# ALBERTA HEALTH SERVICES MIDWIFERY STAFF RULES

Approved: November 1, 2013

Amended: June 28, 2021

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# PART 1. GENERAL PROVISIONS

## 1.0 PREAMBLE

1.0.1 The Alberta Health Services (AHS) Midwifery Staff Rules (the Rules) are prepared in accordance with section 1.6.1 of the AHS Midwifery Staff Bylaws (the Bylaws), as adopted and approved.

1.0.2 The Rules provide the means to implement and give effect to the Bylaws, and govern the day to day management of Midwifery Staff affairs, and nothing in them shall alter the intent and purpose of the Bylaws.

1.0.3 The Rules shall also govern the conduct of the Midwifery Staff as it relates to Zones, Sites of Clinical Activity, Programs and Professional Services operated by AHS.

1.0.4 Additional details and procedures for operations may be described in the policies of the Provincial Midwifery Administrative Office or other Midwifery organizational structures, and the terms of reference of committees that it may establish. If there is a conflict between any provisions of these Rules and the rules or policies of the Provincial Midwifery Administrative Office, or a related committee, the provisions of these Rules shall prevail.

1.0.5 AHS is committed to involving the Midwifery Staff in the creation and revision of Policies which are applicable to the Midwifery Staff.

1.0.6 Registered Midwives are responsible to review and remain informed regarding new or revised Bylaws, Rules and AHS Policies which are applicable to, or of importance to, the Midwifery Staff. Notification of new and revised Bylaws, Rules and Policies is the responsibility of the portfolio of the Vice President and its Provincial Midwifery Administrative Office through established communication methods.

1.0.7 Midwifery Staff with questions or comments regarding the Bylaws, Rules and/or Policies may bring them to the attention of the Provincial Midwifery Administrative Office.

## 1.1 DEFINITIONS

1.1.1 Unless otherwise provided herein, all defined terms have the same meaning as that ascribed to them in the Definitions section of the Bylaws. Definitions as found in the Bylaws are attached as Appendix A and are subject to any amendments to the Bylaws. They are provided solely for the convenience of the reader.

1.1.2 Additional Definitions as found in these Rules:

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| Category | Any one of the categories of Appointment to the Midwifery Staff |

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| | referred to in section 3.1 of the Bylaws. |
| Facility Administrator | An AHS administrative leader, designated as a facility Vice-President, facility Executive Director, facility Director, or facility Manager, and responsible for the overall management of the facility. |
| Impact Analysis | An assessment that estimates the effect on available resources of a change or proposed change in the Midwifery Workforce Plan, or an individual Registered Midwife's Clinical Privileges, or a new Procedure or new Programs and Professional Services. |
| Legal Representative | Person(s) other than the Client who are legally authorized to make decisions in partnership with, or in substitution for, the Client as described in the AHS Consent Policy, and pursuant to relevant legislation including, but not limited, to the *Alberta Guardianship and Trusteeship Act* (Alberta), the *Personal Directives Act* (Alberta) *and the Mental Health Act* (Alberta). |
| Midwifery Staff Association | An association of the AHS Midwifery Staff. |
| Midwifery Workforce Planning Committee | A committee established as such pursuant to these Rules. |
| Most Responsible Midwife | The single, designated Registered Midwife who carries the primary responsibility for the care of a Client within a Site of Clinical Activity. |
| Personal Directive | A personal directive of a Client related to health care under the *Personal Directives Act (Alberta)*. |
| Physician | A person licensed in independent practice and in good standing with the College of Physicians and Surgeons of Alberta pursuant to the *Health Professions Act* (Alberta). |

1.1.3 Where the contents so require, words importing the singular number shall include the plural and vice versa, and words importing persons shall include corporations and vice versa.

# PART 2. MIDWIFERY ORGANIZATIONAL STRUCTURE OF AHS

## 2.0 ORGANIZATIONAL STRUCTURE

2.0.1 The Organizational Structure of the Midwifery Staff includes, but is not limited to:

a) Administrative leadership positions: Vice President, Provincial Midwifery Director, and Clinical Midwifery Directors (the roles and responsibilities for these positions are described in the Bylaws);

b) The Provincial and Zone committees: The Provincial Midwifery Executive Committee and its subcommittees including the Bylaws and Rules Review Committee, Hearing Committees, the Immediate Action Review Committee; the subcommittees including the Midwifery Zone Application Review Committee; and

c) Zone Midwifery Clinical Departments (described in the Bylaws).

2.0.2 These groups shall be subject to the collective responsibilities identified in the Bylaws and these Rules, and the appointed leaders of these groups will be responsible for ensuring that these responsibilities are carried out.

2.0.3 The appointment and accountability, responsibilities and duties of the Vice President, Provincial Midwifery Director, and Clinical Midwifery Directors are found in Part 2 of the Bylaws.

2.0.4 The purpose of the Provincial Midwifery Executive Committee is found in Part 2 of the Bylaws.

2.0.5 The creation, modification, and dissolution of Zone Midwifery Clinical Departments are found in Appendix B of these Rules.

## 2.1 SEARCH COMMITTEE FOR PROVINCIAL MIDWIFERY DIRECTOR

### 2.1.1 GENERAL PROVISIONS – SEARCH COMMITTEE

Unless otherwise specified in the vacancy posting, a Search Committee shall be constituted according to the following principles:

a) A Search Committee for the position of Provincial Midwifery Director shall be established by the Vice President or designate;

b) Search Committees shall consist of a minimum of three persons with representation dependent on the position being filled;

c) Representation shall, at a minimum, include one member of the Midwifery Staff drawn from a pool of three Midwifery Staff nominated by the Midwifery Staff Association and selected by the Vice President or designate; one member from

the portfolio of the Vice President; and one individual from the relevant AHS operational portfolio identified by the Vice President or designate; and

d) Search Committees shall make recommendations to the Vice President. The Vice President shall not be bound by the Search Committee's recommendations.

## 2.2 SEARCH COMMITTEE FOR CLINICAL MIDWIFERY DIRECTOR(S)

### 2.2.1 GENERAL PROVISIONS – SEARCH COMMITTEE

Unless otherwise specified in the vacancy posting, a Search Committee shall be constituted according to the following principles:

a) A Search Committee for the position of Clinical Midwifery Director shall be established by the Provincial Midwifery Director or designate;

b) Search Committees shall consist of a minimum of three persons with representation dependent on the position being filled;

c) Representation shall, at a minimum, include one member of the Midwifery Staff drawn from a pool of three Midwifery Staff nominated by the Midwifery Staff Association and selected by the Provincial Midwifery Director or designate; one member from the portfolio of the Provincial Midwifery Director; and one individual from the relevant AHS operational portfolio identified by the Provincial Midwifery Director or designate; and

d) Search Committees shall make recommendations to the Provincial Midwifery Director. The Provincial Midwifery Director shall not be bound by the Search Committee's recommendations.

### 2.2.2 GENERAL PROVISIONS – TERM OF APPOINTMENT

Unless otherwise specified in the vacancy posting, the term of appointment for Clinical Midwifery Director shall be up to five years.

## 2.3 PROVINCIAL AND ZONE COMMITTEES

### 2.3.1 GENERAL PROVISIONS

#### 2.3.1.1 TERMS OF REFERENCE

Each provincial and Zone committee shall develop such terms of reference as required for its effective functioning, consistent with the provisions of the Bylaws and these Rules.

Terms of reference shall include but are not limited to: purpose, composition including alternative members if any, duties and responsibilities, decision-making processes, and reporting and notification requirements.

#### 2.3.1.2 MEETING FREQUENCY

Except as otherwise specified, the committee shall meet at least quarterly and more frequently at the call of the chair, unless otherwise set forth in the Bylaws or these Rules.

#### 2.3.1.3 COMMITTEE MEMBERS

a) To assure responsible deliberation and decision making, a broad provincial and system-wide perspective is required of committee members regardless of their individual practice type and geographic location;

b) Unless otherwise specified, committee members shall be appointed for a term of two years, and shall serve until the end of this period or until the member's successor is appointed, unless the member resigns or is removed from the committee;

c) All committee members shall:

i. display ethical and business-like conduct;
ii. avoid and declare conflicts of interest, and maintain the confidentiality of the committee's business necessary for its effective functioning;
iii. participate constructively in committee activities and treat, as paramount, the efforts of the committee to fulfill its mandate and achieve its objectives;
iv. treat other committee members and AHS staff with respect;
v. demonstrate a willingness to address all matters openly and transparently;
vi. be accountable to their committee;
vii. exercise the powers and discharge the duties of their office honestly, in good faith, and in the best interests of the committee;
viii. exercise the degree of care, diligence and skill that a reasonably prudent person would in comparable circumstances;
ix. attend meetings on a regular and punctual basis;
x. be familiar with the committee terms of reference, relevant Policies, and the AHS organizational structure, as well as the rules of procedure and proper conduct of a meeting; and
xi. actively discourage inappropriate conduct by other committee members.

d) The Vice President or designate(s) shall, unless otherwise specified, be an ex-officio, non-voting member of all provincial committees specified in the Bylaws and these Rules.

e) The Provincial Midwifery Director or designate(s) shall, unless otherwise specified, be an ex-officio, non-voting member of all provincial committees specified in the Bylaws and these Rules.

#### 2.3.1.4 REMOVAL

If a member of a committee ceases to be a member of the Midwifery Staff, fails to discharge their responsibilities as a committee member pursuant to section 2.3.1.3 c) of these Rules, or if other reasonable grounds exist, that member may be removed by the Vice President or designate.

#### 2.3.1.5 VACANCIES

a) Unless otherwise specifically provided, vacancies of a member on any committee shall be filled in the same manner in which an original appointment to the committee is made until the completion of that member's term;

b) In an exceptional circumstance, the Vice President or designate may appoint an interim replacement member to fulfill a member's committee term until the vacancy can be filled in the same manner in which an original appointment to such committee was made.

#### 2.3.1.6 COMMITTEE CHAIR

a) Provincial level committees - Except as otherwise specified in the Bylaws or these Rules, the Vice President or designate, in conjunction with committee members, shall jointly confer and select the committee chair. The committee chair shall be selected from amongst the members of the committee. A vice chair may be appointed by the committee, and if so, the vice chair shall be appointed from amongst the voting committee members.

b) Zone level committees – Except as otherwise specified in the Bylaws or these Rules, the Provincial Midwifery Director or designate, in conjunction with committee members, shall jointly confer and select the committee chair. The committee chair shall be selected from amongst the members of the committee. A vice chair may be appointed by the committee, and if so, the vice chair shall be appointed from amongst the voting committee members.

#### 2.3.1.7 QUORUM AND MANNER OF ACTION

a) Except as otherwise specified in the Bylaws or these Rules, the quorum for a committee shall be fifty one percent majority of the members entitled to be present and vote.

b) Except as otherwise specified in the Bylaws or these Rules, the actions of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the committee. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, provided any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by the Bylaws.

c) Except where otherwise provided for in the Bylaws and these Rules, committee meetings may be conducted in-person, by teleconference or videoconference. Committee actions arising from a meeting, such as a recorded vote, may be conducted in-person, by e-mail or other electronic means, teleconference or videoconference.

#### 2.3.1.8 MINUTES

Minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the vote taken/agreement on matters (where recording is required). A copy of the minutes shall be signed by the committee chair of the meeting and forwarded to the Provincial Midwifery Administrative Office.

#### 2.3.1.9 CONDUCT OF MEETINGS

Unless otherwise specified by the committee, meetings shall be guided by Robert's Rules of Order (Newly Revised, Tenth Edition).

## 2.4 PROVINCIAL MIDWIFERY EXECUTIVE COMMITTEE

### 2.4.1 ESTABLISHMENT

The Provincial Midwifery Executive Committee is established pursuant to section 2.4 of the Bylaws and is accountable to the Vice President.

### 2.4.2 COMPOSITION

The Provincial Midwifery Executive Committee shall be composed of the following persons:

a) Voting members;
b) Ex-officio or non-voting members; and

c) Ex-officio non-voting members, optional attendance.

#### 2.4.2.1 VOTING MEMBERS

The following members shall attend and except where stated otherwise vote on all issues for discussion at Provincial Midwifery Executive Committee meetings:

a) the chair;
b) up to five members from the Midwifery Staff nominated by the Midwifery Staff Association and selected by the Vice President or designate;
c) the Provincial Midwifery Director;
d) the Clinical Midwifery Director(s), and
e) up to five representatives as appointed by the Vice President or designate.

#### 2.4.2.2 EX-OFFICIO NON-VOTING MEMBERS

The following shall attend all meetings of the Provincial Midwifery Executive Committee but may not vote:

a) the Vice President or designate; and
b) a medical staff representative as determined by the CMO.

#### 2.4.2.3 EX-OFFICIO NON-VOTING MEMBERS, OPTIONAL ATTENDANCE

The following may attend all meetings of the Provincial Midwifery Executive Committee but may not vote:

a) the CEO of AHS; and
b) two representatives, or designates appointed by the Vice President or designate.

### 2.4.3 DUTIES AND RESPONSIBILITIES

2.4.3.1 The Provincial Midwifery Executive Committee shall consider, advise and report to: 1) AHS and the Vice President and Provincial Midwifery Director on all matters at a provincial level and 2) the Clinical Midwifery Director(s) on all matters at a Zone level pertinent to Client care and to the Midwifery Staff, and on all items referred to it. These matters include but are not limited to:

i. quality and safe Client care
ii. interdisciplinary Client care and teamwork
iii. AHS service planning and delivery
iv. Midwifery workforce planning
v. Registered Midwife satisfaction
vi. all other responsibilities and duties assigned to it by the Bylaws and these Rules

2.4.3.2 The Provincial Midwifery Executive Committee shall oversee:

i. the overall functioning of administrative committees
ii. the overall functioning of the Bylaws and these Rules

### 2.4.4 SUBCOMMITTEES

The Provincial Midwifery Executive Committee may, from time to time, establish any subcommittees or ad hoc subcommittees for specific assignments it determines are necessary to assist in fulfilling its duties and responsibilities.

The terms of reference of any subcommittee or ad hoc subcommittee will be specified at the time of creation and amended as required, and will reflect decision-making processes for the subcommittee or ad hoc subcommittee.

### 2.4.5 STANDING SUBCOMMITTEES

These shall be as follows, or as amended from time to time by the Provincial Midwifery Executive Committee, pursuant to section 2.4.3 of these Rules:

a) Midwifery Workforce Planning Committee
b) Midwifery Zone Application Review Committee

## 2.5 BYLAWS AND RULES REVIEW COMMITTEE

### 2.5.1 ESTABLISHMENT

The Bylaws and Rules Review Committee is established pursuant to sections 1.5 and 1.6 of the Bylaws.

### 2.5.2 COMPOSITION

The Bylaws and Rules Review Committee shall be composed of the following voting members:

a) one representative appointed by the Vice President or designate, who shall act as chair;
b) three Members from the Midwifery Staff, nominated from the Midwifery Staff Association and selected by the Vice President or designate; and
c) three representatives as appointed by the Vice President or designate.

The following exclusion criteria apply to the Midwifery Staff representatives:

i. Member of council of the College of Midwives of Alberta
ii. Alberta Association of Midwives Board member
iii. Registered Midwife with a contracted AHS administrative/ leadership position

#### 2.5.3 DUTIES AND RESPONSIBILITIES

a) The Bylaws and Rules Review Committee shall fulfill the duties tasked to it pursuant to sections 1.5 and 1.6 of the Bylaws.

b) Without limiting the foregoing, the Bylaws and Rules Review Committee shall review and study in any manner it deems appropriate proposed amendments to the Bylaws and these Rules recommended by itself and the parties specified in sections 1.5 and 1.6 of the Bylaws, shall confer with the College of Midwives of Alberta and other parties as appropriate, and make such recommendations as it deems necessary.

c) Pursuant to section 1.5.4 of the Bylaws, amendments to the Bylaws put forth to the Midwifery Staff for consideration shall be communicated to all Midwifery Staff by established communication methods at least sixty days before being voted upon by ballot conducted through the Provincial Midwifery Administrative Office.

## 2.6 HEARING COMMITTEES, IMMEDIATE ACTION REVIEW COMMITTEE & MEMBERSHIP SELECTION PROCESS

2.6.1 The Provincial Administrative Midwifery Office shall establish a pool of Midwifery Staff members who are nominated by the Midwifery Staff Association. This pool will be used to identify members to participate in Immediate Action Review Committees or Hearing Committees, as outlined in sections 2.7 and 2.8 of these Rules.

2.6.2 The criteria for selection of the Hearing Committee and Immediate Action Review Committee shall include but are not limited to: geographical representation from within AHS; not currently serving in an AHS or other Midwifery advocacy organization leadership position; possessing an interest in/experience with disciplinary processes/hearing committees; having a reputation for fairness; and extensive clinical experience.

2.6.3 The Vice President or designate shall select an ad hoc four-person, Immediate Action Review Committee, which shall consist of three members of the Midwifery Staff selected by the Vice President or designate which are drawn from a pool of five Midwifery Staff nominated by the Midwifery Staff Association; and one representative appointed by the Vice President or designate. The Vice President or designate shall select a chair from amongst the members of the committee.

## 2.7 HEARING COMMITTEE

#### 2.7.1 ESTABLISHMENT

A Hearing Committee is established as required pursuant to sections 6.5 and 6.7.9 of the Bylaws.

### 2.7.2 COMPOSITION & MEMBERSHIP

A Hearing Committee shall be composed of five voting members including a chair, all of whom are selected following the Hearing Committee selection process pursuant to section 2.6 of these Rules.

2.7.2.1 The Vice President or designate shall be responsible for selecting a five-person Hearing Committee. The Committee shall consist of three members of the Midwifery Staff selected by the Vice President or designate which are drawn from a pool of five Midwifery Staff nominated by the Midwifery Staff Association; and two representatives appointed by the Vice President or designate for each specific hearing Committee established pursuant to sections 6.5 and 6.7.9 of the Bylaws. The Vice President or designate shall select a chair from amongst the members of the Hearing Committee.

2.7.2.2 The Provincial Midwifery Administrative Office shall be responsible for the orientation, training and remuneration of the Hearing Committee members. The payment of honoraria and expenses to members assigned to a specific hearing Committee shall be in accordance with relevant Policies.

2.7.2.3 The Vice President or designate shall also be responsible for considering any objection to the composition of a Hearing Committee established pursuant to section 2.6.2.1 above provided by the Affected Midwife. Prior knowledge of the subject matter of the hearing does not automatically disqualify a designate from being a member of the Hearing Committee. Should the Vice President or designate determine that the objection of the Affected Midwife is with merit, the Vice President shall designate a replacement member for that Hearing Committee.

2.7.2.4 The quorum for each Hearing Committee shall be three voting members including the chair.

2.7.2.5 The term of the Hearing Committee members shall expire upon completion of its activities.

### 2.7.3 DUTIES AND RESPONSIBILITIES

The purpose of the Hearing Committee is to consider a Concern referred to it in respect to an Affected Registered Midwife by receiving information and hearing evidence, and shall make recommendations pursuant to section 6.5 of the Bylaws. A Hearing Committee shall fulfill its duties in a fair and impartial manner.

### 2.7.4 CONDUCT OF MEETINGS

a) Meetings of the Hearing Committee may be held in person, by videoconference or teleconference provided that Hearings shall require the personal attendance of members.

b) Meetings of the Hearing Committee shall be held in a location of its choice.

c) A Hearing Committee shall determine such procedures it deems appropriate and in its sole discretion provided that such procedures do not conflict with and are not inconsistent with section 6.5 of the Bylaws.

## 2.8 IMMEDIATE ACTION REVIEW COMMITTEE

### 2.8.1 ESTABLISHMENT

An Immediate Action Review Committee shall be established pursuant to section 6.7 of the Bylaws.

### 2.8.2 COMPOSITION & MEMBERSHIP

2.8.2.1 The Immediate Action Review Committee shall be composed of four members pursuant to section 2.6 of these Rules.

2.8.2.2 The Vice President or designate shall select an ad hoc four=person, Immediate Action Review Committee, which shall consist of three members of the Midwifery Staff selected by the Vice President or designate which are drawn from a pool of five Midwifery Staff nominated by the Midwifery Staff Association; and one representative appointed by the Vice President or designate. The Vice President shall select a chair from amongst the members of the committee.

2.8.2.3 The term of the Immediate Action Review Committee members shall expire upon completion of its activities.

### 2.8.3 DUTIES AND RESPONSIBILITIES

The purpose of the Immediate Action Review Committee is to receive and consider all relevant information and evidence that led to the Immediate Action including any written submission from the Affected Registered Midwife, and prepare a report and recommendation regarding the disposition of the Immediate Action in respect to an Affected Registered Midwife pursuant to section 6.7 of the Bylaws.

### 2.8.4 CONDUCT OF MEETINGS

a) The Immediate Action Review Committee shall fulfill the duties tasked to it pursuant to section 6.7 of the Bylaws.

b) Meetings of the Immediate Action Review Committee may be held in person, electronically, by videoconference or teleconference, and may be held in a location designated by the Immediate Action Review Committee in its sole discretion.

c) The Immediate Action Review Committee shall determine such procedures it deems appropriate and in its sole discretion provided that such procedures do not conflict with and are not inconsistent with section 6.7 of the Bylaws.

## 2.9 MIDWIFERY ZONE APPLICATION REVIEW COMMITTEE

### 2.9.1 ESTABLISHMENT

The Midwifery Zone Application Review Committee is established pursuant to section 2.8 of the Bylaws.

### 2.9.2 COMPOSITION

The Midwifery Zone Application Review Committee shall be composed of the following persons:

a) Provincial Midwifery Director;
b) Clinical Midwifery Director for the applicable Zone(s);
c) two members of the Midwifery Staff selected by the Vice President or designate from a pool of four Midwifery Staff, nominated by the Midwifery Staff Association; and
d) two representatives appointed by the Vice President or designate.

### 2.9.3 DUTIES AND RESPONSIBILITIES

The purpose of the Midwifery Zone Application Review Committee is to review all initial Applications to the Midwifery Staff and prepare a written recommendation (to accept, deny, or amend the application); and to review all Requests for Change to a Midwifery Staff Appointment and Clinical Privileges and prepare a written recommendation (to accept, deny, or amend the Request for Change).

### 2.9.4 CONDUCT OF MEETINGS

a) The Midwifery Zone Application Review Committee shall fulfill the duties tasked to it pursuant to sections 3.4, 3.5 and 3.6 of the Bylaws;

b) Meetings of the Midwifery Zone Application Review Committee may be held in person, electronically, by videoconference or teleconference; and

c) The Midwifery Zone Application Review Committee shall determine such procedures it deems appropriate and in its sole discretion provided that such procedures do not conflict with and are not inconsistent with sections 3.4, 3.5 and 3.6 of the Bylaws.

# PART 3. RULES APPLICABLE TO ALL MIDWIVES

## 3.0 PREAMBLE

Part 3 of these Rules are applicable to all Registered Midwives and complement the provision of Part 3 of the Midwifery Staff Bylaws.

## 3.1 MIDWIFERY WORKFORCE PLAN AND RECRUITMENT

### 3.1.1 AHS MIDWIFERY WORKFORCE PLAN

a) AHS shall have a Midwifery Workforce Plan which shall provide information and projections to guide the recruitment and retention for Midwifery Services.

b) The Midwifery Workforce Plan, or components thereof, shall be updated annually according to the sequence of steps outlined in sections 3.1.1 d) to 3.1.1 g) of these Rules.

c) The Provincial Midwifery Executive Committee shall determine the overarching principles to be used to develop Midwifery Workforce Plans. These principles shall include, but are not limited to, Client access, the distribution of the Registered Midwife workforce, available resources, service delivery changes within AHS, and Registered Midwife input.

d) The Provincial Midwifery Executive Committee shall establish a Midwifery Workforce Planning Committee with the membership appointed by the Vice President or designate.

e) Locations for midwifery services, and the number of positions to provide those services, will be proposed within the Midwifery Workforce Plan.

f) Approval to initiate recruitment for midwifery services will consider any impact on resources, operations within a Site of Clinical Activity and the AHS Zone, and on AHS budget.

g) The Midwifery Workforce Planning Committee shall submit its Midwifery Workforce Plan to the Provincial Midwifery Executive Committee for endorsement with final approval by the Vice President or designate.

### 3.1.2 RECRUITMENT

Recruitment opportunities shall be determined by AHS, in consultation with operational leadership, and as guided by the Midwifery Workforce Plan.

a) With the exception of the Locum Tenens Staff categories (who are exempted from the requirements of this provision), the following process shall be used to coordinate Registered Midwife recruitment according to the approved Midwifery Workforce Plan:

b) Proposed positions for recruitment will be categorized by the Provincial Midwifery Director as being either new or replacement positions, and as being resource-neutral or resource-requiring.

c) For each proposed position;

i. Approval shall be linked to the AHS budget process and the availability of required resource(s) and funding for midwifery services within the fiscal year.

ii. For each proposed position, an Impact Analysis that identifies the operational impact shall be completed.

iii. The Vice President, or designate, approves opportunities for recruitment.

d) Only after approval shall recruitment to positions be initiated and an application for Appointment and Privileges be available.

### 3.1.3 EXCEPTIONAL CIRCUMSTANCES

Pursuant to section 3.8 of the Bylaws, under exceptional circumstances as determined and approved by the Provincial Midwifery Director or designate, the Zone Midwifery Clinical Department may undertake an active recruitment without completing the steps outlined in section 3.1.2 of these Rules.

## 3.2 ACCOUNTABILITY TO CLINICAL MIDWIFERY DIRECTOR

Each Registered Midwife is accountable to the Clinical Midwifery Director in the first instance for the responsibilities and obligations contained in the Bylaws and these Rules.

## 3.3 MIDWIFERY STAFF APPOINTMENT AND CLINICAL PRIVILEGES

### 3.3.1 CRITERIA FOR APPOINTMENT TO THE MIDWIFERY STAFF

a) A Midwifery Staff Appointment is conditional upon:

i. the verification, to the satisfaction of AHS, of the applicant's training, experience and qualifications;
ii. an assessment of the applicant's suitability, ability and willingness to accept and discharge their responsibilities as a condition to join the Midwifery Staff; and
iii. a determination by AHS that the Appointment is warranted within the Midwifery Workforce Plan and supportable after completion of an Impact Analysis.

b) Each applicant must:

i. be registered and possess a Permit to practice Midwifery in the province of Alberta;
ii. possess suitable liability insurance to the satisfaction of AHS;
iii. possess appropriate educational qualifications as identified by the Provincial Midwifery Executive Committee;
iv. be willing to participate in teaching and training of Midwifery Students as reasonably required and supported by AHS; and
v. be willing to perform administrative committee functions as reasonably required and supported by the Zone Midwifery Clinical Leadership Structure(s) and Zone(s).

The activities outlined in 3.3.1 b) iv. and v. above shall not place undue burden on any individual Registered Midwife and will be based upon mutually agreed upon levels of participation.

c) Consideration of each applicant shall also be based on their:

i. clinical experience, competence, ability and character;
ii. ability to interact professionally and appropriately with their peers;
iii. demonstrated judgment and ethical conduct; and
iv. demonstrated professional competence.

### 3.3.2 APPLICATION PROCESS FOR A MIDWIFERY STAFF APPOINTMENT AND GRANT OF CLINICAL PRIVILEGES

a) All individuals involved in the granting of Appointments and Clinical Privileges shall act and make the necessary recommendations with due dispatch.

b) All applications shall be made on the Midwifery Staff Appointment and Clinical Privileges Application form (the Application).

c) On request for an Application to the Midwifery Staff, the Provincial Midwifery Administrative Office shall first determine whether the prospective applicant is applying for an Appointment & Clinical Privileges for an approved position, or is

applying in the Locum Tenens category. Only if the prospective applicant is requesting an application for an approved position, or is applying to the Locum Tenens category, shall the prospective applicant be given an Application to complete. Otherwise, the Application will not be provided, and the prospective applicant shall be advised that no relevant opportunities currently.

d) If an Application is provided, the applicant shall indicate:

i. the Zone(s) in which they wish an Appointment;
ii. the category of Midwifery Staff Appointment being sought; and
iii. the Clinical Privileges (if any) being requested for the Zone(s).

e) This Application shall be accompanied by:

i. The names of three references who can attest to the character and professional competence of the applicant based on firsthand knowledge obtained within the previous four years. A prospective partner or principal shall not be eligible as a reference. This exclusion shall not apply to the members of the Zone Midwifery Clinical Department in which a Registered Midwife was trained and is now applying.
ii. A copy of their Practice Permit and certificate of registration in good standing from the College of Midwives of Alberta;
iii. An original security check with results that are satisfactory to AHS;
iv. Proof of suitable liability insurance to the satisfaction of AHS; and
v. A signed waiver and release to permit collection of the information required for Application.

f) An Application will be considered incomplete until such time as all required items specified in sections 3.3.2 d) and e) of these Rules have been received and have been considered to fully and satisfactorily meet the outlined standards of Midwifery Staff membership. Any failure to provide complete information to the satisfaction of the Midwifery Administrative Office will render the Application null and void and no further processing will occur.

g) All applicants shall be interviewed by the Clinical Midwifery Director, or designate(s), and such other persons as the Vice President, or designate, determines are appropriate for the applicants being considered. The interview shall be organised by the Provincial Midwifery Administrative Office and may be conducted by electronic media. The interview will include an evaluation of the applicant's qualifications.

h) An Impact Analysis on a form provided by the Provincial Midwifery Administrative Office shall accompany an application for review.

### 3.3.3 CLINICAL PRIVILEGES

a) A delineation of Sites of Clinical Activity and Programs and Professional Services that the Registered Midwife is eligible to access, and the Procedures that the Registered Midwife is deemed to be competent and eligible to perform, within a Zone(s) will be defined by the Clinical Privileges granted by AHS to that Registered Midwife.

b) If Programs and Professional Services or clinical services and related resources are transferred between Sites of Clinical Activity, AHS may accordingly transfer, and adjust if necessary, the Clinical Privileges of the Registered Midwife(s) affected, provided:

i. reasonable notice is given to the Registered Midwife affected;
ii. after due consideration to any representations received in response to such notice; and
iii. the new Site of Clinical Activity has appropriate resources.

c) The granting of Clinical Privileges shall be based on the needs of AHS; the Midwifery Workforce Plan; the resources available and the Sites of Clinical Activity required for the requested Procedures and access to Programs and Professional Services; the Registered Midwife's registration, specific training, documented experience in categories of treatment areas or specific Procedures, current competence; and general recommendations drawn from quality assurance and other quality improvement activities and reviews.

d) Within the Clinical Privileges granted, Registered Midwives are expected to practice within the scope of their profession and the limits of their formal training and experience.

e) No recommendation on Clinical Privileges is meant to prevent any Registered Midwife from performing any Procedure on any person in an emergency situation where failure to perform that Procedure may result in death or serious injury or harm to the person.

f) List of Procedures for Clinical Privileges – Process for Establishment, Maintenance, and Changes pursuant to section 3.2.5 of the Bylaws.

i. The Zone Midwifery Clinical Department shall develop a list of Procedures for Clinical Privileges with input from its members and through a process determined by the Zone Midwifery Clinical Department.
ii. This list shall be reviewed by the Zone Midwifery Clinical Department at a minimum of every two years.
iii. The list of Procedures for Clinical Privileges shall include the core Procedures expected of Zone Midwifery Clinical Department members with Canadian clinical placement training, and those which require extra

training and supervision beyond that normally expected in a Canadian clinical placement training program; those Procedures which are resource intensive; and those Procedures whose utilization needs to be monitored for quality control and Client safety reasons.

iv. Each list of Procedures for Clinical Privileges for the Zone Midwifery Clinical Department shall be reviewed by the Provincial Midwifery Executive Committee for consistency with provisions of the Bylaws and between Zone Midwifery Clinical Departments. The Provincial Midwifery Executive Committee may make such changes as it may determine.

g) Process to Add Procedures New to AHS and Requiring a Grant of Clinical Privileges pursuant to section 3.2.5.2 of the Bylaws.

i. From time to time, new technologies and procedures will become available. It is the responsibility of Zone Midwifery Clinical Department to develop a list of proposed Procedures new to AHS and requiring a grant of Clinical Privileges. Input is required from its members through a process determined by the Zone Midwifery Clinical Department. Input will also be sought from the applicable AHS health technology assessment and product evaluation portfolios.

ii. This list shall include an assessment of the need for the proposed Procedure, the ability of AHS to support the Procedure, and the proposed credentialing criteria.

iii. The Zone Midwifery Clinical Department shall make a recommendation for introduction of a new Procedure within AHS to the Vice President. Final approval by the Vice President or designate is required.

### 3.3.4 INFORMATION REQUIRED FOR CONTINUATION ON THE MIDWIFERY STAFF

a) Each Registered Midwife shall inform AHS of any criminal convictions, or actions (including disciplinary actions, professional sanctions, or the imposition of any monitoring requirement) that, on an immediate basis, directly impact their ability to practice, and/or patient safety.

b) Each Registered Midwife, as a condition of their continuation on the Midwifery Staff, shall submit a properly completed and signed information verification and attestation form to the Provincial Midwifery Administrative Office within the specified timeframe.

c) The verification and attestation form shall be provided to all Midwifery Staff within 12 months of their Midwifery Staff Appointment and annually thereafter requesting but not limited to the following information:

i. any action including past and pending investigations which have been undertaken regarding the Registered Midwife's professional status or

qualifications including but not limited to registration, disciplinary actions/professional sanctions, and the imposition of any monitoring requirement;

ii. current evidence of suitable malpractice insurance to the satisfaction of AHS;

iii. current registration from the College of Midwives of Alberta;

iv. disclosure of any physical or mental health issue as it relates to the performance of the responsibilities specified in the Bylaws and these Rules, and the safe and competent exercise of the Clinical Privileges granted;

v. any matter in which the Registered Midwife has been named as a defendant in a civil law suit relating to their professional practice or been the subject of any professional liability judgments or judicial orders or involved in any arbitration proceedings;

vi. any professional liability judgments, orders, or settlements against their and the status of such matters;

vii. any criminal convictions or outstanding criminal charges with details about any such instances; and

viii. evidence as to the legal right to live and work in Canada for non-citizens and permanent residents.

## 3.4 PERFORMANCE ASSESSMENT TO MOVE FROM PROBATIONARY STAFF TO ACTIVE STAFF

a) Pursuant to sections 3.1.7.1 b) and 3.1.7.1 c) of the Bylaws, an Appointment to the Probationary Staff category shall be considered a time during which the Registered Midwife's competence, capabilities, and contribution shall be evaluated by the Zone Midwifery Clinical Department.

b) After a full evaluation, as outlined in the following performance assessment procedure, the Registered Midwife may be appointed to the Active Staff category.

c) This performance assessment shall include but not be limited to the following:

i. review of Programs and Professional Services accessed by the Registered Midwife, the Procedures performed and performance in the Sites of Clinical Activity to which access has been granted;

ii. information on continuing professional development during appointment to the Probationary Staff category;

iii. clinical performance as judged by clinical audit;

iv. contribution to and participation in other clinical and administrative responsibilities as assigned;

v. resource utilization patterns;

vi. ability to work effectively with other staff and in a team environment;
vii. ability to perform the functions and fulfill the responsibilities of a Registered Midwife; and
viii. contribution to and participation in teaching programs and activities.

## 3.5 PERIODIC REVIEW

a) In the context of the Registered Midwife's Appointment to the Active, Temporary, or Locum Tenens Staff category and Clinical Privileges, Periodic Reviews provide the Registered Midwife and the Clinical Midwifery Director or designate(s) with an opportunity to review the Registered Midwife's professional performance, to determine planned or considered changes to the Registered Midwife's practice including Clinical Privileges, to identify professional development goals, and to exchange information regarding the functioning of the Zone Midwifery Clinical Department.

b) Until age 65, a Periodic Review of Registered Midwives in the Active Staff category will occur every three years or more frequently as specified in the grant of Clinical Privileges.

c) A Periodic Review of Registered Midwives in the Locum Tenens Staff category shall be undertaken at the conclusion of the first year or at the end of the time identified for the Locum Tenens position (whichever is sooner).

d) A Periodic Review of Registered Midwives in the Temporary category shall be undertaken at 12 months, or at the end of the time identified for the Temporary position (whichever is sooner).

e) At age 65, a Periodic Review of all Registered Midwives with an Appointment will be conducted annually.

f) The Provincial Midwifery Administrative Office shall by 31 December of each year prepare an annual schedule of Periodic Reviews which are required to be performed in the next 12 months. That monthly schedule shall be provided to the Clinical Midwifery Director. The Clinical Midwifery Director or designate(s) shall provide each Appointed Registered Midwife with sixty days' notice of their planned Periodic Review.

g) The Periodic Review shall be initiated by the Clinical Midwifery Director or designate and shall be conducted between the Registered Midwife and the Clinical Midwifery Director or designate. Where a Registered Midwife has Clinical Privileges in more than one Zone, the Clinical Midwifery Director or designate shall confer with the relevant midwifery administrative leaders of the other Zone(s).

h) The Periodic Review must include all matters relevant to the Active, Temporary, or Locum Tenens Staff category of Appointment and Clinical Privileges granted to the Registered Midwife.

i. The Provincial Midwifery Administrative Office in consultation with the Zone Midwifery Clinical Department will develop an information package of items to be provided to the Registered Midwife and to the Clinical Midwifery Director or designate at least sixty days prior to the scheduled Periodic Review. This information package shall contain documentation related to section 3.6 i), items i, iii, vi, and vii and section 3.6 j), items i, ii and iv below.

ii. Prior to the Periodic Review, the Registered Midwife and the Clinical Midwifery Director or designate shall compile sufficient relevant information to appropriately inform a discussion about section 3.6 i), items ii, iv, and v and section 3.6 j), item iii below.

i) The matters which shall be reviewed during a Periodic Review include, but are not limited to:

i. the terms, conditions and major responsibilities contained in the Registered Midwife's Midwifery Staff Letter of Offer, and any amendments subsequently made to its terms and conditions;

ii. actions arising from the previous Periodic Review;

iii. the individual Registered Midwife's responsibilities and accountabilities as described in section 4.2 of the Bylaws;

iv. the fulfillment of, or need for, continuing professional development and maintenance of competence activities consistent with the requirements of the Zone Midwifery Clinical Department and College of Midwives of Alberta;

v. any physical or mental health issues that are affecting the Registered Midwife's ability to practice;

vi. a discussion of compliance with Policies for completion of health records as defined under Part 4 Health Records of these Rules; and

vii. the provision of service and coverage as defined under Part 4 of these Rules.

j) The matters which may be reviewed during a Periodic Review include, but are not limited to:

i. a review of objective quality data (non-identifiable as to Client source) for the Registered Midwife as they relate to past performance and potential future changes to their midwifery practice;

ii. a collated assessment (non-identifiable as to source) of the Registered Midwife by relevant health care teams, other Registered Midwives and Clients with respect to their ability to interact professionally and effectively with peers, AHS administrative leaders and staff, and Clients.

Such assessments shall consist of written feedback following a process developed and approved by the Provincial Midwifery Executive Committee;

iii. a discussion of the Registered Midwife's involvement in the administrative and Midwifery Staff activities of AHS which shall include attendance at meetings and participation in and contribution to the activities of the Zone Midwifery Clinical Department and Site(s) of Clinical Activity; and

iv. a discussion of the utilization of AHS resources and compliance with AHS quality initiatives.

k) Where an assessment of a Registered Midwife by relevant health care teams, other Registered Midwives with Appointments and Clients pursuant to section 3.6 h) ii above occurs, the assessment shall be done utilizing objective, evidence-based methods as developed or adopted by the Provincial Midwifery Executive Committee, and approved by the Vice President or designate.

l) The results of the Periodic Review shall be documented by the Clinical Midwifery Director or designate, and a copy provided to the Registered Midwife and included in the Registered Midwife's file within fourteen days of the completion of the Periodic Review. Except as required by law or permitted by the Bylaws, the written summary of the Periodic Review prepared by the Clinical Midwifery Director or designate, together with recommendations, plans and/or Registered Midwife's comments shall be confidential and shall not be disclosed to any person or entity without the express consent of the Registered Midwife.

## 3.6 ORIENTATION AND ACTIVATION OF CLINICAL PRIVILEGES

a) Each new Registered Midwife with an Appointment shall be oriented to relevant AHS systems and processes and their Sites of Clinical Activity. This is a joint responsibility of each new Registered Midwife, AHS and the Clinical Midwifery Director.

b) Activation of Clinical Privileges or access to certain AHS resources requires the successful completion of:

i. IT/IM systems training
ii. Privacy protection training
iii. Occupational Health and Safety assessments

c) This orientation will vary depending on the Registered Midwife's prior association with and knowledge of AHS and the Site(s) of Clinical Activity and, aside from exceptional circumstances as approved by the Provincial Midwifery Director, the activation of Clinical Privileges shall not occur until the completion

of the orientation. In general, it should ensure that the Registered Midwife has been:

i. given access to a copy of the Bylaws and these Rules of the Midwifery Staff, the AHS Midwifery Staff orientation package, and relevant Policies, and has had an opportunity to review them;
ii. oriented to the reporting relationships pertinent to their Appointment both within and external to their Zone Midwifery Clinical Department;
iii. oriented to the physical plan of the relevant Site(s) of Clinical Activity and the range of Programs and Professional Services offered in the Site(s) of Clinical Activity;
iv. oriented to health records and requirements for recorded care; and,
v. oriented to the ambience, philosophy, and general operating procedures of the relevant Site(s) of Clinical Activity.

d) The orientation will be provided by one or more of:

i. Clinical Midwifery Director or designate;
ii. The Facility Administrator(s) or designate(s);
iii. Facility operational staff;
iv. Others as may be required.

e) A checklist will be completed during the orientation and placed in the Registered Midwife's file, and the Clinical Midwifery Director shall be notified by the Provincial Midwifery Administrative Office.

# PART 4. AHS CLIENT CARE AND APPOINTED REGISTERED MIDWIFE-RELATED PROVISIONS COMMON TO ALL ZONES

This section of the Rules describes Client care and Appointed Registered Midwife-related provisions which are common to all Zones.

## A. CLIENT CARE

### 4.1 ADMISSION OF CLIENTS

4.1.1 A Client whose clinical condition warrants admission shall be admitted to an appropriate Site of Clinical Activity by an Appointed Registered Midwife with appropriate Clinical Privileges. Upon requesting or accepting such an admission and care of the Client, the Registered Midwife shall be designated as the Client's Most Responsible Midwife.

4.1.2 All Clients admitted to Sites of Clinical Activity require a provisional diagnosis by the Most Responsible Midwife(s).

4.1.3 A Registered Midwife who wishes to admit a Client to a Site of Clinical Activity shall book these admissions according to established Site of Clinical Activity admitting procedures.

4.1.4 A Client requiring admission shall be:

a) Admitted by the Most Responsible Midwife; or,

b) Referred prior to admission to another Appointed Registered Midwife who has appropriate Clinical Privileges to admit and care for the Client (in most instances this should include a personal conversation with the potential receiving Registered Midwife);

4.1.5 The Most Responsible Midwife shall indicate to the staff caring for the Client, and in the Client's health record, that they are the Most Responsible Midwife.

4.1.6 No Client shall be admitted to a facility under a Registered Midwife without that Registered Midwife's agreement. If an appropriate Registered Midwife willing and able to accept the admission and care of the Client cannot be identified by the time of accommodation in the Site of Clinical Activity is available, the Clinical Midwifery Director or designate, shall assign a Most Responsible Midwife.

4.1.7 The Most Responsible Midwife and any other Registered Midwife providing care to the Client shall provide sufficient information about the client to staff as may be necessary to ensure protection of other Clients or Site of Clinical Activity staff, or to ensure protection of the admitted Client from self-harm.

## 4.2 ATTENDANCE UPON CLIENTS

4.2.1 Each Client shall receive timely and professional care appropriate to her condition. The frequency of attendance will be determined having regard to the condition of the Client, Zone Midwifery Clinical Department requirements, and these Rules.

4.2.2 Each Client in an acute care Site of Clinical Activity shall be attended at least daily by the Most Responsible Midwife or designate.

## 4.3 REGISTERED MIDWIFE'S ORDERS

4.3.1 Medication and treatment orders shall be in compliance with applicable Policies.

4.3.2 All orders shall be either written in the Client's health record or entered directly into the Client's electronic health record (if applicable). If orders are in writing, they shall be written using dark ink, on the appropriate form and shall be legible, complete, dated, timed and signed by the Most Responsible Midwife or designate. A ballpoint or similar pen shall be used where multiple copies are expected.

4.3.3 It shall be the duty of the Most Responsible Midwife to review the orders for their Clients on a regular basis.

4.3.4 Requests for consultations shall be in writing on the appropriate consultation request form or shall be entered directly into the Client's electronic health record (if applicable), and shall include the reason for consultation, a brief history, and specific timelines in which the consultation is to be provided (based upon the nature of the Client's condition and circumstances). Direct Registered Midwife to Registered Midwife and/or Registered Midwife to Practitioner discussion shall occur in urgent cases, and is preferable in all cases.

## 4.4 INFORMED CLIENT CONSENT

4.4.1 When providing care to Clients within AHS facilities, Registered Midwives shall review and abide by the AHS Consent to Treatment/Procedure(s) policy and procedures, as well as by relevant legislation.

## 4.5 LEAVING AGAINST ADVICE

If a Client leaves a Site of Clinical Activity without the prior order or authorization of the Most Responsible Midwife or designate:

a) Whenever possible, written acknowledgment by the Client and/or their Legal Representative that the Client is leaving against the Registered Midwife's advice shall be requested, and

b) The Most Responsible Midwife or designate shall make a notation on the Client's health record that the Client has left the Site of Clinical Activity against medical advice.

## 4.6 DISCHARGE PLANNING/BED MANAGEMENT/BED UTILIZATION

4.6.1 Registered Midwives with Appointments shall work together, and with AHS staff, administrative leaders, midwifery administrative leaders and medical administrative leaders, to ensure that inpatient beds occupied by clients are managed in an effective and efficient manner within, and across, all Sites of Clinical Activity and Zones. Bed utilization and management should ensure that:

a) Client access to Sites of Clinical Activity in the Zone is granted on the basis of need;

b) Clients are treated in the most appropriate Site of Clinical Activity to meet their particular needs;

c) Standards of Client care are continually evaluated to improve the quality of Client care and optimize Client lengths of stay; and

d) Clients are discharged from Sites of Clinical Activities in an appropriate and timely manner.

4.6.2 Client discharge planning shall commence at the time of admission to an acute care Site of Clinical Activity. Where possible, for elective admissions or inter-Site of Clinical Activity transfers, discharge plans and arrangements should be made prior to admission. It is the responsibility of the Most Responsible Midwife, and consulting Registered Midwives with Appointments (if appropriate) to anticipate and begin early planning for discharge with the maternal care team and other relevant health care professionals. Discharge planning must involve the Client and the Client's family and/or the personal or referring Registered Midwife. It also includes timely transmission of sufficient Client information to facilitate safe and responsible care after discharge from an AHS facility.

4.6.3 The Client shall be discharged only on the order of the Most Responsible Midwife or designate.

4.6.4 Most Responsible Registered Midwives are required to discharge Clients according to Policy set by AHS, the Zone Midwifery Clinical Department and/or the Site of Clinical Activity. Wherever feasible, discharge orders shall be written in advance of the planned day of discharge in order to facilitate the process of discharging a Client.

## 4.7 ADVANCED CARE PLANNING AND GOALS OF CARE DESIGNATION

4.7.1 Each Registered Midwife with an Appointment shall be familiar with the Advanced Care Planning and Goals of Care Designation Policy and Procedure.

## 4.8 CLIENT DEATH

4.8.1 Pronouncement of death must be made in accordance with any applicable AHS Policies and legislation.

4.8.2 In accordance with Policies, the following will be notified in the event of a Client death:

a) the next of kin,

b) the Zone Medical Officer of Health.

c) the Medical Examiner, in all circumstances required by the *Fatality Inquiries Act* (Alberta).

# B. REGISTERED MIDWIFE-RELATED

## 4.9 SERVICE COVERAGE

4.9.1 Each Registered Midwife shall ensure safe and effective service coverage for the Clients for whom they are the Most Responsible Midwife. Pursuant to sections 4.2.7.1 c) of the Bylaws, Registered Midwives, when unavailable for whatever reason, will make arrangements with another Appointed Midwife(s), or appropriate care provider, for the care of their Clients. This may be accomplished by specific arrangements or by participating in an on-call schedule with other Registered Midwives who have similar and appropriate Clinical Privileges at the Site(s) of Clinical Activity.

4.9.2 Responsibilities for service coverage include but are not limited to:

a) Responding appropriately to calls and requests from other Registered Midwives with Appointments and other health professionals regarding Clients for whom they are responsible while providing service coverage or about whom they have been consulted. Registered Midwives with Appointments shall attend Clients appropriately, in a timely fashion, and in accordance with Zone Midwifery Clinical Department policy. Such calls and requests may originate from within the Site(s) of Clinical Activity, including emergency departments, and externally from Client referral and transfer call lines, community offices and clinics, or other sources.

b) Discussing with a referring or consulting Registered Midwife with an Appointment the urgency of the consultation and, when possible, offering advice to a referring Registered Midwife with an Appointment in advance of the consulting Registered Midwife attending the Client. Such discussion may include arranging in-person attendance at an appropriate time and location, and follow-up of cases not requiring emergent assessment.

c) Working collaboratively with a referring Registered Midwife with an Appointment to stabilize the Client and provide urgent care if applicable and as required, and consistent with the level of facility and resources available.

d) Working collaboratively with a referring Registered Midwife with an Appointment to coordinate the timely admission or appropriate transfer of the Client as required and in accordance with Zone Midwifery Clinical Department policies. This includes communicating directly with the receiving Registered Midwife with an Appointment.

4.9.3 Pursuant to section 4.1.3.3 of the Bylaws, Registered Midwives with Appointments and AHS midwifery administrative leaders shall work to ensure that service coverage. Referral, and consultation schedules do not place work demands on individual Registered Midwives that prevent the Registered Midwife from providing safe Client care and service coverage.

4.9.4 Pursuant to section 4.2.7.1 b) of the Bylaws, Registered Midwives with Appointments shall manage their other concurrent clinical activities in order to ensure that they can safely and appropriately fulfil their service coverage duties and responsibilities.

4.9.5 Registered Midwives with Appointments, initially amongst themselves, and, if required, subsequently with their Clinical Midwifery Director(s) or designate(s) and/or Site of Clinical Activity shall work Collaboratively to resolve any issues or disputes related to appropriate service coverage and/or on-call schedules. If unsuccessful, the issue or dispute shall be referred to the Vice President or designate for resolution as required.

## 4.10 SUPERVISION OF STUDENTS

4.10.1 At any given time, each Midwifery Student shall have one or more Registered Midwives with Appointments in the Site of Clinical Activity designated as the supervisor of that trainee's experience.

4.10.2 In all cases involving supervision of Midwifery Students, the Most Responsible Midwife must maintain sufficient knowledge of the Client to ensure the Client is receiving safe and appropriate care, and must remain readily available to assist the Midwifery Student, or intervene if necessary.

4.10.3 When involved in the education of Midwifery Students, Registered Midwives with Appointments shall supervise all Procedures undertaken by Midwifery Students. However, if the Midwifery Student has obtained and demonstrated the necessary skills, and is considered competent, to perform Procedures independently, the supervising Registered Midwife or designate shall only be required to be available to assist or intervene if necessary.

4.10.4 When involved in the education or supervision of Midwifery Students, Registered Midwives with Appointments must ensure that the Midwifery Students are aware they have the following responsibilities:

a) to explain their role in the Client's care to the Client and/or their Legal Representative;
b) to inform the Client and/or their Legal Representative of their name and that of the Most Responsible Midwife;
c) to notify the supervising Registered Midwife when a Client's condition is deteriorating, the diagnosis or management is in doubt, or where a Procedure with possible serious adverse effects is planned;
d) to inform the supervising Registered Midwife when discharge is appropriate and planned;
e) to notify the supervising Registered Midwife of all Clients assessed on behalf of the Registered Midwife; and

f) to assess all referrals and consultations in a timely fashion as appropriate to the Client's condition.

## 4.11 DESIGNATION OF MOST RESPONSIBLE MIDWIFE/TRANSFER OF RESPONSIBILITY

### 4.11.1 Identification of Most Responsible Registered Midwife

a) Every midwifery Client admitted to a Site of Clinical Activity, or who receives emergent, urgent or scheduled evaluation or treatment on an ambulatory or "day Procedure" basis in a Site of Clinical Activity, shall have an identified Most Responsible Midwife. The identity of the Most Responsible Midwife shall be documented in the Client's health record at the time of admission and the Client shall be informed of their name by the Registered Midwife, their designate, or the nursing staff responsible for the Client's care. The Most Responsible Registered Midwife has the duty, responsibility and authority to assess their Client as soon as required by the clients condition at admission, direct all midwifery care for that Client while in the Site of Clinical Activity, and to make reasonable efforts to ensure continuity of care within the facility and following discharge.

b) The Most Responsible Midwife may designate any agreeable Registered Midwife(s) with Appointment(s) to provide concurrent care where this will provide benefit to the Client. However, such designation will not have the effect of transferring ultimate responsibility for the Client from the Most Responsible Midwife.

### 4.11.2 Transfer of Responsibility

a) The designation and responsibilities of the Most Responsible Midwife may be transferred from one Registered Midwife to another provided that the receiving Registered Midwife agrees and has the appropriate Clinical Privileges. The Most Responsible Midwife shall document the transfer, and the receiving Registered Midwife shall document acceptance, in the Client's health record.

b) The designation and responsibilities of the Most Responsible Midwife may be transferred to another health care provider, provided that the receiving provider agrees and has the appropriate Clinical Privileges. The Most Responsible Midwife shall document the transfer, and the receiving provider shall document acceptance, in the Client's health record.

c) The Most Responsible Health care Practitioner or designate shall ensure the Client and/or their family, the Client's Legal Representative, and other health care providers involved in providing continuing care to the Client are informed of the transfer.

## 4.12 MIDWIFERY ETHICS

Ethical considerations are an integral part of health care at all levels. Registered Midwives with Appointments may seek the advice of the Zone or Site of Clinical Activity clinical ethics team in difficult decisions or relationships that are related to human and Client rights, health and safety of the Client or staff and other Registered Midwives, multiculturalism, issues of spirituality, faith and religion or other ethical considerations.

## 4.13 RESEARCH

Registered Midwives with Appointments are encouraged to participate in, and/or support, approved research activities within AHS and to consider recommending the participation of their Clients in relevant and approved research activities.

## 4.14 DISRUPTIVE BEHAVIOUR IN THE HEALTH CARE WORKPLACE

Registered Midwives with Appointments shall be familiar with the relevant guidelines or policies of AHS and the College of Midwives of Alberta with respect to disruptive behaviour. Such documents will be applied as a framework when addressing complaints/allegations of disruptive behaviour by Registered Midwives within the AHS health care workplace.

## 4.15 PERSONAL DIRECTIVES

a) When a Client is admitted to a Site of Clinical Activity, it should be determined if they have a personal directive. If so, the Most Responsible Midwife should discuss the provisions of the personal directive with the Client and/or her Legal Representative, and ensure that a copy is included in the Client's health record. A personal directive may also include any requests that the Client may have with regard to organ and tissue donation.

b) Client health record Information transferred to other Sites of Clinical Activity or health care institutions will include a copy of the Client's personal directive.

# C. DOCUMENTATION, RECORDS AND RECORD KEEPING

## 4.16 HEALTH RECORDS

4.16.1 General Guidelines:

a) All Registered Midwives with Appointments shall complete their health records within the specified period(s) of time using the systems made available.

b) AHS has a legal obligation to protect health information. The information belongs to the Client but AHS is the legal custodian of the health record. Original or copies of health records are not to be removed from a Site of Clinical Activity unless authorization is received from AHS Health Information Management, or unless in compliance with a legally valid Subpoena Duces Tecum or a legally valid search warrant.

c) Community-based health records may travel with the Client, family members (authorized in writing by the Client) and/or the Client's Legal Representative during the provision of care in compliance with formally documented processes and relevant legislation.

d) Confidentiality of Client medical information is paramount. Registered Midwives with Appointments must respect and adhere to relevant Policies governing privacy and access to health records.

4.16.2 Documentation Standards

4.16.2.1 General Characteristics

A health record shall be maintained for each Client who is evaluated or treated, or who receives emergency, inpatient or ambulatory care within any Site of Clinical Activity. All significant clinical information pertaining to a Client shall be incorporated in the Client's health record.

4.16.2.2 General Standards

a) All Registered Midwives with Appointments making entries into a Client's health record shall include documentation of the date and time of the entry, their role/title and, in the case of written entries, an identifiable signature, preferably accompanied by their printed name. Where available, the use of the electronic signature is mandatory (i.e. some dictation/transcription systems or electronic health records). A handwritten, original signature is required in all other circumstances (with the exception of existing delegated authentication processes).

4.16.2.3 Admission (History and Physical) Note

a) The Most Responsible Midwife is responsible for an admission note documenting the history, pertinent physical examination and plan of management for all Clients admitted under their care.

b) Completion of an admission note may be delegated to a Midwifery Student. The Most Responsible Midwife, nevertheless, remains responsible for ensuring the recorded information is complete and accurate.

c) Admission Note Requirements:

i. Every inpatient must have an admission note completed within twenty-four hours following admission.
ii. For Clients re-admitted to hospital within thirty days of discharge for the same or related problem, a copy of the previous/most recent complete admission note, accompanied by a note documenting the changes that have occurred since discharge, will suffice.
iii. For obstetrical Clients an original or reproduction of the prenatal record is acceptable as an admission note but must be authenticated and validated by the Most Responsible Midwife.
iv. For Clients transferred from one Site of Clinical Activity to another, a note detailing the reasons for the transfer and the condition of the Client upon arrival at the receiving Site of Clinical Activity, together with a copy of the admission note from the sending Site of Clinical Activity, shall constitute an admission note for the record for the receiving Site of Clinical Activity. Copies of the relevant portions of the Client's health record from the sending Site of Clinical Activity should be included in the Client's health record in the receiving Site of Clinical Activity.

d) Recommended Minimum Content of an Admission Note:

i. Identification Information with respect to the Client.
ii. The reason(s) for admission, or chief complaint.
iii. Details of pregnancy, including, when appropriate, assessment of the Client's emotional, behavioural and social status.
iv. Relevant past medical history, review of body systems, medication reconciliation, presence or absence of allergies, and relevant past social and family histories appropriate to the age of the Client.
v. Details of a complete physical examination.
vi. Documentation of relevant recent or available laboratory or diagnostic imaging tests.
vii. A comprehensive list of active Client care needs, with an appropriate differential diagnosis as required.
viii. A statement of the conclusions drawn from the admission history and physical examination and an initial plan of management.
ix. Level of care designation or a summary or copy of the Client's personal directive if appropriate.
x. Estimated length of stay and documentation of Client issues or circumstances that may prolong the length of stay or will require advanced discharge planning.

4.16.2.4 Progress Notes

a) The Most Responsible Midwife is responsible for recording and maintaining progress notes for Clients under their care. Progress notes must serve as a

pertinent chronological record of the Client's course in hospital as well as any change in condition, interpretation of the results of diagnostic tests and the effect of treatment.

b) Documentation and maintenance of progress notes may be delegated to a Midwifery Student. The Most Responsible Midwife, nevertheless, remains responsible for ensuring the recorded information is complete and accurate.

c) Daily progress notes are recommended for Clients in acute care Sites of Clinical Activity. Notwithstanding these guidelines, progress notes shall be completed whenever there is a significant change in the Client's condition or management, and whenever unexpected events or outcomes occur.

d) Recommended minimum content of Progress Notes:

i. Response to treatment.
ii. Acute or unexpected changes in the Client's condition.
iii. Adverse reactions to drugs and/or other treatments.
iv. Interpretation of the results of diagnostic tests, particularly significant or unusual test results.
v. Fundamental decisions about ongoing management including but not limited to medication, invasive Procedures, consultations, treatment goals, and decisions regarding level of care/resuscitation.
vi. Any Procedures or Clinical Services completed/provided.
vii. Discharge plans.
viii. Documentation in the event of death.
ix. Any other information as may be pertinent, such as temporary leaves, refusal of treatment or leaving against advice.
x. Any requests for consultation, when consultations have occurred, and the outcome of consultations.
xi. Discussion to support informed decision making/consent, including documentation of decisions made.

4.16.2.5 Registered Midwife Orders

a) All Midwifery orders must be documented on the approved order sheet with the time, date of the entry, and a legible signature, preferably accompanied by their printed name. Where electronic order entry is available, utilization of the system is mandatory.

b) The identity of the Registered Midwife with an Appointment covering in the case of an absence of the Most Responsible Midwife and all transfers of care between the Registered Midwife and the Physician shall be documented in the orders.

c) Verbal and Telephone Orders:

i. Verbal orders are acceptable only in emergency situations.

ii. Telephone orders should be limited to those situations in which prompt or immediate direction for Client care is required and the ordering Registered Midwife with an Appointment is not able to access the Client's health record or electronic order entry in a period of time appropriate for the circumstances requiring an order. Facsimile (fax) transmission of orders written by the ordering Registered Midwife is preferred to telephone orders. Faxed orders must include the ordering Registered Midwife's legible signature, preferably accompanied by their printed name.

iii. Verbal and telephone orders shall only be accepted and recorded by persons authorized to do so and in accordance with Policy.

iv. Telephone orders communicated by a third party acting on behalf of the Registered Midwife with an Appointment shall not be accepted, unless such a person is another Registered Midwife with an Appointment or a resident. However, In emergency situations when the Registered Midwife cannot personally provide a telephone order, such orders may be relayed by an AHS staff member so long as the staff member doing so is physically present with, and can be heard by, the ordering Registered Midwife.

v. Verbal and telephone orders must be repeated back to the ordering Registered Midwife and, according to AHS Policy, will be signed by the authorized person to whom they were dictated, along with the name of the ordering Registered Midwife.

vi. Verbal and telephone orders shall be countersigned within twenty-four hours. Verification of verbal and telephone orders shall be the responsibility of the ordering Registered Midwife with an Appointment and must comply with Policy.

vii. Order sets shall be signed by the Registered Midwife with an Appointment for each Client to whom they are applied. Order sets must be approved and periodically reviewed by the Clinical Midwifery Director in accordance with Policy.

4.16.2.6 Anaesthetic Records

The Registered Midwife with an Appointment shall assess and record the administration of any anaesthetic in accordance with Policies.

4.16.2.7 Consultation reports

When a Registered Midwife provides a consultation to another health care provider:

a) Consultation reports are to be written, dictated and/or electronically entered and signed in the health record within twenty-four hours of assessment of the Client.

b) Recommended Minimum Content for Consultation Reports:

i. identification information with respect to the Client.
ii. findings of the consultation and recommendations for management of the Client.

4.16.2.8 Discharge Summaries

a) The Most Responsible Midwife at the time of discharge of the Client from the Site of Clinical Activity is responsible for completing a discharge summary.

b) Completion of discharge summaries may be delegated to a Midwifery Student. The Most Responsible Midwife, nevertheless, remains responsible for ensuring that the discharge summary is accurate and comprehensive.

c) Completion Requirements:

i. A discharge summary is required for each admission in a manner that is conducive to electronic access and distribution (i.e. dictation, direct electronic entry, and/or scanning).

ii. Discharge summaries should be completed within fourteen days after the chart is made available to the Registered Midwife with an Appointment post-discharge.

d) Recommended minimum content of a Discharge Summary:

i. Identification Information with respect to the Client.
ii. pertinent health history.
iii. brief description of the reason for admission.
iv. course in hospital.
v. a brief summary of the care provided during admission, including operations/Procedures and major investigations, treatments and outcomes.
vi. most responsible diagnoses.
vii. secondary diagnoses.
viii. the condition of the Client at the time of discharge.
ix. discharge plan, including further investigations or consultations to be completed, discharge medication reconciliation, recommended physical activity, instructions to other caregivers, and follow-up (if any) by the Most Responsible Registered Midwife or consulting Registered Midwives with Appointments.

x. any specific instructions given to the Client and/or their family, as pertinent.

4.16.2.9 Autopsy Reports

When an AHS autopsy is completed, an autopsy report shall be included in the health record. AHS shall take reasonable action to endeavour to obtain the reports of autopsies undertaken by the Medical Examiner and have them included in the Client's health record.

4.16.2.10 Ambulatory/Outpatient Reports

a) All entries on ambulatory Clients must be documented by the Registered Midwife with an Appointment on the approved forms and shall include the time, date and identifiable signature, preferably accompanied by their printed name.

b) The Most Responsible Midwife shall ensure the ambulatory/outpatient records of all Clients in their care are completed.

c) Completion of ambulatory/outpatient records may be delegated to a Midwifery Student. The Most Responsible Midwife, nevertheless, remains responsible for ensuring the recorded information is complete and accurate.

d) Completion Requirements

i. Every ambulatory Client must have an ambulatory/outpatient record completed within twenty-four hours.
ii. To facilitate the ongoing provision of care, for each Client who receives continuing ambulatory/outpatient care, a summary outlining the changes that have occurred since the last visit is required.

e) Recommended minimum content of ambulatory/ outpatient records:

i. The reason(s) for the visit.
ii. The relevant history and the physical findings, including the Client’s vital signs as clinically appropriate.
iii. Diagnostic and therapeutic orders.
iv. Clinical observations, including the result of treatment.
v. Reports of diagnostic tests and surgery and Procedures, and their results.
vi. Reports of any consultations or telephone/verbal advice obtained.
vii. Final diagnosis or impression.
viii. Client disposition and any instructions given to the Client and/or their family for care.
ix. Allergies and medications, both current and prescribed.
x. Referrals to another health care provider with an Appointment and/or Programs or Professional Services.

4.16.3 Health Record Completion Guidelines

All members of the Midwifery Staff shall complete health records within the following timelines using the systems made available.

| TYPE OF REPORT | TIMELINES FOR COMPLETION |
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| Admission Note (History, Physical Examination, Impression and Plan) | Completed within twenty-four hours following admission except in a surgical emergency, in which case the Admission Note is to be completed, if at all possible, prior to the surgical Procedure. |
| Verbal Midwifery Orders | Verified within twenty-four hours. |
| Discharge Summary | Completed within fourteen days of chart being made available. |
| Emergency Notes | Completed prior to discharge of the Client from the Emergency Department. |
| Ambulatory/Outpatient Records | Written, dictated, or electronically entered within twenty-four hours of visit. |
| Consultation Reports | Written, dictated or electronically entered within twenty-four hours (preferably upon completion of the consultation). |
| Progress Notes | Daily progress notes are recommended for Clients in acute care Sites of Clinical Activity. Notwithstanding these guidelines, progress notes shall be completed whenever there is a significant change in the Client's condition or management, and whenever unexpected events or outcomes occur. |

4.16.4 Curtailment of Clinical Privileges for Incomplete Health Records:

4.16.4.1 Curtailment of Clinical Privileges for Incomplete Health Records

a) AHS Health Information Management staff at each AHS Site of Clinical Activity will monitor the completion of Clients' health records by Registered Midwives with Appointments.

b) After a Client has been discharged from a Site of Clinical Activity, the Client's health record will be made available to the Registered Midwife with an Appointment in the designated health record completion area of the Site of Clinical Activity.

c) If the Client's health record is incomplete fourteen days after it is made available post-discharge, Health Information Management will send a notification to the Registered Midwife with an Appointment.

d) If at any time, the Registered Midwife with an Appointment accumulates ten or more Client health records that have been incomplete for more than twenty eight days after they have been provided to the Registered Midwife for completion, or any single Client health record has remained incomplete more

than ninety days after it has been provided to the Registered Midwife for completion, the Site of Clinical Activity shall notify the Registered Midwife, the PMAO, and the Clinical Midwifery Director. Unless the Clinical Midwifery Director determines that there are extenuating circumstances, the PMAO shall, fourteen days later, curtail the Registered Midwife's Clinical Privileges as described in section 4.16.4.2 of these Rules. This curtailment in Clinical Privileges shall continue until all outstanding health records are completed.

e) Curtailment of Clinical Privileges encompasses all inpatient and ambulatory activity within all Sites of Clinical Activity.

4.16.4.2 During the period of curtailment of clinical privileges, the Registered Midwife in default ***shall*** be permitted and expected to:

a) Continue to care for their own Clients admitted prior to the date of curtailment of Clinical Privileges.

b) Fulfill their obligations with regard to service coverage responsibilities during which time the Registered Midwife may treat and consult on emergent cases and provide coverage for Clients under the care of their Zone Midwifery Clinical Department service / colleagues.

4.16.4.3 During the period of curtailment of clinical privileges, the Registered Midwife in default shall ***not*** be permitted to:

a) Admit Clients.

b) Write orders on their personal Clients who are admitted under the care of another Registered Midwife with an Appointment.

c) Treat Clients in their Site(s) of Clinically Activity except to continue to care for Clients for whom they were the Most Responsible Midwife prior to the curtailment.

4.16.4.4 End of the Period of Curtailment of Clinical Privileges

All Clinical Privileges will be reinstated upon completion of all incomplete Client's health records that led to curtailment of clinical privileges. If the Registered Midwife with an Appointment fails to complete the Client's health records that led to the curtailment of clinical privileges within fourteen days of the curtailment being imposed, either a Concern or Immediate Action shall be initiated by the Clinical Midwifery Director.

## D. OTHER

## 4.17 DISASTER PLANNING/EMERGENCY PREPAREDNESS

As required, and according to AHS and Facility Disaster/ Emergency Preparedness Plans each Registered Midwife with an Appointment shall participate in disaster and emergency preparedness planning/exercises, and in the actual activation/implementation of plans in the event of an external/internal disaster or public health emergency, including those resulting in major service disruption.

## 4.18 PHARMACY

Each Registered Midwife with an Appointment shall be governed by Policies regarding the prescribing, administering, and/or dispensing drugs and therapeutic agents. These include Policies introduced by the Provincial Pharmacy and Therapeutics Committee and its subcommittees, and those related to the Provincial Formulary.

## 4.19 COMMUNICABLE DISEASES

a) Registered Midwives with Appointments shall provide care within their area of expertise to all Clients, including those known or suspected of having a communicable disease. Registered Midwives shall also ensure that all appropriate precautions are taken to prevent transmission of these communicable diseases to others, including themselves.

b) It is the duty of all Registered Midwives with Appointments to take appropriate action to protect themselves and Clients from known, suspected or possible communicable disease(s). Such action shall include compliance with basic infection prevention and control strategies, referred to as routine practices (also known as standard or universal blood and body fluid precautions), for every Client encounter. Additional precautions may be necessary for Clients with pathogens transmitted by contact, droplet or airborne routes. As determined by an AHS occupational health Physician and/or a Zone Medical Officer of Health, alteration and/or restriction of Midwifery duties or, when necessary, exclusion of the Registered Midwife from work may also be required as defined by the Registered Midwife's susceptibility to, and potential for transmission of, a communicable disease.

c) The Registered Midwife with an Appointment shall follow the current hand washing Policy and the current isolation Policy.

d) Registered Midwives with Appointments shall have awareness of policies and required actions to take in the event of a needle stick injury.

e) The Most Responsible Registered Midwife shall be accountable for notifying the Zone Medical Officer of Health of all cases of communicable disease where such notification is required by law.

## PART 5. RULES APPLICABLE TO AN INDIVIDUAL ZONE OR ZONES

5.0 A Zone, through the Provincial Midwifery Executive Committee, may develop Zone Rules where necessary to reflect circumstances unique to the Zone, provided that such Zone Rules do not conflict with and are not inconsistent with the Bylaws, Part 3 of these Rules (Rules Applicable to all AHS Zones), or Part 4 of these Rules (AHS Client Care and Registered Midwife-related Provisions Common to all Zones).

5.1 Zone Rules so developed shall follow the approval process pursuant to section 1.6 of the Bylaws.

5.2 These Zone Rules shall govern the day to day management of Midwifery Staff activities within the Zone, and nothing in them shall alter the intent and purpose of the Bylaws or Parts 1 through 4 of these Rules inclusive.

## APPENDIX A – DEFINITIONS FROM THE MIDWIFERY STAFF BYLAWS

The definitions, captions, and headings are for convenience only and are not intended to limit or define the scope or effect of any provisions of these Rules.

In this document the following words have the meanings set opposite to them:

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| **Academic Midwife** | A member of the Midwifery Staff who also possesses an appointment as a Full-Time Faculty or Clinical Faculty member with the Faculty of Health and Community Studies of Mount Royal University. |
| **Active Staff** | The Registered Midwives who are appointed to the Active Staff category pursuant to these Bylaws. |

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| **Advisor** | A person, lay or professional, who provides guidance, support, or counsel to a Registered Midwife with an Appointment pursuant to these Bylaws. |
| **Affected Midwife** | A Registered Midwife with an Appointment who is the subject of a Triggered Initial Assessment, Triggered Review or Immediate Action. |
| **AHS Agent** | A person, other than an AHS employee, senior officer or board member, who is authorized to bind AHS, purports to bind AHS or who directly or indirectly controls AHS funds. |
| **AHS Board or Board** | The single governance board of Alberta Health Services appointed by the Minister. |
| **AHS Code of Conduct** | The code of conduct established by AHS. |
| **AHS Conflict of Interest Bylaw** | The conflict of interest bylaw established by AHS. |
| **AHS Representative** | An AHS employee, senior officer, Agent or board member. |
| **Alberta Health Services or AHS** | The health authority established pursuant to applicable legislation for the Province of Alberta. |
| **Application** | The forms and process used to apply for a Midwifery Staff Appointment and Clinical Privileges in the manner specified in these Bylaws and the Rules. |
| **Bylaws** | The specific provisions established as these Midwifery Staff Bylaws. |
| **Bylaws and Rules Review Committee** | A committee established as such pursuant to these Bylaws. |
| **Client** | An individual receiving health services from Midwifery Staff. Client includes reference to patient, family or co-decision maker. |
| **Clinical Midwifery Director or Clinical Director** | A Registered Midwife with an AHS Appointment and Privileges who is the midwifery clinical leader of a Zone(s). |
| **Clinical Privileges** | The delineation of the Procedures that may be performed by a Registered Midwife; the Sites of Clinical Activity in which a Registered Midwife may |

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| | perform Procedures or provide care to Clients; and the Programs and Professional Services that are available to a Registered Midwife in order to provide care to Clients. |
| **Collaboration or Collaborate** | The positive interaction of two or more health disciplines that bring their unique skills and knowledge to assist clients and families with their health decisions. |
| **College of Midwives of Alberta** | The regulatory body which governs the Registered Midwife. |
| **Complainant** | A Client or their legal representative(s), a member of the public, a Practitioner, or another Registered Midwife(s) who initiate(s) a Concern. |
| **Concern** | A written complaint or concern from any individual or group of individuals about an appointed Registered Midwife's professional performance and/or conduct, either in general or in relation to a specific event or episode of care provided to a specific Client. |
| **Consensual Resolution** | A consensual and confidential process to resolve a Concern. Consensual Resolution includes the Affected Midwife, the relevant AHS midwifery administrative leader(s), and any other relevant person(s). |
| **Hearing** | The process of addressing Concerns where a Triggered Initial Assessment and Consensual Resolution have not resolved the matter or are not considered appropriate means to resolve the matter. |
| **Hearing Committee** | A committee established as such pursuant to these Bylaws. |
| **Immediate Action** | An immediate suspension or restriction of a Registered Midwife's Midwifery Staff Appointment and/or Clinical Privileges without first conducting a Triggered Review pursuant to these Bylaws. |
| **Immediate Action Review Committee** | A committee established as such pursuant to these Bylaws. |
| **Locum Tenens** | A Registered Midwife temporarily placed into an existing practice and/or Site of Clinical Activity in order to facilitate the short term absence of another Registered Midwife with an Appointment. |

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| **Midwifery Organizational Structure** | The midwifery organizational structure of AHS aligned with these Bylaws and the Rules. |
| **Midwifery Services or Specified Clinical Midwifery Services** | Clinical services as defined by the College of Midwives of Alberta and the relevant Alberta midwifery regulation. |
| **Midwifery Staff** | Registered Midwives who possess an Appointment pursuant to these Bylaws, collectively and individually as the context requires. |
| **Midwifery Staff Appointment or Appointment** | The admission of a Registered Midwife to the AHS Midwifery Staff. An Appointment grants administrative access to AHS and identifies a Registered Midwife as an affiliate of AHS. |
| **Midwifery Staff Association** | An association of the AHS Midwifery Staff. In the absence of a Midwifery Staff Association, the Provincial Midwifery Administrative Office will engage the appropriate stakeholder group(s). |
| **Midwifery Staff Letter of Offer** | An offer to join the Midwifery Staff which specifies the category of Appointment, assignment to a Zone(s) Clinical Department(s), delineation of specific Clinical Privileges (if applicable), and the details of major responsibilities and roles. |
| **Midwifery Student** | A student whose practice experience in AHS is covered by an AHS student placement agreement. |
| **Midwifery Workforce Plan** | An AHS plan which provides projections and direction with respect to the recruitment, retention and organization of the Midwifery workforce. |
| **Midwifery Zone Application Review Committee or MZARC** | A committee established as such pursuant to these Bylaws. |
| **Minister** | The appointed member of the Executive Council of Alberta who is charged with carrying out the statutory responsibilities conferred on them as Minister of Health. |
| **Other Providers** | Corporations, partnerships or legal entities other than AHS which own and/or operate approved hospitals, within the Province of Alberta or which offer diagnostic and treatment services and programs. |

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| **Periodic Review** | A periodic review of the professional performance and all matters relevant to the Appointment and Clinical Privileges of a Registered Midwife with an Appointment in the Active or Locum Tenens Staff categories. |
| **Policies** | Administrative and operational governance documents established by AHS with respect to its operations and Sites of Clinical Activity, facilities, programs and services. |
| **Practitioner** | An individual who has an AHS Medical Staff Appointment. |
| **President & Chief Executive Officer or CEO** | The chief executive officer appointed by the Board of AHS to have overall administrative responsibility for AHS. |
| **Primary Zone Midwifery Clinical Department or PZMCD or Primary Zone** | The Zone Midwifery Clinical Department in which a Registered Midwife with an Appointment undertakes the majority of their Midwifery Staff responsibilities and roles, and through which changes in Appointment, Performance Reviews, and other administrative actions pursuant to these Bylaws will be managed. |
| **Probationary Staff** | The Registered Midwives who are appointed to the Probationary Staff category pursuant to these Bylaws. |
| **Procedure** | A diagnostic or therapeutic intervention for which a grant of Clinical Privileges is required. |
| **Professional Code of Ethics** | The Code of Ethics established by the provincial College of Midwives of Alberta. |
| **Programs and Professional Services** | Diagnostic and treatment services and programs operated by or for AHS to which Registered Midwives with relevant Clinical Privileges can refer Clients. |
| **Provincial Midwifery Administrative Office or PMAO** | An operational office of the Vice President portfolio. |
| **Provincial Midwifery Director or Provincial Director of Midwifery Services** | The administrative leader accountable for Midwifery Services at AHS. |
| **Provincial Midwifery** | A committee established as such pursuant to these Bylaws. |

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| **Executive Committee or PMEC** | |
| **Registered Midwife** | A person registered and in good standing with the College of Midwives of Alberta. |
| **Request to Change** | A request to change the category of Appointment and/or the Clinical Privileges of a Registered Midwife pursuant to these Bylaws. |
| **Return-In-Service Agreement or RiSA** | A signed agreement between AHS and the Registered Midwife with an Appointment indicating that the Registered Midwife will continue to work for AHS for a specified period of time after the Registered Midwife has received an investment from AHS. |
| **Rules** | The specific provisions established as Midwifery Staff Rules pursuant to these Bylaws. |
| **Search Committee** | A committee established as such pursuant to the Rules. |
| **Sites of Clinical Activity** | The locations and programs operated by AHS, listed in the grant of Clinical Privileges, where a Registered Midwife with an Appointment may perform Procedures, or provide care to Clients. The Sites of Clinical Activity may include Zones, facilities, specific Programs and Professional Services within facilities, and/or Telemedicine. |
| **Telemedicine** | The provision of services for Clients, including the performance of Procedures, via telecommunication technologies, when the Client and the Registered Midwife with an Appointment are geographically separated. |
| **Temporary Staff** | The Registered Midwives who are appointed to the Temporary Staff category pursuant to these Bylaws. |
| **Triggered Initial Assessment** | An investigation and initial assessment of a Concern or other information/complaints about a Registered Midwife with an Appointment. |
| **Triggered Review** | A review undertaken in response to a Concern about an appointed Registered Midwife's professional performance and/or conduct. |

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| **Vice President or VP** | The most senior executive of AHS responsible for midwifery services, appointed by the CEO. |
| **Zone** | A geographically defined organizational and operational sub-unit of AHS defined by the Vice President, the boundaries of which may not be aligned with AHS zones and which may be revised from time-to-time by the Vice President. |

## APPENDIX B – CREATION, MODIFICATION AND DISSOLUTION OF ZONE MIDWIFERY CLINICAL DEPARTMENTS

Changes in a Zone's Midwifery Clinical Department structure shall be made according to the following provisions:

a) The Provincial Midwifery Director will periodically assess the Zone's Midwifery Clinical Department structure to determine whether any change is required (creating, combining, or eliminating Zone Midwifery Clinical Departments for better organizational efficiency and improved Client care.

b) In addition,

   i. one or more Zone Midwifery Clinical departments may request that the Provincial Midwifery Director consider changes to the Zone's Midwifery Clinical Department structure.
   ii. a group of Midwifery Staff Registered Midwives who satisfy the criteria for Zone Midwifery Clinical Department designation, as set forth below, may request consideration of such designation by petitioning the Provincial Midwifery Director and/or the Provincial Midwifery Executive Committee in writing and providing appropriate supporting documentation for such a designation.

c) In addition to the criteria and factors described in sections 2.3.1, 2.3.2 and 2.3.3 of the Bylaws, the following factors shall be considered by the Provincial Midwifery Director and the Provincial Midwifery Executive Committee in determining whether the creation of a Zone Midwifery Clinical Department is warranted:

   i. there are a minimum of twenty five Midwifery Staff (for Midwifery Clinical Departments) who would be available and who are willing to be appointed to the proposed Zone Midwifery Clinical Department; and
   ii. the level of clinical service and activity that will be provided by the proposed Midwifery Clinical Department is substantial enough to warrant imposing the responsibilities and expectations of a Midwifery Clinical Department (pursuant to the Bylaws and these Rules) upon the proposed members.

d) In addition to the criteria and factors described in sections 2.3.1, 2.3.2 and 2.3.3 of the Bylaws, the following factors shall be considered by the Provincial Midwifery Director and the Provincial Midwifery Executive Committee in determining whether the dissolution or amalgamation of a Zone Midwifery Clinical Department(s) is warranted:

i. there is no longer an adequate number of Midwifery Staff in the Zone Midwifery Clinical Department to enable it to accomplish the functions set forth in the Bylaws and these Rules;
ii. there are an insubstantial number of Clients or an insignificant amount of clinical service and activity to warrant the imposition of the responsibilities and expectations of a Zone Midwifery Clinical Department (pursuant to the Bylaws and these Rules) upon the members of the Zone Midwifery Clinical Department;
iii. the Zone Midwifery Clinical Department fails to meet on at least a quarterly basis;
iv. the Zone Midwifery Clinical Department fails to fulfill all designated responsibilities and functions; or
v. no qualified individual is willing to serve as Clinical Midwifery Director.

e) Prior to creating, modifying or dissolving a Zone Midwifery Clinical Department, the Provincial Midwifery Director shall consult with all affected Registered Midwives.

f) Recommendations for changes to a Zone's Midwifery Clinical Department structure require the endorsement of the Clinical Midwifery Director and a majority of voting members present at a duly constituted meeting of the Provincial Midwifery Executive Committee. If the recommendation for change(s) is supported, the recommendation will be forwarded to the Vice President or designate for review and final approval.