GUIDELINES FOR MIDWIVES

3rd Edition - September 2001

An Bord Altranais

First Edition: November 1990.

Revised: April 1994.

Second Edition: November 1994.

Third Edition: September 2001.

These guidelines have been revised and developed by the Midwifery Sub-Committee of An Bord Altranais. It is planned that further revisions will be undertaken in response to changes in legislation and the practice of midwifery.

The Midwifery Sub-Committee welcomes written comments with regard to the guidelines from midwives or any other interested parties. These should be sent to:

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Published by An Bord Altranais.

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1. Introduction.

An Bord Altranais, in developing and publishing the *Guidelines for Midwives,* has two main aims:

1. To inform Registered Midwives of the legislation that governs or informs their practice and to make them aware of the responsibilities and accountabilities that accrue to them as a result of that legislation.

2. To provide guidance to Registered Midwives and assist their decision making so that the care they provide is based on the best available evidence and has regard for both the safety of mother and baby and the provision of a satisfactory childbirth experience for women.

1.1 Every Registered Midwife, practising in Ireland, is responsible for having a copy of, and being familiar with, the contents of the *Guidelines for Midwives* and it should inform her* practice.

1.2 Each Registered Midwife is accountable for her own practice. This applies regardless of whether or not she is self-employed or employed by a healthcare provider.

1.3 Each Registered Midwife is required to give due regard to these and any subsequent documents issued by An Bord Altranais:

The Code of Professional Conduct for each Nurse and Midwife, April 2000.

Scope of Nursing and Midwifery Practice Framework, April 2000.

Guidance to Nurses and Midwives on the Administration of Medical Preparations, 2000.

Guidance to Nurses and Midwives on the Development of Policies, Guidelines and Protocols, December 2000.

Guidance for Nurses and Midwives with Serious Contagious/Infectious Diseases, 2001.

(*It is acknowledged that not all midwives are female but for the sake of clarity, the terms 'she' and 'her' are used throughout this document except where quoting from a particular source).

2. A Philosophy of Midwifery.

Midwifery practice is underpinned by values that guide the way in which midwives deliver care. An Bord Altranais considers that the following values should underpin midwifery practice and provide the basis for the formulation of a philosophy of midwifery:

1. Childbirth is viewed as part of the life cycle, a normal healthy event.
2. The focus of midwifery practice is pregnant women and their families and delivering women-centred maternity services.
3. Midwifery care is delivered in a manner that respects the uniqueness and dignity of each person, regardless of culture and religion.
4. The concept of partnership between the woman and the midwife is fundamental to midwifery practice. It is based on mutual trust, support and collaboration, which facilitates informed choice and decision-making and the empowerment of both the woman and the midwife.
5. Decisions about an individual midwife's scope of practice should always be made with the woman's and her family's best interests foremost and in the interest of promoting and maintaining best quality maternity services for women and their families.
6. Midwifery practice is based on the best available evidence.
7. Midwifery practice involves advocacy for the individual woman and her family.
8. Midwifery practice should always be based on principles of professional conduct as outlined in the latest version of *The Code of Professional Conduct for each Nurse and Midwife* and the *Guidelines for Midwives* produced by An Bord Altranais.

3. The Definition of a Midwife.

An Bord Altranais endorses the definition of a midwife as adopted and amended by The International Confederation of Midwives, the International Federation of Gynaecologists and Obstetricians, and the World Health Organisation.

That definition states that:

"A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and

has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.

She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for women but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service."

The definition of a midwife was adopted by the International Confederation of Midwives (ICM) in 1972 and by the International Federation of Gynaecologists and Obstetricians (FIGO) in 1973. It was later adopted by the World Health Organisation (WHO). The definition was amended by ICM in 1990 and this amendment was ratified by FIGO in 1991 and by WHO in 1992.

4. The Scope of Midwifery Practice.

The scope of midwifery practice is the range of roles, functions, responsibilities and activities that a Registered Midwife is educated, competent and has authority to perform.

More specifically, the scope of midwifery practice is identified in the EEC Directive of 1980 (80/155/EEC).

It states that:

"Member states shall ensure that midwives are at least entitled to take up and pursue the following activities:

1 to provide sound family planning information and advice;

2 to diagnose pregnancies and monitor normal pregnancies; to carry out examinations necessary for the monitoring of the development of normal pregnancies;

3 to prescribe or advise on the examinations necessary for earliest possible diagnosis of pregnancies at risk;

4 to provide a programme of parenthood preparation and a complete preparation for childbirth including advice on hygiene and nutrition;

5 to care for and assist the mother during labour and to monitor the condition of the fetus in utero by the appropriate clinical and technical means;

6 to conduct spontaneous deliveries including where required, an episiotomy and in urgent cases a breech delivery;

7 to recognise the warning signs of abnormality in the mother or infant which necessitate referral to a doctor and to assist the latter where appropriate; to take the necessary emergency measure in the doctor's absence, in particular the manual removal of placenta, possibly followed by manual examination of the uterus;

8 to examine and care for the newborn infant; to take all initiatives which are necessary in case of need and to carry out where necessary immediate resuscitation;

9 to care for and monitor the progress of the mother in the postnatal period and to give all necessary advice to the mother on infant care to enable her to ensure the optimum progress of the newborn infant;

10 to carry out the treatment prescribed by a doctor;

11 to maintain all necessary records."

An Bord Altranais supports the right of all midwives to practice in accordance with the EEC Council Directive 80/155/EEC.

4.1 If a midwife wishes to, or is being asked to, expand her practice, she should refer to the *Scope of Nursing and Midwifery Practice Framework, April 2000,* produced by An Bord Altranais, and work through the decision-making framework. Nothing in this or any other document produced by An Bord Altranais should be construed as prohibiting a midwife from expanding her practice in relation to any particular practice/procedure provided she has ascertained, by working through the decision-making framework, that it is appropriate to do so.

4.2 An Bord Altranais endorses the practice of developing policies, guidelines and protocols to support the provision of best quality care to women and babies. Midwives should consult the publication *Guidance to Nurses and Midwives on the Development of Policies, Guidelines and Protocols, December 2000* in order to ascertain how best to do this. However, An Bord Altranais acknowledges that policies, guidelines and protocols cannot possibly account for every particular circumstance that a midwife may encounter. They should provide a background to individualised care. Midwives must be cognisant that their own professional judgement

should not be compromised or ignored if deviation from policies, guidelines or protocols is appropriate. However, the decision should not be taken lightly and, where appropriate, consultation with colleagues is advisable. Reasons for the deviation should be clearly documented.

Each midwife has a responsibility to familiarise herself with any policies, guidelines or protocols produced by her employer or her supervising authority.

4.3 A key element in relation to determining scope of practice is competence. A midwife must make a judgement as to whether she is competent to carry out a particular role or function. She must also take measures to develop and maintain the competence necessary for professional practice. Competence is not static. A midwife may learn a specific skill but the knowledge underpinning that skill may change over time. This can affect the ability to practice that skill. In addition, practice is necessary to maintain competence. A midwife must acknowledge any limitations of competence and refuse in such cases to accept delegated or assigned functions. If appropriate, the midwife must take measures to gain competence in the particular area. The maintenance of competence and ensuring its continuing development is achieved by engaging in continuing professional development. Midwives have a personal responsibility to engage in continuing professional development. Midwives in managerial positions also have a role in encouraging, supporting and assisting midwives to engage in continuing professional development in order that they may remain competent practitioners of midwifery.

5. Registration and Practice as a Midwife.

An Bord Altranais acknowledges and supports the distinct professional identity of midwives.

Midwives are currently registered in the Midwives Division of the Register maintained by An Bord Altranais as laid down in the Nurses Act, 1985.

5.1 An individual may not use the title 'midwife' unless her name is entered in the Midwives Division of the Register. The correct title to be used by midwives is 'Registered Midwife' or RM. No other title should be used.

5.2 An individual may not practise as a midwife unless her name is entered in the Midwives Division of the Register and she has paid the appropriate Retention Fee in the current year.

5.3 Whilst there is no legal requirement to do so, An Bord Altranais recommends that a midwife returning to practice after an absence of five years or more should complete a *Return to Midwifery Practice Course* prior to engaging in midwifery practice or being employed as a midwife. This is in order to update her theoretical knowledge and clinical skills. It falls within the remit of employers to insist that such a course be completed. Information about such courses may be obtained from An Bord Altranais.

6. Specific Requirements and Guidelines for Midwives not employed by a Health Board/Maternity Hospital/Maternity Unit.

6.1 Under current legislation governing midwives, Section 57 (1) of the Nurses Act, 1985 states that:

"Where a midwife, who is not employed by a health board or by a hospital authority providing maternity services or by a maternity home authority, is practising or proposes to practise midwifery, he shall notify the health board, or health boards, as the case may be, in whose functional area he practices or intends practising of such practise or proposal to practise."

6.1.1 This requirement includes those midwives who are employed as *Practice Nurses* and who provide any aspect of midwifery care as part of that role.

6.1.2 The midwife should provide, in writing to the Health Board, details of her full name, address, phone number and information about the capacity in which she intends to practice, e.g. domiciliary midwifery practice, practice nurse. Midwives employed as *Practice Nurses* should indicate, in their letter of notification, whether or not they will be engaged in the provision of a home birth service. If a midwife intends to practise from an address other than her home address, she should give details of this. A copy of her current An Bord Altranais registration certificate should be enclosed.

6.1.3 This notification of intention to practice should be renewed on an annual basis in March of each year. March is selected so that the midwife has received her current An Bord Altranais registration certificate and will be able to enclose a copy of it.

6.2 Section 57 (2) of the Nurses Act, 1985 states that:

> "It shall be the duty of a health board in whose functional area a midwife of the type referred to in subsection (1) of this section is practising or proposes to practise to exercise, in accordance with regulations made by the Minister, general supervision and control over such a midwife."

It is up to each Health Board to decide how Section 57(2) is actually implemented. In practice, the Director of Public Health Nursing in the specific area where the midwife practices is usually delegated to carry out this role and function.

6.3 A midwife, such as described in Section 57 (1) of the Nurses Act, 1985, should familiarise herself with any local health board/health authority regulations that may exist and which are relevant to her practice.

A midwife must provide every reasonable facility for inspection, by a designated representative of the Health Board/Health Authority or An Bord Altranais, of:

- methods of practice,
- records,
- equipment,
- such part of any premises as she may use for professional practice. The private residence of any woman that the midwife may care for is excluded from this provision.

6.5 A midwife who enters into an agreement with a woman to provide for her care, should take all reasonable steps to ensure that the woman can make contact with her within a reasonable time period. Prior to entering into an agreement with the woman, the midwife should take note of:

a) the time it is likely to take for the midwife to travel to the woman's proposed place of giving birth,

b) the time it is likely to take to transfer the woman to the nearest maternity facility,

c) the woman's past and current health status, her past obstetrical history and her current obstetrical status.

Only then can the appropriateness of any agreement be considered.

6.6 If a midwife is going to be, or becomes, unavailable to a woman whom she has agreed to provide care for, she should notify the woman and

make appropriate alternative arrangements for the woman's care. This may involve arranging, with the woman's consent, for another midwife to provide care or for the woman to attend a maternity facility. The possibility of this occurring should be discussed early in the woman's pregnancy. The fact that this discussion took place should be documented in the woman's chart.

7. Home births.

It would be inappropriate for An Bord Altranais to issue specific guidelines with regard to the suitability of women for home birth. However, a midwife should base her decision to attend at a home birth on an assessment of the individual woman, the competence of the midwife and the best available evidence at that time.

In making a self-assessment as to whether or not she is competent to provide care at a home birth, a midwife should take cognisance of the breadth and depth of her knowledge and clinical experience and not just the number of years she has been a midwife. It is strongly recommended that a midwife who does not have prior experience of attending at home births should not initially attend at home births without the presence of another midwife who has experience in this area.

When entering into an agreement to provide care for a woman having a home birth, the midwife should make clear to the woman that circumstances may arise which would cause the midwife to recommend that consultation with another health professional or transfer to a maternity facility is appropriate. The midwife should document any discussion that takes place in this regard.

7.1 If the woman is requesting a type of care that the midwife considers is not consistent with safe practice and the woman is reluctant to accept the advice of the midwife in this regard, the midwife should –

a) discuss the situation fully with the woman, identifying all options that may be available to her.

b) seek the advice of professional colleagues.

c) continue to provide care for the woman until such time as the situation has been resolved or the midwife is satisfied that the woman has made appropriate alternative arrangement for her care.

d) if the situation remains unresolved, it is advisable that the midwife notifies the person, appointed by the health board to act in a

midwifery supervisory capacity, of the situation.

e) all discussions and actions that take place should be clearly documented.

7.2 If a woman indicates to a midwife that she wishes to be transferred to a maternity facility, the midwife should respect the woman's wishes and assist in making arrangements for the transfer. The midwife should exercise her professional judgement as to the advisability of transfer if the woman's labour is at such an advanced stage as to possibly make transfer unsafe. This should be explained to the woman and documented in the woman's chart.

8. Emergency Situations.

Nothing in this document or any other document produced by An Bord Altranais should be construed as preventing a midwife from taking appropriate action in the case of an emergency. A midwife, whilst initiating emergency care, should call to her assistance a qualified health professional. This individual should be someone whom the midwife may reasonably expect to have the requisite skills and experience necessary to assist the midwife. Due consideration should also be given to the location of the emergency situation and the decision about whom best to call for assistance. At all times, the best interests of the mother and baby should be the priority.

8.1 All practising midwives should have the necessary knowledge, skills and appropriate equipment to provide emergency care in the following situations:

a) Antepartum haemorrhage.

b) Postpartum haemorrhage.

c) Eclamptic fit.

d) Cord prolapse.

e) Shoulder dystocia.

In addition, midwives should be familiar with the particular adaptations that need to be made to Cardio-Pulmonary Resuscitation (CPR) techniques if they are to be carried out on a pregnant woman.

8.2 With regard to resuscitation of the neonate, all midwives should have the necessary knowledge, skills and equipment to provide care to a baby by:

a) Maintenance of normal body temperature.

b) Clearing of the airway – through suctioning and positioning.

c) Assessment of respiratory effort, heart rate and colour.

d) Provision of tactile stimulation, when required.

e) Provision of free-flow oxygen, when required.

f) Provision of bag and mask ventilation, when required.

g) Provision of cardiac massage, when required.

All midwives should be able to assist another health professional who is intubating a baby and who is administering resuscitation medications. It is not expected that all midwives will have the knowledge and skills necessary to carry out intubation but nothing in this document should be construed as preventing a midwife from carrying out this procedure provided she is competent to do so. In an emergency situation, where appropriate medical assistance is not readily available, it may be appropriate for midwives to administer resuscitation medications.

8.3 Deviations from the norm.

Where a deviation from the norm, which is outside the scope of practice of a midwife, becomes apparent in the mother and/or baby, the midwife should consult with or refer the woman and/or baby to an appropriate health professional. The individual circumstances of each case will dictate who is the most appropriate health professional. The consultation/referral should be clearly documented.

8.4 Midwives not in current practice.

A person, employed as a nurse but with a midwifery qualification, may in an emergency be called upon to deal with an obstetric emergency situation or care for a woman in an advanced stage of labour. In such a situation, whilst calling for assistance, the person should provide care to the woman to the best of her ability. If this situation arises on a not infrequent basis, e.g. because of geographic location, then the person should discuss with their manager the need for them to attend a refresher course in order to update their skills. Their nurse manager has a responsibility to assist in facilitating attendance at such a course. The nurse manager should also take steps to ensure the provision of basic equipment that may be required in such a situation.

9. Prohibition on attending a woman in childbirth.

Section 58 of the Nurses Act, 1985 states that:

(1) No person shall attend a woman in childbirth unless such a person is –

(a) a midwife, or

(b) a registered medical practitioner, or

(c) undergoing training to be a medical practitioner or a midwife and gives such attention as part of a course of professional training, or

(d) undergoing experience and training in obstetrics and gives such attention as part of a course of professional training,

unless such attention is given, otherwise than for reward, in any case of sudden or urgent necessity where neither a midwife nor a registered medical practitioner is immediately available.

(2) Any person who acts in contravention of subsection (1) of this section shall be guilty of an offence and shall be liable on summary conviction of a fine not exceeding £1,000".

10. Record Keeping.

Record keeping is an integral part of midwifery practice and a reflection of the standard of an individual midwife's professional practice.

Record keeping is essential for the following reasons:

a) To document the condition and care of women and babies.

b) To facilitate communication between the woman and all members of the healthcare team.

c) To provide documentary evidence that may be required for the purposes of

i) Clinical audit,

ii) Childbirth debriefing,

iii) Dealing with complaints,

iv) Fitness to Practice enquiries,

v) Medico-legal enquiries.

Record keeping may also be necessary for

d) Teaching of midwifery students.

e) Use in research – subject to ethical considerations.

10.1 Midwives should be aware that women are entitled, under the Freedom of Information Act, 1997 to access a copy of any healthcare records that are maintained by a healthcare institution and which applies to them.

10.2 An Bord Altranais recommends that standards of record keeping by midwives be audited at local level.

10.3 Recommendations for good quality record keeping include the following:

10.3.1 - All entries should be written in legible handwriting. Midwives who have handwriting that is difficult to read should print their entries.

10.3.2 - Entries should be dated and timed using the 24-hour clock. The timing of entries is particularly important in the labour/delivery record and if complications occur.

10.3.3 - Entries should be in chronological order.

10.3.4 - All signatures should be legible and the surname should be written in full. The use of initials is not acceptable except on charts where there is a designated place to write a full signature and initials and thereafter, in that chart, initials are used e.g. a drug administration record.

10.3.5 - If all members of the healthcare team write in the same areas of the chart, the status of each individual making an entry in the chart should be clearly identifiable. When signing entries midwives should write *Clinical Midwife Manager 1,2 or 3 (CMM 1,2 or 3), Clinical Midwife Specialist (CMS), Staff Midwife (S/M), Midwifery Student (M/Std) or (Registered Midwife) R.M.* as appropriate.

10.3.6 - If a midwife consults with or makes a referral to another member of the healthcare team, then that person should be clearly identified by name in the chart. 'Seen by doctor' or 'doctor informed' is <u>not</u> acceptable.

10.3.7 - All decisions to take no immediate action but review the situation later ('wait and see') should be clearly documented.

10.3.7 - It is best practice to document in the notes as soon as possible after providing midwifery care. However, this may at times prove to be difficult especially in an emergency situation. Late entries are acceptable provided that they are clearly documented as such. It

should always be clear from the notes what time an event occurred and what time the record was written.

10.3.9 - Abbreviations, if used, should be ones that are easily recognisable e.g. APH = antepartum haemorrhage. It is recommended that each maternity facility draw up an approved list of abbreviations. *Right* and *left* should always be written in full and not abbreviated to *R* and *L*.

10.3.10 - All narrative notes should be accurate, factual, unambiguous and devoid of any derogatory remarks. Narrative notes should be written frequently enough to give a picture of a woman or baby's condition to anyone reading them.

10.3.11 - Entries made in error should be bracketed and have a single line drawn through them so that the original entry is still legible. They should be signed and dated. No attempt should be made to alter or erase the entry made in error. Erasure fluid e.g. Tippex, should never be used.

10.3.12 - Cardiotocograph traces (CTG) All CTG traces should have identification details clearly written at the beginning of the trace i.e. name of woman, date and time. If the CTG machine has an automatic timer on it, this should be checked against the actual time and any errors noted and rectified.

It is essential to record the maternal pulse once at the beginning of the trace and document it on the trace. Any interruptions in the trace should be explained. At the end of the trace, a note should be made of either delivery details or why the trace was stopped. All reviews of the trace by midwifery or medical staff should be documented. (An Bord Altranais is not in any way suggesting that all women should have CTG traces carried out. Their use should be as clinically indicated).

10.4 Storage of records:

All healthcare facilities have in place a system for the storage of past and current records. Midwives who work independently must take responsibility themselves for the appropriate storage of records. Records should be kept in a secure, damp-proof and fireproof place and filed in such a way as to make them easily retrievable. For medico-legal purposes, records should be kept for a minimum of 25 years. For advice on the appropriate maximum length of time that records should be kept for, the midwife should consult her insurance provider. If such a midwife is ceasing to practice, she should contact the health board/health authority in whose area she practices, with a view to arranging to transfer the records to their safekeeping.

11. Delegation.

Delegation is the transfer of authority by a midwife to another person to perform a particular role/function.

Each Registered Midwife is accountable for her own practice. The midwife who is delegating (the delegator) is accountable for the decision to delegate. This means that the delegator is accountable for ensuring that the delegated role/function is appropriate and that support and resources are available to the person to whom the role/function has been delegated. The midwife (or other person) to whom the particular role/function has been delegated is accountable for carrying out the delegated role/function in an appropriate manner.

When delegating a particular role/function, the midwife must take account of the following principles:

1. The midwife must ensure that the primary motivation for delegation is to serve the interests of the woman and/or baby.
2. The midwife must ensure that the delegation is appropriate with reference to the definition and philosophy of midwifery.
3. The midwife must take the level of experience, competence, role and scope of practice of the person to whom the role/function is being delegated into account.
4. The midwife must not delegate to junior colleagues, tasks and responsibilities beyond their skill and experience.
5. The midwife must ensure appropriate assessment, planning, implementation and evaluation of the delegated role/function.
6. The midwife must communicate the role/function in a manner understandable to the person to whom it is being delegated.
7. The midwife must decide on the level of supervision and feedback necessary.

A midwife to whom a particular role/function has been delegated should take account of the following principles:

1. The midwife must consider if it is within her current scope of practice. If the delegated role/function is beyond the current scope of practice of the midwife, the midwife will need to consider the appropriateness of this delegation. In this circumstance the midwife must refer to An Bord Altranais' *Scope of Practice Framework.*

2. The midwife must acknowledge any limitations of competence.
3. The midwife must provide appropriate feedback to the delegator.

12. Responsibilities towards Midwifery Students

All Registered Midwives have responsibilities with regard to the teaching, support and supervision of midwifery students. Registered Midwives should regard it as an integral part of their role to assist midwifery students in acquiring and developing their knowledge and, in particular, their clinical skills. When delegating to midwifery students, Registered Midwives should take account of the guidelines as set out in *Section 11* of this document.

13. Notification of Births.

Section (1) Subsections (1) and (2) of the Notification of Births Act, 1907 and Notification of Births Act (Extension), 1915 provides that:

"It is the duty of the parent and *any person in attendance on the mother at the birth, or within six hours of the birth,* whether the child is born alive or dead, to notify, within thirty-six hours, the medical officer of health of the district of the birth".

13.1 In practice, most healthcare institutions, in conjunction with the local health board/health authority, have in place a system whereby this obligation is fulfiled. However, a midwife should ascertain that such a system is in place and that she does not have any particular function in this regard.

13.2 Midwives in independent midwifery practice should take note of their obligations in this regard.

The second page (yellow page) of the four-part Birth Notification /Registration Form should be utilised for the Notification of Births. This should be sent to the Medical Officer of Health of the district where the birth took place.

The third page (green page) of the form should be completed, by the midwife, and sent to The Information Management Unit in the Department of Health and Children.

The four-part Birth Notification/Registration Form is available from the office of the Superintendent Registrar of Births, Deaths and Marriage. There is a Superintendent Registrar for every county.

14. Registration of Births.

Section (1) of the Births and Deaths Registration (Ireland) Act, 1880 provides that:

It is the duty primarily of the father or mother to give to the registrar of births information of the birth within forty-two days, in the case of every child born alive. In default of the father or mother this duty falls upon every person, *including the midwife,* present at the birth.

14.1 In practice, most healthcare institutions have in place a system whereby this obligation is fulfiled and whereby mothers/parents are assisted in the process of registering their baby's birth. However, a midwife should ascertain that such a system is in place and that she does not have any particular function in this regard.

14.2 Midwives in independent midwifery practice should take note of their obligations in this regard. The first page (white copy) of the four-part Birth Notification /Registration Form should be utilised. This should be sent to the Registrar of the district in which the birth took place.

14.3 The particulars entered in the Register of Births are governed by the Registration of Births Act, 1996. Mothers/parents should give due consideration to the particulars entered in the Register. This is particularly important with regard to the surname that the baby is to be given when the birth is registered. A wish to change particulars may involve a lengthy and costly procedure and may, ultimately, not be successful.

Further information may be obtained from the Superintendent Register's Office.

14.4 Abandoned babies:

It should also be noted that, under Section (3) of the Births and Deaths Registration (Ireland) Act, 1880:

When a living new born child is found exposed it is the duty of any person finding the child and of *any person in whose charge such child is placed* to give the appropriate information and particulars to the registrar within seven days.

15. Registration of Stillbirths.

Stillborn babies are registered under the terms of the *Stillbirths Registration Act, 1994.* This Act applies to "a child born weighing 500 grammes or more or having a gestational age of 24 weeks or more who shows no sign of life".

The commencement date for the Act was the 1st January 1995. All stillbirths occurring after this date must be registered. The parents may register stillbirths that occurred before this date, if they so wish.

15.1 The registration procedure.

The mother or father of a stillborn baby may, within forty-two days of the birth, register the stillbirth. They will require a certificate signed by a registered medical practitioner, who has attended the birth or has examined the child, stating, in the opinion of the medical practitioner, the weight and gestational age of the child and naming, where applicable, the hospital in which the birth occurred or which had care of the mother following the birth. If the medical practitioner is not fully satisfied that the birth was a stillbirth, the medical practitioner shall refer the matter to the coroner.

Once the parents have registered the stillbirth, the Registrar will notify the hospital named in the certificate, or the medical practitioner who signed it, that such registration has taken place. If the parents do not register the birth within the designated forty-two days, then the Registrar will write to the mother and inform her that if the parents do not register the stillbirth within three months (i.e. a further six weeks), then the hospital or medical practitioner is obliged by law to do so. The letter that the mother receives will inform her that if the hospital completes the registration process, it has implications for the way the stillbirth is registered, especially if the parents are not married.

If, within three months of the stillbirth, the parents do not complete the registration process, then the hospital or medical practitioner must, within four months of the stillbirth, register the stillbirth.

In practice, most healthcare institutions have in place a system whereby this obligation is fulfiled and whereby mothers/parents are assisted in the process of registering the stillbirth of their baby. However, a midwife should ascertain that such a system is in place and that she does not have any particular function in this regard.

15.2 Home births and stillbirth/neonatal death.

If a stillbirth or neonatal death occurs at a home birth, the midwife in

attendance is not authorised to certify the stillbirth or neonatal death. She should explain to the parent(s) that the certificate has to be signed by a Registered Medical Practitioner. If the medical practitioner is not fully satisfied as to the cause of the stillbirth, then the medical practitioner must report the matter to the coroner (Stillbirths Registration Act, 1994). A medical practitioner may only certify a death if the medical practitioner is satisfied that the death is the result of natural illness or disease for which the person who died has been seen and treated by a registered medical practitioner within one month before the death took place (Coroners Act, 1962). If these conditions do not apply, then the medical practitioner must report the matter to the coroner. The coroner may stipulate that a post-mortem examination is carried out. In these circumstances, the consent of the parent(s) is not required. In the case of a neonatal death, the coroner may also decide to hold an inquest. The coroner will then forward a certificate of stillbirth/death to the Registrar's Office.

The midwife providing care for the mother has an important role in explaining the legal requirements of the situation to the parent(s) and in facilitating the legal process. The midwife should document any discussions that take place in this regard.

16. Use of Medical Preparations.

An Bord Altranais has prepared a document to assist midwives in relation to the administration of medical preparations, including epidural analgesia. Midwives should be familiar with, and adhere to, the directions of An Bord Altranais as published in *Guidance to Nurses and Midwives on the Administration of Medical Preparations 2000* or any subsequent editions of this document.

A midwife is responsible for any medical preparation that she administers. A midwife must not administer any medical preparation unless she is thoroughly familiar with its use. In particular, she must ascertain that there is no contraindication to the use of the particular medical preparation during pregnancy, in lactating women or to a neonate, as appropriate. If a midwife is not thoroughly familiar with a particular medical preparation, she should consult the manufacturers information leaflet, an up-to-date drug reference textbook or a pharmacist.

The control and administration of medical preparations is governed by the Misuse of Drugs Act, 1977, the Misuse of Drugs Act, 1984 and regulations made pursuant to these acts. A midwife must adhere to all relevant aspects of

Irish legislation related to the administration of medical preparations. Most relevant aspects of the legislation are incorporated into the *Guidance to Nurses and Midwives on the Administration of Medical Preparations 2000.* However, two specific pieces of legislation has particular relevance for midwives:

1. *Misuse of Drug Regulations, 1988 (S.I. No. 328 of 1988).*

   Article10 of these regulations states in sub-article (1) that "a midwife who is employed by a health board or a hospital authority to provide community based maternity services or who has in accordance with the provisions of section 57 of the Nurses Act, 1985, (No.18 of 1985) notified to a health board her intention to practise may so far as is necessary for her practice as a midwife, have in her possession or administer any medical preparation which contains pentazocine or pethidine".

   Article 10, sub-article (2) states that "Nothing in sub-article (1) shall be construed as authorising a midwife to have pentazocine or pethidine in her possession unless it has been obtained on foot of a written order signed by the midwife and an appropriate medical practitioner setting out the name and address of the midwife, the purpose for which the drug is required and the quantity to be obtained".

   Article 10, sub-article (3) states that "In this article –"appropriate medical practitioner" means a registered medical practitioner practising in the area in which the midwife practices.

   Article 17, sub-article (3) states that "A midwife authorised under article 10 to have pethidine in her possession shall –

   (a) on each occasion on which she obtains a supply of pethidine, enter in a book kept by her and used solely for the purposes of this sub-article the date, the name and address of the person from whom the drug was obtained, the amount obtained and the form in which it was obtained; and

   (b) on administering pethidine to a patient, enter in the said book as soon as practicable the name and address of the patient, the amount administered and the form in which it was administered".

2. *Medical Preparations (Prescription and Control of Supply) Regulations, 1996 (S.I. No.69 of 1996).*

   Article 14, (1) (b) provides for "the supply of a medicinal product by way of wholesale dealing". The definition of "supply by way of wholesale dealing" includes the supply of a medicinal product to a person who

obtains the product for "(b) administration in the course of a professional practice".

The Chief Pharmacist of the Department of Health and Children has advised An Bord Altranais that Article 14, sub-article 1(b) facilitates the provision of, to a midwife providing community based midwifery care, a supply of medicinal products for use in her practice. A prescription is not required for such a supply. The medicinal products that may be supplied are those that are identified in Article 5, (1) of the Regulations. These are "(a) any medicinal product which is or which contains a substance specified in column 1 of the First Schedule" and "(b) any medicinal product which is intended for parenteral administration".

An Bord Altranais takes the view that a midwife providing community based midwifery care may obtain, under the above Regulations, and have in her possession a supply of the following medical preparations for use in her practice:

(a) Ergometrine Maleate.

(b) Lignocaine.

(c) Naloxone Hydrochloride

(d) Oxytocin (For use in the 3rd stage of labour/management of postpartum haemorrhage only)

(e) Such fluids for intravenous infusion that may be required for the management of haemorrhage.

(f) Syntometrine.

All such medical preparations should be stored in such a way as to have due regard to safety, security and the manufacturer's instructions re storage conditions.

The midwife should keep a written record of when and where the supply was obtained, the amount obtained, and when, and for whom, the medical preparations were used. Any out of date medical preparations should be returned to a pharmacist for disposal and the midwife should keep a record of this.

17. Use of Complementary Therapies.

The use of complementary therapies is becoming more commonplace and they have recognised potential benefits. Complementary therapies include, but are not limited to, acupressure, acupuncture, aromatherapy, herbalism, homeopathy, massage therapy, reflexology and yoga. Midwives who wish to use complementary therapies in the course of their midwifery practice should note the following:

a) They should have undertaken an educational programme that equips them with the necessary knowledge and skills to use such therapies. If the programme was confined to a particular form of complementary therapy, then the midwife should confine her practice to the use of that particular therapy only.

b) They should be fully aware of any contraindications or restrictions to the use of a particular therapy in relation to pregnant women, lactating women or babies. This is particularly the case in relation to the use of aromatherapy, herbal preparations, homeopathic preparations and reflexology.

c) The woman should consent to the use of such therapies.

d) If a woman requests that a midwife initiate or utilise a form of complementary therapy, the midwife should only do so if she has the necessary knowledge and skills.

e) Midwives who are employed by a healthcare provider should obtain the agreement of their employer to the use of such therapies in their practice.

f) The midwife should document the use of such therapies and the response to their use.

g) The midwife is fully accountable for the use of such therapies.

17.1 The right of a woman to self-administer any form of complementary therapy should be respected. However, if a midwife has any concerns about the appropriateness of using a particular therapy, she should discuss fully those concerns with the woman. It may be appropriate to obtain additional information or advice about the use of a particular therapy. The self-administration of complementary therapies, and any discussion about it, should be documented in the woman's chart.

18. The Midwife as a possible Source of Infection.

18.1 The document *Guidance for Nurses and Midwives with Serious Contagious/Infectious Diseases* (An Bord Altranais, 2001), states that a midwife who believes that she may have been exposed to, or be infected with, any serious contagious/infectious disease, e.g. Hepatitis viruses, Tuberculosis, Human Immunodeficiency Virus (HIV) should:

1. Seek specialist medical advice and diagnostic testing. It is unethical for a midwife who considers that she might be infected with a serious contagious/infectious disease not to seek diagnostic testing.
2. Adhere to the specialist medical advice received. If the diagnostic test is positive, the midwife must follow specialist medical advice on how her professional practice must be limited in order to protect clients. Any midwifery practice involving exposure-prone procedures must cease while awaiting specialist medical advice.
3. Consider carefully her personal/professional accountability as defined in most recent edition of *The Code of Professional Conduct for each Nurse and Midwife* produced by An Bord Altranais. Failure to follow specialist medical advice would be in breach of the midwife's ethical duty of care and may amount to professional misconduct.

18.2 In addition, where a midwife has reason to believe that she has contracted or has been in contact with someone who has an infection that might pose a threat to the well-being of a mother and/or baby, she should notify her employer or supervising authority as soon as is reasonably possible. She should then follow any directions that the employer/supervising authority may give in this regard. This would apply to infections other than those identified in section 16.1 above.

19. Responsibilities in relation to Child Protection and Welfare.

(This section of *Guidelines for Midwives* has been adapted from *Children First – National Guidelines for the Protection and Welfare of Children – 1999).*

19.1 Society has a duty of care towards children and everyone should be alert to the possibility that children with whom they are in contact may be being abused. At present there is voluntary reporting of child abuse in Ireland. In 1999, the Department of Health and Children developed *National Guidelines for the Protection and Welfare of Children.* These comprehensive guidelines are directed at a wide range of individuals and

agencies that have contact with children. The main aim of the National Guidelines is to assist people in identifying and reporting child abuse.

Midwives may, in the course of their practice, become aware of or suspect that a child is being abused. If a midwife suspects child abuse, she should report her concerns to the relevant health board. When a midwife is employed in the public sector, this report to the health board is usually made by the midwife notifying a social worker in the healthcare institution in which she works. This social worker will then liaise with the appropriate health board staff. If a midwife is self-employed, she should make direct contact with the social worker on duty in the relevant health board. In the event of an emergency, or non-availability of health board staff, the report should be made to An Garda Siochana. This may be done at any Garda Station.

It is important that persons reporting suspected child abuse to the health board should establish the basis for their concerns. At the same time, they should not interview the child or the child's parents/carers in any detail without first consulting the health board; this may be more appropriately carried out by the health board social worker or An Garda Siochana. If a person has misgivings about the safety of a child and would find it helpful to discuss their concerns, they should not hesitate to contact someone in the health board such as a social worker, public health nurse or other professional staff to discuss the matter. Any professional who suspects child abuse should inform the parents/carers if a report is to be submitted to the health board or An Garda Siochana unless doing so is likely to endanger the child.

19.2 The *Protection for Persons Reporting Child Abuse Act, 1998* provides immunity from civil liability to persons who report child abuse "reasonably and in good faith" to designated officers of health boards or any member of An Garda Siochana.

19.3 Retrospective Disclosures by Adults.

In recent years there have been increasing numbers of disclosures by adults of abuse that took place during their childhood. It is recognised that the experience of pregnancy or becoming a mother may prompt a woman to disclose past experience of abuse. In these situations, it is essential that consideration be given to the current risk to any child who may be in contact with the alleged abuser. If any risk is deemed to exist, the midwife should report the allegation without delay. Investigation of disclosures by adult victims of past abuse frequently uncovers current incidences of abuse and is therefore an effective means of stopping the

cycle of abuse. The need to refer the woman who disclosed the past abuse for counselling or other support should be considered.

19.4 Under-Age Pregnancy.

For the purposes of the criminal law, the age of consent to sexual activity is 17 years. This means, for example, that a sexual relationship between two 16 year olds who are boyfriend and girlfriend is illegal, although it might not be regarded as constituting child abuse. When a pregnant girl under 17 years presents to a health service, a health professional will undertake an assessment and attempt to establish whether this pregnancy is the result of child sexual abuse. This assessment is usually carried out by a social worker. It is important to acknowledge the sensitivity required in order to facilitate vulnerable young girls to avail of medical or therapeutic services and to satisfy relevant legal requirements.

19.5 Confidentiality.

Ethical and statutory codes concerned with confidentiality and data protection provide general guidance. They are not intended to limit or prevent the exchange of information between different professional staff who have a responsibility for ensuring the protection of children. **Giving information to others for the protection of a child is not a breach of confidentiality.**

For further information or guidance, please consult the *National Guidelines for the Protection and Welfare of Children* or Health Boards/Health Authority.

20. Health and Safety Issues.

The issue of health and safety at work is governed by the *Safety, Health and Welfare at Work Act, 1989, the Safety, Health and Welfare at Work (General Applications) Regulations, 1993* and regulations made subsequent to the Act which give effect to a number of EC Directives. Breaches of the Act or Regulations can lead to criminal prosecution.

All midwives, whether employers, employees or self-employed, have duties and obligations under this legislation and need to be familiar with the relevant sections of the legislation. What follows is a brief guide to the areas that may be pertinent to midwives – for further information, a health and safety officer, the appropriate legislation or the Health and Safety Authority should be consulted.

Section 6 of the Act sets out the general duties of employers.

Section 7 of the Act sets out the general duties of employers, self-employed and persons concerned with places of work to persons other than their employees and who would include students, patients, visitors and locum or contract staff.

Section 9 of the Act sets out the general duties of employees. The main provisions of this section of the Act direct the employee to

a) to take reasonable care for her own safety and that of any other person who may be affected by his acts or omissions while at work.

b) to co-operate with the employer.

c) to use protective appliance, clothing, equipment, etc provided for safety.

d) to report, without unreasonable delay, any defects that might endanger safety.

Section 12 of the Act obliges employers to prepare a safety statement. *Regulation 10 of the Safety, Health and Welfare at Work (General Applications) Regulations, 1993* indicates that the safety statement must be in writing and must be shown to all employees. *Section 13* of the Act and *Regulation 12* of the Regulations provides for a consultation process between employer and employee and the appointment of a safety representative.

Regulation 17 and the *First, Second, Third and Fourth Schedules* of the *(General Application) Regulations* details requirements for places of work with regard to ventilation, temperature, lighting, floors, doors and gates, and sanitary facilities.

Regulation 2 and *21* and the *Sixth and Seventh Schedules* of the *(General Application) Regulations* provide details with regard to personal protective equipment.

Regulation 27 and *28* and the *Eight and Ninth Schedule* of the *(General Applications) Regulation* provide details with regard to manual handling of loads.

All midwives have a duty to abide by the relevant health and safety legislation that pertains to their role. Midwives have a responsibility to protect both themselves and others.

20.1 Midwives should have sufficient knowledge of the *Safety, Health and Welfare at Work (Pregnant employees, etc) Regulations, 1994* so as to be able to advise pregnant and lactating women with regard to the provisions of these regulations.

21. Responsibilities in relation to research.

Midwives have a responsibility to provide care to women and babies that is based on the best available evidence. The main way in which this evidence is produced is by the carrying out of research studies that are methodologically and ethically sound. Midwives should support and facilitate the carrying out of such studies. However, at all times, due consideration must be given to safeguarding and protecting the rights of women, babies and midwives themselves. If a midwife has any concerns about a particular research study or about an individual woman's participation in a study, she should voice those concerns to the appropriate person(s).

21.1 Midwives in managerial roles have a responsibility to

a) encourage and support the carrying out of research that is methodologically and ethically sound.

b) if necessary, seek expert advice to ensure that proposed research is of good quality and ethically sound.

c) ensure that the process of carrying out research does not compromise standards of care.

d) respect the rights of staff who do not wish to participate in a particular research study.

e) use research disclosure of poor practices as a means of improving practice and not for disciplinary purposes.

21.2 Midwives who carry out research have a responsibility to

a) pay due regard to the ethical principles that should underpin all research – beneficence, non-maleficence, justice, autonomy and veracity.

b) not undertake research that is beyond their capabilities without seeking the assistance of experts in the field.

c) seek the approval of an Ethics Committee. This is essential if women and/or babies are being studied. If the participants are health professionals, then approval by an Ethics Committee may not be required but the principle of *informed consent* must be adhered to.

d) not exploit any professional relationship they may have with the participants.

e) respect anonymity and confidentiality.

f) acknowledge any biases that may exist.

g) make known the findings of the research.

22. Responsibilities in relation to protecting, promoting and supporting breastfeeding.

It is the right of every mother to make an informed choice about how she wishes to feed her baby. Information about the benefits of breastfeeding and the risks associated with choosing not to breastfeed must be provided in order for a mother to make an informed choice. A mother may then choose to breastfeed or not breastfeed, rather than choosing between formula milk or breast milk. Midwives have a clear role, both legally and professionally, in this regard.

22.1 The legal situation.

The *European Communities (Infant Formula and Follow-on Formulae) Regulations, 1998 (S.I. No.243 of 1998)* governs the composition, labelling and marketing of infant formula in Ireland. These regulations put into Irish law the provisions of a number of EC Directives. Responsibility for enforcement of the regulations rests with the Food Safety Authority of Ireland and its agents and breaches of the regulations can result in prosecution. A number of *Articles* of the *Regulations* have relevance for midwives and are as follows:

Article 10, Sub-Article (6) states that "The provision of free or low-priced products, samples or any other promotional gifts to the general public, including inter alia, pregnant women, mothers or members of their families, either directly or indirectly, via the health care system or health workers by manufacturers and distributors of infant formula or their associates, is prohibited".

Article 11, Sub-Article (1) states that "Information provided on infant and young child feeding for use by families and those involved in the field of infant and young child nutrition shall be objective and consistent in its planning, provision, design and dissemination".

Article 11, Sub-Article (2) Informational and educational materials including, inter alia, written and audiovisual materials, in relation to the feeding of infants and intended to reach pregnant women and mothers of infant and young children, shall include clear information on all of the following:

(a) the benefits and superiority of breast-feeding;

(b) the importance of maternal nutrition and the preparation for and maintenance of breast-feeding;

(c) the possible negative effect on breast-feeding of introducing partial bottle-feeding;

(d) the difficulty of reversing the decision not to breast-feed;

(e) where needed, the proper use of infant formulae, whether manufactured industrially or home prepared.

Article 11, Sub-Article (3) states that "Any material referred to in sub-article (1) shall not use any pictures which may idealise the use of infant formulae. Any such material containing information about the use of infant formulae shall include:

(a) the social and financial implications of its use;

(b) the health hazards of inappropriate foods or feeding methods;

(c) the health hazards of improper use of infant formulae."

Article 12, Sub-Article (2) states that

(a) Donations of informational or educational equipment or materials by manufacturers or distributors or by persons or individuals associated with manufacturers or distributors shall be made only on request of the intended recipient and within guidelines, if any, approved by the Minister.

(b) Such equipment or materials:

(i) may bear the donating company's name or logo;

(ii) shall not refer to a propriety brand of infant formulae;

(iii) shall be distributed only through the health care system."

22.2 Codes of Practice.

In 1981 the World Health Organisation (WHO) published the *International Code of Marketing of Breast-milk Substitutes* (hereafter referred to as the WHO Code). The Irish Government took on board the aims and principles of the WHO Code and developed an Irish version of the Code. *A National Breastfeeding Policy for Ireland* was also published in 1994. The voluntary provisions of the Irish Code have now been superseded by the enactment of the *1998 Regulations* as referred to in section 20.1. The Irish Government continues to support the provisions of the WHO Code. The code refers to infant formula, other milk products, cereals, teas and juices, bottles and teats.

The Code seeks to encourage and protect breastfeeding and to control inappropriate marketing practices used to promote products for artificial feeding. The Code includes these important provisions:

a) No advertising of all these products to the public.

b) No free samples to mothers of all of these products.

c) No promotion of products in health care facilities.

d) No company representatives to advise mothers.

e) No gifts or personal samples to health workers.

f) No words or pictures idealising artificial feeding, including pictures of infants, on the labels of the products.

g) Information to health workers should be scientific and factual.

h) All information on artificial feeding, including the labels, should explain the benefits of breastfeeding, and the costs and hazards associated with artificial feeding.

Notes

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