

Midwifery in Nova Scotia

Report of the external assessment team

July 12, 2011

Honourable Maureen MacDonald
Minister
Department of Health and Wellness
4th floor,
Joseph Howe Building
1690 Hollis St
Halifax, Nova Scotia
B3J 2R8

Dear Minister MacDonald:

In accordance with the Statement of Work issued in April 2011, the external assessment team is pleased to submit its report to you of the Nova Scotia midwifery program. We appreciate the opportunity to conduct the review and provide our recommendations.

Respectfully submitted,



Acknowledgements

We extend our thanks to the many individuals who generously gave of their time to meet with us. The hospitality, friendly reception, candid discussion and readiness to support midwifery pervaded all our meetings. Staff members within Primary Health Care, Department of Health and Wellness generously provided support and information. We especially thank Rebecca Attenborough and Marilyn Muise from the Reproductive Care Program for outstanding logistic support. Our task was made easier as a result of the efforts of others. Our sincere hope is that actions resulting from our recommendations will strengthen midwifery in Nova Scotia for the benefit of mothers and their infants.

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Purpose of the external assessment

An external assessment was requested by the Department of Health and Wellness (DHW) to provide advice about Nova Scotia's midwifery program in general as well as site specific recommendations. In doing so the team was to provide an independent assessment of the key recommendations developed by the MIENS Committee based on the midwifery implementation evaluation submitted in December 2010. The team was asked to examine the strengths and challenges at each of the model sites and provide advice about rebuilding the midwifery service at the IWK, to make recommendations about quality improvement and risk management, and reaching priority populations.

Members of external review team

A four person team with expertise in primary maternity care including midwifery was invited to carry out the external assessment.

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 (Former) Assistant Dean, Faculty of Health Sciences and Director, Midwifery Education Program.
 (Former) practicing midwife, Hamilton, Ontario.
 (Former) Midwifery Implementation Coordinator, Ontario Ministry of Health and Long Term Care.

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Head, Department of Family Practice, BC Women's Hospital
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 (Former) Member, Midwifery Implementation Committee of BC
 (Former) Member, Registration Committee and Appeals Committee, College of Midwives of BC
 Extensive leadership in quality improvement programs and initiatives, BC Women's Hospital
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 Health Sciences Centre
 Winnipeg, Manitoba
 Founding Board member of Canadian Association of Perinatal and Women's Health Nurses

Conduct of the assessment

The recruitment of team members was finalized in April 2011. Materials relevant to the implementation of midwifery in Nova Scotia were provided to all members. The Team Leader visited the three model sites in April (18-20) to gather preliminary information, meet principals at each site and plan the team visit which took place May 17-21, 2011. The schedule of visits is included in Annex 1. We held team meetings to discuss our observations and formulate tentative recommendations. Follow-up questions were managed by email and phone as needed. Drafts of the report were circulated to team members for corrections and additions. Team members endorsed all final recommendations.

Findings of the assessment

The following section provides an overview of the establishment of midwifery in Nova Scotia followed by a summary of midwifery in each model site. The summary findings were informed by background documents and the numerous interviews held during the team visit.

Midwifery in Nova Scotia

Midwifery regulation was achieved in 2009 and was the culmination of work that began in the late 1990's. Achieving this milestone was very significant for Nova Scotia midwives and supportive consumers. The Midwifery Regulatory Council of Nova Scotia (MRCNS) became official when midwifery legislation was proclaimed. The Council has a multidisciplinary membership with a midwife chairperson. A part-time registrar is its only staff person.

A one-time assessment of individuals holding midwifery qualifications took place in early 2009 just prior to proclamation. On the basis of the assessment, the Council determined eligibility for registration. Some initial registrants had provisional licenses that necessitated supervision by a person approved by the Council, usually a midwife holding a license without conditions or restrictions.

The MRCNS is still in a developmental phase; for example a mandatory peer review and quality assurance program are not yet in place, nor are there sufficient registrants to carry out these functions.

Health Districts were invited to submit proposals for implementing a midwifery service; three were received and three were accepted. An initial budget accommodated 7 full time midwifery positions with 3 allocated to IWK and 2 each to South Shore District Health Authority (SSDHA) and Guysborough Antigonish Strait Health Authority (GASHA). No other districts have submitted or been invited to submit a proposal. No new positions have been added since the initial hiring.

Midwives are employed by the District Health Authority (IWK in Halifax), receive a salary, benefits and coverage of professional liability insurance. They report to a unit/program manager who, at the time of the external review, was a nurse in all sites.

The DHW established a stakeholder committee (MIENS) to monitor implementation. Part of their task was securing an assessment of integration one year after services were established. The DHW was concerned sufficiently by the implementation evaluation and the suspension of the IWK service in late 2010 to request this external assessment.

Description of model sites

Izaak Walton Killam (IWK) Health Centre

No midwifery services have been offered since December 2010. Initially 4 midwives were hired to fill the 3 FTE positions. Three of the 4 midwives had existing caseloads when regulation came into effect; their experience in Nova Scotia was largely based in providing home birth in the pre-regulation period. One midwife had previous experience in regulated midwifery in Canada. Of the first hires, one full time person remains but is on leave of absence for an uncertain period.

We heard many perspectives about the integration difficulties. Some problems appeared attributable to a short lead-in time to have midwifery established, some to creating a fit between a model of midwifery practice and the large maternity care service that is known for excellence in perinatal high risk care, and others to the awkward fit of a hospital employment model when midwives are autonomous primary maternity care providers who conduct a large portion of their work outside the hospital.

Interprofessional and interpersonal conflicts were both cause and effect for a widespread loss of trust and confidence among all parties. We discerned sadness, disappointment and regret across all sectors at the present circumstance coupled with a desire to re-establish midwifery at IWK.

Strengths:

- Commitment to re-build a midwifery team to provide care to women in Halifax; support and interest from many individuals to see midwifery succeed
- Strong program in primary maternity care within Family Medicine
- Interest from obstetrics and administration in bringing a more focused approach to low risk (normal) birth
- Strong interest from women in Halifax to have midwifery re-established

Challenges:

- Overcoming previous history and re-building positive working relationships
- Recruiting midwives to work in Halifax in view of previous difficulties

- Clarifying and managing operational accountabilities and professional practice accountabilities
- Developing a culture of respect and support for normal birth when the dominant ethos is that of high risk care and preventing untoward events

Guysborough Antigonish Strait Health Authority (GASHA)

Two full-time midwives are based at St Martha's Regional Hospital in Antigonish; one began in August 2009, the second was hired in August 2010. No midwifery service existed in the area prior to regulation. The midwives are employees of the Health Authority and responsible to the Manager, Children and Women's Health Unit. They work with two obstetricians (a 3rd recently retired) who have been long established in the community. A hospital clinic was established when the midwives arrived. Together the obstetricians and midwives provide primary and secondary maternity care to approximately 400 women per year. The midwives identify low risk women for antepartum visits, attend the labour and birth of low risk women and provide postpartum and infant visits. The intrapartum on-call coverage is shared; midwives cover week days, several week nights and alternate weekends. The obstetricians have a contract for alternate funding for their maternity care work that removes a potentially significant barrier to shared interprofessional practice. We heard from the midwives and others that criticisms have been directed at them for working within the interprofessional model of service provision, but we also learned that women's responses to routine hospital surveys about their care have been very positive.

Family doctors have a strong presence in antepartum care, but most refer to the maternity clinic for late pregnancy care and birth. Uncertainty and tension about midwives' involvement in newborn care are being capably addressed. Family doctors are not participants in the maternity clinic which has resulted in the midwives being closely aligned with obstetricians rather than family physicians.

Beginning efforts are being made to extend antenatal services to sites outside Antigonish with the goal of attracting women into care earlier in pregnancy. There is a special interest in outreach to the First Nations communities in the district. Out-of-hospital birth is not available since attendance by both midwives at births outside the hospital would leave the hospital without a midwife and provide no off-call time for the midwives themselves.

Strengths:

- High level of support for midwives in a district without previous experience of midwifery care.
- The Perinatal Clinic team is enthused and happy with their work. There is a high degree of interpersonal cordiality.
- The involvement of midwives has developed gradually; an orientation period was built into the beginning stages; midwives are undertaking more community outreach.

- Midwives have set realistic limits on their present availability for out-of-hospital births and are committed to integrating out of hospital birth into their services in the future.
- External funds were received to participate in MORE^{OB} (Managing Obstetrical Risk Efficiently; a professional development program that fosters team work, team communication, knowledge and skills to manage obstetrical emergencies. See <http://moreob.com>). The obstetricians, midwives and a family physician are participating.

Challenges:

- Dominance of obstetricians in primary maternity care and alignment of midwives with specialists.
- Achieving continuity of care and developing relationships between women and midwives is more difficult within the shared care model.
- Ensuring long term stability of a suitable alternative to fee for service funding for physicians who provide primary maternity care.
- Establishing closer relationships between midwives and family doctors.

South Shore District Health Authority (SSDHA)

Two full-time midwives are employed by SSDHA. One practiced in Nova Scotia prior to regulation and the other in Ontario and Nova Scotia. They formed a new practice based in Bridgewater at the onset of regulation. Their caseload has steadily grown and is at full capacity currently. They have clinic space in a small home-like building in Bridgewater and plan to offer prenatal visits in the adjacent county. Practice data show that to date 45% of their clients have had home births and a similar percentage is defined to be from diverse populations. Their practice is being affected by the suspension of the IWK midwifery service with a growing number of requests for care from women who live outside the District but are willing to travel to South Shore to access midwifery services.

Until recently the midwives reported to the Primary Care Manager whereas now they report to the Manager of Maternal Child Health, part of acute care services. This resulted from reorganization of responsibilities within the health district and a judgement that issues could be better resolved within the clinical sector where births occurred.

Approximately 400 births per year take place at the South Shore Regional Hospital, the majority under the care of a team of family doctors who provide around the clock coverage. The team recently negotiated a funding contract for an alternative to fee for service for maternity care provision. They provide prenatal care in an outpatient area of the hospital. Four obstetricians (3 FTE positions) provide referral specialist care under an alternate payment plan. Midwives are able to consult with the on-call family doctor or the specialist depending on the client situation. The midwives meet with obstetricians to discuss planned management and sometimes to review cases that raised concerns. They also attend

meetings of the family doctors where cases are discussed. Recently, discussions have been organized with the nursing staff to address emerging issues.

Strengths:

- Experienced midwives who are highly committed to their mode of practice; services are provided across the District and many referrals come from clients
- Midwives are responsive to issues and engage with individuals and groups to solve problems
- Strong history of primary care practitioners providing maternity services
- Congenial working relationships among maternity care providers

Challenges:

- The full caseload and high proportion of home births spread over many parts of the District increase the probability of clusters of births that allow little rest time for midwives
- There are no funds to support a (non-midwife) second attendant; therefore both midwives must attend home births, a situation that can lead to excess fatigue and become unsustainable over time.
- Accepting requests for service from women who reside outside the District is contentious among administrators and some providers
- The midwives are not organizationally aligned with family doctors who provide primary maternity care. There are few shared venues for quality assurance activities, skills training, and other continuing education discussions
- Ensuring long term stability of an alternative to fee for service for physicians providing primary maternity care
- The “independent” practice of the midwives and the strongly held views of clients about their care have underlined differing philosophic perspectives about the interface between medical advice and client autonomy

Identification and analysis of issues

We have formulated the following categories of issues based on the information gathered during our visits. The categories are distilled from many conversations and reflect recurring themes from across the three sites.

- **Sustainability**

There is no announced plan about the future of midwifery in Nova Scotia. More than once we were asked if the purpose of the external review was to recommend closure of the existing two sites. With only four midwives in practice, the present situation is marked by anxiety, uncertainty and a loss of public confidence in government's commitment to midwifery.

In our view midwifery in NS cannot long survive in its present state. If nothing is done, the profession will collapse and the benefits of regulation will not be realized. There are too few members to meet increasing requests for midwifery care, provide services safely and effectively, and attend to the complexity of regulatory and professional association activities that are required of a newly regulated profession.

The investment to date in setting up the regulatory structure and providing publicly funded services is considerable and may appear high in relation to the number of practitioners, but is a necessary part of launching a new profession. DHW is attempting to build a cost-benefit model to assess midwifery that is cause for concern at this early stage, given the very small number of midwifery births to date, the initial investments, ongoing integration costs, and different models of care provision. As well, the qualitative benefits to women of midwifery care are not easily measured and do not convert readily to dollars in economic analyses. Women describe such benefits as being well informed, involved in decision-making and gaining greater self-confidence for parenthood.

- **Clinical leadership**

Some of the interprofessional tensions we observed result from introducing midwives into a health care system that matured without midwives. Their roles as providers of primary maternity care are new, not well understood and cause strain within systems. An experienced midwifery clinical leader at the provincial level would be an interprofessional liaison, bringing perspective and practical information to prevent or resolve many integration issues. She would oversee the standard of clinical practice of midwives, conduct peer reviews and practice audits for quality improvement, and assist with re-building services at the IWK.

- **Employment model**

Midwives in the Nova Scotia employment model are accountable to managers (all have been nurses) for professional practice as well as for logistic/operational arrangements. The mixing of operational and practice accountabilities was evident in descriptions of various group meetings about midwifery. Forums developed for mandatory discussion of client management (an MRCNS requirement) sometimes had inconsistent membership and agendas, often overlapping with solving systems issues and/or de-briefing about an adverse event. Managers noted a large workload related to integration issues that reflect the dual accountabilities.

The employment model succeeds in other locations where there is clear separation of the operational/administrative component of midwifery from the oversight of professional practice. This separation is essential for ensuring that employers do not place restrictions on practice that are inconsistent with professional standards of the regulatory body. Practice oversight is the responsibility of a midwifery leader within an organizational context where midwives are formally aligned with other primary maternity care providers. Such an alignment helps strengthen approaches and policies toward normal birth.

We do not endorse at this juncture introducing self-employed contracting of services as a second model of midwifery organization. This model would require added administrative policies and a reporting structure for no obvious gain. With modifications, the employment model now in place can work well.

- **Quality assurance – quality improvement – risk management**

Differing perceptions about risks and risk management were seen in response to women's choices for home birth and desires to avoid interventions. When women's preferences conflict with usual medical practice many professionals are concerned about ethical and liability questions. Institutional policies/practices designed to minimize risk exposure that are inconsistent with a woman's right to make choices about her care can precipitate controversy and sometimes conflict about how to provide care under those circumstances. Proactive risk management strategies that anticipate controversies and create appropriate protocols can help avoid conflicts arising in the midst of clinical care.

Overall, we noted a lack of planned, regularly scheduled, multidisciplinary quality assurance/quality improvement activities that center on primary maternity care, where research findings, best practices and care protocols are reviewed. Most often it appeared that midwifery care was discussed when there was a need for multidisciplinary input into planning a woman's care or when controversies arose about client situations. These discussions are largely ad hoc and outside an overall quality framework.

The GASHA site has received external funding for undertaking MORE^{OB}, a multidisciplinary continuing education risk management program widely used in Canada. Its prohibitive cost has been a barrier to more widespread use in NS. The experience in other provinces shows that smaller centers benefit from well structured programs such as MORE^{OB} since they often lack on-site resources to prepare and monitor clinical education programs.

- **Priority populations**

An expected competency of midwives is provision of culturally appropriate/competent care across a range of populations; midwifery practices should reflect this competence in their activities and clientele. Because so few midwives are in practice, their caseloads have been quickly filled and requests for care are largely met on a first come – first served basis. Their clinical activities are time consuming and leave little time for engaging in outreach activities, such as meeting with women or community groups who may not have an understanding of midwifery care. In GASHA and South Shore, the midwives are beginning to extend prenatal services into smaller communities as a means of reaching more women. The midwives are required to report their progress in serving priority communities/populations and their caseloads show evidence of reaching a diverse clientele. The requests for midwifery care are likely to quickly exceed the available capacity, which indicates a need for ensuring that outreach and diversity are prioritized.

Recommendations

Our distillation of the issues has resulted in the following series of recommendations. The majority are directed to the DHW to address overall policy considerations. A few concluding recommendations are specific to sites.

We recommend that the DHW:

I. Stabilize and strengthen the existing midwifery services

1. Provide funds for second attendants

Immediately create an annual allocation of funds (estimated at \$20,000 for 1-2 years) to support development of the role (orientation, updating CPR and NRP certification as needed) and contracting of services in GASHA and SSDHA for second attendants (health personnel other than midwives who have a defined skill set, attend and assist the midwife at a home birth). This support would enable GASHA midwives to begin sooner to offer home births and give SSDHA midwives flexibility with on-call arrangements to support their current volume of home births. Second attendants might also be needed during resumption of services in Halifax.

2. Recruit a midwifery practice specialist

Establish a new position and recruit very soon an experienced midwifery leader to be the provincial head of midwifery, contracted by the DHW. (Agreements may be necessary with District Health Authorities to enable some aspects of the position.) The person should be designated a *midwifery practice specialist* with the following areas of responsibility:

- Provide leadership in the recruitment, staffing and organization of the midwifery service in Halifax as a first priority
- Review and recommend practice policies and be the principal liaison to medical, nursing and administrative personnel in the reorganization of the Halifax service
- Be eligible for registration with the MRCNS on the basis of active practice as a midwife in a Canadian province in order to provide (limited) midwifery clinical services in the Halifax area
- Oversee the standard of professional practice, help develop and participate in quality improvement activities in midwifery practice sites
- Contribute to performance appraisals of midwives by assessing practice competency

- Act as a consultant to midwives and others about practice issues and the scope and standards of midwifery practice
- Participate in planning expansion of midwifery; provide direction and assist the integration of midwives into a new district

We recommend an appointment, ideally, for 5 years. An alternative may be secondment of an external leader for no less than one year while recruiting for a longer term appointee. An assessment of the need for and scope of responsibility should be conducted at the end of five years. Aspects of the role may in time be taken over by the professional association or regulatory council. A larger educational role could evolve in conjunction with a part-time attachment to the Reproductive Care Program.

3. Work with DHAs and IWK , SSRH, St Martha's Regional Hospital to implement organizational changes for midwives

We recommend that midwives be credentialed by hospitals in a process analogous to physicians as the means of obtaining privileges consistent with their scope of practice.

Our rationale for recommending a credentialing process for midwives is to recognize and support their responsibilities as primary maternity care providers and assist in establishing collegial relationships with medical staff. There is no inherent contradiction between an employment model and obtaining privileges through a credentialing process with a Departmental appointment. This arrangement has been in place successfully in Manitoba for over a decade. Operational and employee standards belong with the DHA and standards of professional practice with the Department Head. We recommend the accountability be shared between the Department Head and the midwifery practice specialist.

The midwives would be appointed to a hospital department such as primary care /family medicine until there are sufficient midwives in a district to support a midwifery department, or a division of midwifery within family medicine.

Halifax: accomplishing organizational change

- Undertake exploring with Capital District Health Authority (CDHA) the feasibility of assuming the administrative/employer responsibility for midwifery services. This is the clearest way to separate administrative and professional practice accountabilities. The midwives should be located in a setting with other community based primary care services, preferably in a location that provides access for priority populations. One site mentioned to us was the North End Community Health Centre because of its location and the presence of other primary care providers. Potentially, the Center

could contract with CDHA for midwives' services with CDHA as the employer.

- If employment with CDHA proves not to be feasible, then discussions will be required within IWK to continue as the employer but with different arrangements that separate administrative and professional practice accountabilities.
- In either circumstance, we recommend that DHW direct a change to hospital by-laws that would permit midwives to be credentialed within the Family Medicine Department of IWK.

SSDHA and GASHA: accomplishing organizational change

- We recommend that DHW direct changes to the hospital by-laws at St Martha's Regional Hospital and South Shore Regional Hospital that would permit midwives to be credentialed within an appropriate department of the medical staff.

We recommend that the DHW:

II. Announce a plan for growth of midwifery in Nova Scotia

- 1. Articulate a long term goal for the province to have midwives in each District as an essential part of women's health care services. For the near future, establish a target of having 20 FTE funded midwifery positions in total by the end of fiscal 2017.**

New positions should be introduced in stages according to the following timetable:

- An immediate new position for a midwifery practice specialist
- Increase of 1 FTE position to SSDHA within 6-12 months
- Increase of 1 FTE to GASHA in within 12-18 months
- Increase of 5 FTE positions to Halifax by the end of 5 years enabling the formation of 2 practice groups of 4 midwives each (total of 8 positions in Halifax)
- Increase of 1 FTE to SSDHA and 1 FTE to GASHA by the third year to bring each group to 4FTE
- 2 FTE to a new district in 2-3 years increasing to 3 FTE after 2 further years, with provision for second attendants

- In addition to the 20 FTE positions, the MRCNS will require added administrative support to carry out essential functions

2. Introduce midwifery to a new district

We recommend the DHW initiate a process to introduce midwifery within the next 2-3 years into a District without midwives. Both Annapolis Valley Health and Cape Breton Health Authority were suggested to be suitable. There is expressed consumer interest in Annapolis Valley. There may be opportunities within primary maternity care in Cape Breton to work with First Nations communities. The paper we received authored by Mariah Battiste about midwifery in First Nations communities in Cape Breton provides thoughtful ideas for midwifery involvement.

An implementation committee should assist with and monitor an explicit year long integration process of midwives into a new district. The plan should include team building within the maternity service. Midwives should be informally mentored by existing primary health care providers to gain an understanding of usual patterns of practice. Conversely, midwives need to orient existing providers to their professional standards and philosophic principles.

The organizational model of a new practice should be appropriate to the setting, the preferences of midwives and women, and meet standards of the MRCNS. In any new site midwives must be integrated as primary maternity care providers

3. Support overall primary maternity care in parallel with expanding midwifery

We recommend that attention be paid to stabilizing physicians who provide primary maternity care when midwifery is introduced in a new district, particularly where birth volumes are smaller.

Funding strategies that retain family physician and/or obstetrician involvement in primary maternity care are important for promoting collaborative arrangements. Midwives and family doctors can explore a range of options for working together, e.g. shared care, cross-coverage for “back-up” when needed, separate practices with shared quality improvement and continuing education sessions.

We are aware of an innovative funding model in the South Community Birth Program in Vancouver, BC (www.scbp.ca) where midwives and family doctors work in partnership. Income is derived from two funding streams, but partners pool funds and establish individual compensation.

4. Explore partnerships with other Atlantic Provinces to develop educational opportunities

We suggest that Nova Scotia take the lead in forming partnerships with other Atlantic Provinces in developing a bridging program for the region. In order to increase the number of midwives who qualify for NS registration, a bridging program is needed that provides assessment, teaching and skills development on an individual basis for midwives educated in other jurisdictions whose competencies differ from Canadian norms.

Secondly, we suggest that NS explore options for providing university preparation in midwifery for those who aspire to a career in midwifery. An Atlantic consortium of degree granting institutions is one option that would capitalize on keeping students close to their home province. A second option is exploring interprovincial cooperation to “hold” seats for Atlantic students in one or more of the currently existing 7 programs in Canada.

We recommend that the DHW:

III. Formalize accountability for midwives to serve priority populations

We recommend the DHW /Health Authorities require that midwifery practices reserve 50% of midwifery caseloads for women from priority populations and that midwives be expected to take part in community outreach activities as part of paid employment.

Women and infants are often the most disadvantaged members of marginalized groups. Midwifery care offers opportunities for relationship building, health education and participatory decision-making that can build confidence and trust with professions and health care systems.

Activities such as the following can contribute to serving diverse populations

- Work together with stakeholders within the district to develop the profile of priority populations.
- Build relationships and seek opportunities to include women in care who may have minimal understanding of midwifery.
- Stimulate and assist in programs to train doulas (women who provide labour support and “coaching”) who also can provide links to community groups/agencies, knowledge of cultural practices and may share a common language with clients.
- Implement newer approaches to prenatal care, such as group visits that are part of centering pregnancy, a newer form of care that supports community relationships. [See Endnote 1]

- Establish satellite sites for antenatal and postnatal visits in easily accessed facilities (community centres/halls, churches, local health clinics).

We encourage the Midwifery Coalition of Nova Scotia to partner with midwives to develop community outreach programs that increase awareness and knowledge about midwifery care.

We recommend that the DHW:

IV. Strengthen maternity care team functioning and quality improvement processes

We recommend that DHW request RCP undertake working with districts with midwifery services to plan a comprehensive program of quality improvement. RCP has credibility with health care professionals and already leads several quality improvement activities.

We further recommend that as part of the quality improvement program, DHW provide support to Districts that presently have midwifery services (and to any new districts that establish midwifery) to implement MORE^{OB} or Care Team OB, a new program that blends content from the ALSO program with team training. [See Endnote 2] The important principle is the inclusion of all the care providers in the setting to promote increased knowledge, team function and clear communication and action plans for emergency/ life saving skills.

A comprehensive program should incorporate a range of quality improvement activities in addition to the above. Activities such as the following need to be multidisciplinary, coordinated and regularly scheduled:

- mandatory case reviews of near misses,
- significant morbidity and mortality arising from low risk maternity care; follow-up of adverse events
- random chart audits by peers to assess quality of record keeping
- systematic review of the frequency of specific practices e.g. elective induction of labour, frequency of episiotomy, postpartum hemorrhage
- review of situations where client or provider decision making has been controversial
- principles and conduct of consultations
- preventing and resolving work place conflicts
- providing culturally competent and safe care for socially diverse populations
- educational discussions of topics of interest and recent research concerning low risk maternity care

Recommendations specific to the three model sites

I. We recommend the following to the leadership at IWK

- Participate with DHW in recruiting the senior midwife practice specialist and provide a suitable clinical appointment at IWK to facilitate aspects of the role.
- Take steps to credential midwives to the Department of Family Medicine at the IWK with privileges consistent with their scope of practice.
- Undertake development of a program/centre of excellence focused on normal birth, engaging midwives, public members, family doctors, nurses and obstetricians in planning. Orient policies, practices and the physical setting to promote and support care practices that apply to the large percentage of women who are not referred for high risk conditions.
- Amend the present home birth policy such that conflicting obligations to women's choices and employer policies are removed, (e.g. antibiotics when GBS+, inability to use tubs). Restrictive policies that create difficult ethical dilemmas for midwives could result in women resorting to unattended home births.

II. We recommend the following to midwives and others within GASHA

- Create more multidisciplinary opportunities for case reviews, quality improvement discussions (current topics and practices) in which obstetricians, family doctors and midwives are participants.
- The midwives create a plan for attendance at out of hospital births incorporating second attendants to increase service coverage.
- The health authority explore with DHW funding methods to facilitate participation of interested family physicians in the multidisciplinary maternity clinic at St Martha's Regional Hospital. It should be possible to evolve the obstetrical service to a larger consultative role for midwives and family doctors who provide primary maternity care.

- Midwives discuss with St Francis Xavier nursing faculty who are working to increase participation of First Nations people in health professions the possibility of a doula training program.

III. We recommend the following to midwives and others within SSDHA

- Create more multidisciplinary opportunities for case reviews, quality improvement discussions (current topics and practices) in which obstetricians, family doctors and midwives are participants.
- Midwives and public health personnel increase their collaboration to facilitate timely referral of antenatal and postnatal clients to community/social services.
- Midwives keep others fully informed about possible and actual booking of clients who reside outside the district and discuss best approaches for their care. Clients from within the District must have priority in bookings.

Conclusion

We think midwifery in Nova Scotia has good potential and that investment in its future is fully warranted. The preceding recommendations for change reflect local circumstances but also much larger issues. Many of the challenges that arise when midwives are introduced into a health system are not unique to one location or to midwifery itself. Maternity units across this country and elsewhere struggle with similar issues in forging productive collaborative environments. The implementation of midwifery creates change in all parts of the maternity care system. It therefore provides a perfect opportunity to strengthen the entire system of care for childbearing women. We hope the recommendations in this report will assist that effort.

Endnote 1

A detailed description of the model of group prenatal care can be found in: Massey Z, Rising SS, Ickovics J. (2006) *Centering Pregnancy Group Prenatal Care: Promoting Relationship-Centered Care*. JOGNN 35; 286-294. Accessed at www.centeringhealthcare.org/forms/bibliography/massey_2006.pdf

Endnote 2

The following description of the Care Team OB program is from the ALSO training manual, Chapter L, Safety in Maternity Care 2010:

The Care Team OB Program blends the evidence-based maternity care curriculum of the ALSO program with the teamwork development curriculum of the Team Strategies & Tools to Enhance Performance and Patient Safety (TeamSTEPPS®) program to create an institutional course which will meet the requirements for ongoing skills enhancement and emergency preparedness, along with teamwork and communication enhancements necessary to provide for safe, efficient and effective maternity care. The American Academy of Family Physicians (AAFP) and the Department of Defence (DoD) have a contract to create this patient safety product. A two-day Care Team OB Program course combines key ALSO workshops including Shoulder Dystocia, Postpartum Hemorrhage, Intrapartum Fetal Surveillance and Assisted Vaginal Delivery with key TeamSTEPPS workshops including Team Structure, Leadership, Situation Monitoring, Mutual Support, and Communication. Content and concepts learned in the two-day course are then reinforced with ongoing periodic team drills utilizing real life examples followed by structured debriefings in a local setting.