternal lifestyle
2. Health and laboratory screening
3. Fertility awareness, cycle charting, signs and symptoms of pregnancy, and pregnancy spacing

C. Applies knowledge, skills, and abilities in gynecologic care that include but are not limited to the following:

1. Human sexuality, including biological sex, gender identities and roles, sexual orientation, eroticism, intimacy, and reproduction
2. Common screening tools and diagnostic tests
3. Common gynecologic and urogynecologic problems
4. All available contraceptive methods
5. Sexually transmitted infections including indicated partner evaluation, treatment, or referral
6. Counseling for sexual behaviors that promote health and prevent disease
7. Counseling, clinical interventions, and/or referral for unplanned or undesired pregnancies, sexual and gender concerns, and infertility
8. Identification of deviations from normal and appropriate interventions, including management of complications and emergencies utilizing consultation, collaboration, and/or referral as indicated

D. Applies knowledge, skills, and abilities in the perimenopausal and postmenopausal periods that include but are not limited to the following:

1. Effects of menopause on physical, mental, and sexual health
2. Identification of deviations from normal
3. Counseling and education for health maintenance and promotion
4. Initiation or referral for age/risk appropriate periodic health screening
5. Management and therapeutics for alleviation of common discomforts

E. Applies knowledge, skills and abilities in the antepartum period that include but are not limited to the following:

1. Epidemiology of maternal and perinatal morbidity and mortality
2. Confirmation and dating of pregnancy
3. Promotion of normal pregnancy using management strategies and therapeutics as indicated
4. Common discomforts of pregnancy
5. Influence of environmental, cultural and occupational factors, health habits, and maternal behaviors on pregnancy outcomes
6. Health risks, including but not limited to domestic violence, infections, and substance use/abuse
7. Emotional, psychosocial, and sexual changes during pregnancy
8. Anticipatory guidance related to birth, breastfeeding, parenthood, and change in the family constellation
9. Deviations from normal and appropriate interventions, including management of complications and emergencies
10. Placental physiology, embryology, fetal development, and indicators of fetal well-being

F. Applies knowledge, skills, and abilities in the intrapartum period that include but are not limited to the following:

1. Confirmation and assessment of labor and its progress
2. Maternal and fetal status
3. Deviations from normal and appropriate interventions, including management of complications, abnormal intrapartum events, and emergencies
4. Facilitation of physiologic labor progress
5. Measures to support psychosocial needs during labor and birth
6. Labor pain and coping
7. Pharmacologic and non-pharmacologic strategies to facilitate maternal coping
8. Techniques for
    a. administration of local anesthesia
    b. spontaneous vaginal birth
    c. third stage management
    d. performance of episiotomy repair of episiotomy and 1st and 2nd degree lacerations

G. Applies knowledge, skills, and abilities in the period following pregnancy that include but are not limited to the following:

1. Physical involution following pregnancy ending in spontaneous or induced abortion, preterm birth, or term birth
2. Management strategies and therapeutics to facilitate a healthy puerperium
3. Discomforts of the puerperium
4. Self-care
5. Psychosocial coping and healing following pregnancy
6. Readjustment of significant relationships and roles
7. Facilitation of the initiation, establishment, and continuation of lactation where indicated
8. Resumption of sexual activity, contraception, and pregnancy spacing
9. Deviations from normal and appropriate interventions including management of complications and emergencies

VI. Components of Midwifery Care of the Newborn

Independently manages the care of the newborn immediately after birth and continues to provide care to well newborns up to 28 days of life utilizing the midwifery management process and consultation, collaboration, and/or referral to appropriate health care services as indicated.

A. Applies knowledge, skills, and abilities to the newborn that include but are not limited to the following:

1. Effect of maternal and fetal history and risk factors on the newborn
2. Preparation and planning for birth based on ongoing assessment of maternal and fetal status
3. Methods to facilitate physiologic transition to extrauterine life that includes but is not limited to the following:

a. Establishment of respiration
b. Cardiac and hematologic stabilization including cord clamping and cutting
c. Thermoregulation
d. Establishment of feeding and maintenance of normoglycemia
e. Bonding and attachment through prolonged contact with neonate.
f. Identification of deviations from normal and their management.
g. Emergency management including resuscitation, stabilization, and consultation and referral as needed

4. Evaluation of the newborn:
    a. Initial physical and behavioral assessment for term and preterm infants
    b. Gestational age assessment
    c. Ongoing assessment and management for term, well newborns during first 28 days
    d. Identification of deviations from normal and consultation, and/or referral to appropriate health services as indicated
5. Develops a plan in conjunction with the woman and family for care of the newborn for the first 28 days of life, including nationally defined goals and objectives for health promotion and disease prevention:
    a. Teaching regarding normal behaviors and development to promote attachment
    b. Feeding and weight gain including management of common breastfeeding problems
    c. Normal daily care, interaction, and activity including sleep practice and creating a safe environment
    d. Provision of preventative care that includes but is not limited to
        (1) Therapeutics including eye ointment, vitamin K, and others as appropriate by local or national guidelines
        (2) Testing and screening according to local and national guidelines
        (3) Need for ongoing preventative health care with pediatric care providers
    e. Safe integration of the newborn into the family and cultural unit
    f. Appropriate interventions and referrals for abnormal conditions:
        (1) Minor and severe congenital malformations
        (2) Poor transition to extrauterine life
        (3) Symptoms of infection
        (4) Infants born to mothers with infections
        (5) Postpartum depression and its effect on the newborn
        (6) End-of-life care for stillbirth and conditions incompatible with life
    g. Health education specific to the infant and woman's needs:
        (1) Care of multiple children including siblings and multiple births
        (2) Available community resources

REFERENCES

1. Donaldson MS, Yordy KD, Lohr KN, Vanselow NA, eds. *Primary Care: America's Health Care in a New Era*. Washington, DC: National Academy Press; 1996.

2. American College of Nurse-Midwives. Our philosophy of care. http://www.midwife.org/Child-Page-3. Accessed December 17, 2012.

3. American College of Nurse-Midwives. Midwives are primary care providers and leaders of maternity care homes. Position statement. http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000273/Primary%20Care%20Position%20Statement%20June%202012.pdf. Published June 2012. Accessed December 17, 2012.

Source: Basic Competency Section, Division of Education

Approved by the ACNM Board of Directors: December 2012

(Supersedes all previous *ACNM Core Competencies for Basic Midwifery Practice*)

AMERICAN COLLEGE of NURSE-MIDWIVES
With women, for a lifetime™

STANDARDS FOR THE PRACTICE OF MIDWIFERY

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.

STANDARD V

MIDWIFERY CARE IS BASED UPON KNOWLEDGE, SKILLS, AND JUDGMENTS WHICH ARE REFLECTED IN WRITTEN PRACTICE GUIDELINES AND ARE USED TO GUIDE THE SCOPE OF MIDWIFERY CARE AND SERVICES PROVIDED TO CLIENTS.
The midwife:

1. Maintains written documentation of the parameters of service for independent and collaborative midwifery management and transfer of care when needed.
2. Has accessible resources to provide evidence based clinical practice for each specialty area which may include, but is not limited to, primary health care of women, care of the childbearing family, and newborn care.

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. Maintains documentation of the process used to achieve the necessary knowledge, skills and ongoing competency of the expanded or new procedures.

Source: Division of Standards and Practice
Approved: ACNM Board of Directors, March 8, 2003;
Revised and Approved: ACNM Board of Directors, December 4, 2009
Revised and Approved: ACNM Board of Directors, September 24, 2011

(Supersedes the ACNM's Functions, Standards and Qualifications, 1983 and Standards for the Practice of Nurse-Midwifery 1987, 1993. Standard VIII has been adapted from the ACNM's Guidelines for the Incorporation of New Procedures into Nurse-Midwifery Practice)

BOARD OF REGISTERED NURSING
Certified Nurse-Midwifery Committee
Agenda Item Summary

AGENDA ITEM: 10.1
DATE: September 7, 2017

ACTION REQUESTED: The Meeting Schedule for 2018

REQUESTED BY: BJ Snell

BACKGROUND: **Items to be discussed and considered: Possible Action**

NEXT STEPS: Place on Board agenda.

FISCAL IMPACT, IF ANY: **None**

PERSON(S) TO CONTACT:

Janette Wackerly, MBA, BSN, RN
Supervising Nursing Education Consultant
Janette.Wackerly@dca.ca.gov
(916) 574-7686