

**DEPARTMENT OF STATE**  
**DIVISION OF PROFESSIONAL REGULATION**  
**1795 MIDWIFERY ADVISORY COUNCIL**

Statutory Authority: 24 Delaware Code, Section 1799HH(c) (24 Del.C. §1799HH(c))

**FINAL**

**ORDER**

**1795 Midwifery Advisory Council**

The Midwifery Advisory Council, pursuant to 24 Del.C. §1799HH(c), proposed to adopt regulations governing the practice of midwifery in the State of Delaware. As a newly created Council, regulating a profession that first required licensure by virtue of legislation enacted June 9, 2015, these regulations are comprehensive, and all newly created.

**Summary of the Evidence and Information Submitted**

Following publication in the Delaware *Register of Regulations* on May 1, 2016 a public hearing was held on May 25, 2016. Written comment periods were held open for thirty days following the initial publication on May 1, 2016, and an additional fifteen days following the May 25, 2016 public hearing. At the hearing, the Board accepted as evidence and marked as the Board's Exhibit 1 documentation of publication of the notice of the public hearing in the *News Journal* and the *Delaware State News*.

During the public hearing, the Council received public comment from Ms. Katherine Kline, home birth mom and advocate. Ms. Kline stated that she recognizes that the regulations aren't perfect and a lot of work needs to be done, but she believes that the structure of the MAC is such that this can be adjusted going forward. Now, the most important thing is getting the mothers who have been patiently waiting getting the care they desperately want. When Ms. Kline was first involved in the midwifery bill, her son Joey was a year old and he is now three. During the time since the bill was first being worked on, she became pregnant again and had to travel to Pennsylvania to birth at home with a midwife. She is begging for these regulations to go through as fast as possible.

The Council also received public comment from Ms. Allie Heiger, a registered nurse and home birth advocate in the state of Delaware. After reviewing the regulations, Ms. Heiger believes that after all of this time, we really need to move forward. She likes how the rules and regulations have ended up. She is happy with the formulary that she reviewed and likes the access that it provides midwives to safely address mothers in the field. Several states do not have a formulary and the states that do have formularies consistent with what Delaware is proposing. Ms. Heiger would really like to move forward with having a baby in the state, and she is holding off until she can do so without having to ask a midwife to commit a felony. Ms. Heiger thanked the Committee for all of its hard work on these regulations.

During the written public comment period, a letter dated June 3, 2016 was received from Cara A. Kinzelman, PhD, Director, State Government Affairs for the American College of Nurse-Midwives. This comment was labeled Board Exhibit 2. Ms. Kinzelman indicated that the CM credential is equivalent to the CNM credential, and that the CM credential has a scope of practice that includes a full range of primary health care services for women from adolescence beyond menopause, including prescribing controlled substances and other medications. CNMs and CMs provide care in diverse settings such as ambulatory care clinics, private offices, community and public health systems, homes, hospitals and birth centers. CPMs, by contrast, provide care to normal, low-risk populations in the out-of-hospital setting, and have a more limited scope of practice than CNMs and CMs. Ms. Kinzelman expressed that the American College of Nurse-Midwives is concerned that the current regulations conflate the CM credential with the CPM credential, and requests that the MAC amend the rules to replace each occurrence of "midwife" with the more specific term "Certified Professional Midwife" and defer consideration of the CM role at this time, promulgating separate rules governing the CM credential to avoid conflation of the two distinct midwifery roles. If deferment is not possible, Ms. Kinzelman requests that the MAC conform its regulations to the ACNM national standards, including granting CMs full prescriptive authority, up to and including, the ability to prescribe all Schedule II controlled substances and incorporating the ACNM standard-setting document, *Standards for the Practice of Midwifery*, into the regulations.

The MAC received a letter from Ms. Karen Jefferson, chair of the Committee for the Advancement of Midwifery Practice of the American College of Nurse-Midwives. Ms. Jefferson's letter was marked Board Exhibit 3. Ms. Jefferson indicates that she is a practicing CM from New York and she has had admitting privileges at five different hospitals in that state. Ms. Jefferson's letter then mirrored Ms. Kinzelman's, Board Exhibit 2.

The MAC received a letter from Trinisha C. Williams, Membership Chair of the New York State Association of Licensed Midwives, an association of the American College of Nurse-Midwives. Ms. Williams' letter was marked Board Exhibit 4. Ms. Williams indicates that she has been a practicing CM in New York for 13 years, and that she has admitting privileges in three hospitals in that state. Ms. Williams indicates she is interested in practicing midwifery in Delaware to be closer to her

extended family. Ms. Williams' letter then mirrored Ms. Kinzelman's, Board Exhibit 2.

The MAC received a letter dated June 4, 2016 from Ms. Dana Perlman, Program Director of the Midwifery Institute at Philadelphia University. Ms. Perlman's letter was marked Board Exhibit 5. Ms. Perlman indicated that CMs attend the same accredited graduate programs, earn the same degree, and take the identical national certification exam by the AMCB as CNMs. The program prerequisites are followed by courses in basic health skills, orientation to varied environments of health care and health care ethics, and course work relevant to midwifery including medical, surgical, community, pediatric, geriatric, and mental health issues. All students complete clinical training under the supervision of a CNM or CM in the full scope of midwifery care as defined by the ACNM. The remainder of Ms. Perlman's letter mirror's Ms. Kinzelman's, Board Exhibit 2.

The MAC received a letter dated June 7, 2016 from Jill Panunto, a Delaware resident, mother of two, small business owner, doula, and birth advocate. Ms. Panunto's letter was marked Board Exhibit 6. Ms. Panunto indicated her support for the regulations and asked for their swift adoption.

The MAC received a letter from Ms. Marian Seliqini, a Certified Midwife practicing in New York state. Ms. Seliqini's letter was marked Board Exhibit 7. Ms. Seliqini indicated her support for full recognition of the established scope of practice of the Certified Midwife. Ms. Seliqini stated she provides full-scope ObGyn care to patients from early adolescence through menopause, consulting and collaborating with physicians where appropriate. She will soon be attending training to perform colposcopies, expanding her scope of practice. Ms. Seliqini has privileges at St. Luke's Cornwall hospital and prescribing privileges, including controlled substances. Ms. Seliqini concluded by saying she would love to be able to include Delaware in her future employment searches.

The final letter the MAC received was from Ms. Jennifer Barraclough, a RN who works in the state of New Jersey. Ms. Barraclough's letter was marked as Board Exhibit 8. Ms. Barraclough indicated that she loved being a doula and decided to continue on this path to become a midwife. However, she did not have a desire to pursue a nursing degree. She excelled in her CM program, but was saddened to learn that CMs could not obtain hospital privileges in the state of New Jersey. She was then forced to obtain her RN, spending thousands of dollars on a degree she did not want. Ms. Barraclough closed her letter by imploring the MAC to reconsider regulating CMs differently than CNMs.

In addition to the correspondence, the MAC received specific comments to its proposed regulations, sent on behalf of the ACNM, that appear to have been drafted by Ms. Kinzelman and Ms. Perlman. These regulation-specific comments were marked Board Exhibit 9. The changes came with a cover letter, urging the MAC to not limit the prescriptive authority of CMs equivalent to CPMs and instead providing CMs prescriptive authority equal to that of CNMs.

### **Summary of the Findings of Fact**

As a newly created council, the Midwifery Advisory Council is charged with the responsibility of creating regulations: 24 **Del.C.** §1799HH(c). Beginning in September 2015, the MAC met on a monthly basis, formulating regulations governing the practice of midwifery in the state of Delaware. In so doing, the MAC conducted an in-depth review of its statutory mandates, reviewed the governance of midwifery in other states to determine what has and has not worked, reviewed national association guidelines, sought and received input from the Board of Medical Licensure and Discipline, and drew upon its collective expertise in the practice to create the regulations published as proposed on May 1, 2016.

The MAC recognizes that changes to the regulations may need to be made once they are put into operation. However, the MAC is cognizant of the public comments received that urge the swift adoption of these regulation. See comments of Ms. Panunto, Ms. Kline, and Ms. Heiger. Moreover, the MAC recognizes that the practice of midwifery is completely unregulated until such time as these regulations are adopted and applications for licensure can be accepted.

With regard to the comments of Ms. Kinzelman, Ms. Jefferson, Ms. Williams, Ms. Perlman, Ms. Seliqini, and Ms. Barraclough, the MAC understands the concern expressed that, in the opinion of the commenters, the regulations limit what should be the scope of practice of CMs. For example, public comments posited that CMs should be permitted to practice in hospital or birthing center settings. The MAC regulations, however, do not set forth the standards for hospitals to determine whether or not to grant privileges. Further, the regulations do not preclude a CM from practicing in a hospital or birthing center setting. Indeed, aside from specific regulations governing the practice of midwifery in a home birth setting, the regulations are completely silent as to practice loci. A CM practicing in a hospital or birthing center will need privileges from that location, and it is completely within the discretion of those providers to grant or deny those privileges.

Board Exhibit 9, the specific language suggested by the ACNM for inclusion in the MAC regulations overwhelmingly suggests non-substantive changes to the regulations, suggesting new language covering topics already covered. The suggested additions to the ethical mandates (2.0) and record keeping provisions (3.0) provide only new language for regulations already provided. The addition of these regulations would be the undesirable insertion of mere surplusage and are therefore rejected. The MAC further rejects the suggestion of adding "3.9 Certified midwifery practice may be expanded beyond the ACNM core competencies to incorporate new procedures that improve care for women and their families" *et seq.* as a regulation may not, as this proposed regulation does, exceed the scope of the enabling statute.

These commenters also maintain that blanket prescriptive authority for CMs should be included in the regulations, and the prescriptive formulary set forth in the regulations unduly limits CMs, whose prescriptive authority should mirror that of Certified Nurse Midwives. Likewise, proposed regulation addition 3.6.2 contemplates CM prescribing for "controlled

substances categories II – V.” Delaware’s limited prescriptive authority for CMs, however, is consistent with the overwhelming majority of other states that regulate the practice of midwifery. There is no legislative history to support affording a new license type, such as CM, full and total prescriptive authority, to include controlled substances. In fact, the MAC recognizes that during the past legislative session, the General Assembly amended Title 24, Chapter 19 with regard to the practice of Advance Practice Nurses. Previously, Advance Practice Nurses were required to apply for full prescriptive authority. As amended, Delaware law now affords full prescriptive authority to Advance Practice Nurses upon the granting of licensure; however, all newly licensed APRNs must first work under a collaborative agreement with a physician or podiatrist for at least two years and 4,000 hours. The full, independent prescriptive authority sought by the CMs would be unprecedented in the state and would be greater than that currently afforded CNMs.

Additionally, the MAC is charged with the licensure and regulation of non-nurse midwifery. Practice limitations have been imposed on both CMs and CPMs as a result of the MAC’s enabling statute as well as the Board of Medical Licensure and Discipline. It is the hope of the Council that, over time and with the successful integration of regulated midwifery practitioners into the healthcare system as a whole, the general assembly may be convinced to loosen some of these restrictions and broaden the scope of practice for all midwives.

Finally, the MAC recognizes the commenters’ suggestion that regulations specifically relating to CMs may still be necessary. In order to effectuate such a scheme without unduly delaying the implementation of regulations *in toto* the MAC plans to meet with representatives of the ACNM in the upcoming months to address the specific concerns of that organization and its membership and develop additional regulations specifically pertaining to CMs for submission for approval from the Board of Medical Licensure and Discipline.

### **Decision of the Board**

Having found that the proposed regulations are necessary as outlined herein, the Council finds that the regulations shall be adopted as final in the form as proposed. These regulations will become effective ten days following publication of this order in the Delaware *Register of Regulations* on July 1, 2016.

**IT IS SO ORDERED** this 15<sup>th</sup> day of June, 2016 by the Midwifery Advisory Council.

Philip Shlossman, M.D.

Susan DiNatale

Shannon Burdeshaw

Pat Gallagher

### **1795 Midwifery Advisory Council**

#### **1.0 Definitions**

**“Board”** means Delaware Board of Medical Licensure and Discipline.

**“Certified midwife”** or **“CM”** means a practitioner who has received certification by the American Midwifery Certification Board (“AMCB”) or its equivalent or successor.

**“Certified professional midwife”** or **“CPM”** means a practitioner who has received certification by the North American Registry of Midwives (NARM) or its equivalent or successor.

**“Council”** means the Midwifery Advisory Council of the Board of Medical Licensure and Discipline.

#### **2.0 Ethical Standards for Midwives**

**2.1** The midwife shall refuse to provide or continue care and refer the woman to other professionals if the life or health of either the mother or baby is at risk as defined by these regulations.

**2.2** The midwife works in partnership with each woman she serves. The midwife:

**2.2.1** Offers her experience, care, respect, counsel and support to each woman she serves;

**2.2.2** Freely shares her midwifery philosophy, professional standards, personal scope of practice and expertise, as well as any limitations imposed upon her practice by local regulatory agencies and state law;

**2.2.3** Recognizes that each woman she cares for is responsible for her own health and well-being;

**2.2.4** Accepts the right of each woman to make decisions about her general health care and her pregnancy and birthing experience;

**2.2.5** Negotiates her role as caregiver with the woman and clearly identifies mutual and individual responsibilities, as well as fees for her services;

**2.2.6** Communicates openly and interactively with each woman she serves;

**2.2.7** Provides for the social, psychological, physical, emotional, spiritual and cultural needs of each woman;

**2.2.8** Does not impose her value system on the woman;

**2.2.9** Solicits and respects the woman’s input regarding her own state of health;

**2.2.10** Respects the importance of others in the woman’s life.

- 2.3 Midwifery actions are prioritized to optimize well-being and minimize risk, with attention to the individual needs of each woman and baby. The midwife:
- 2.3.1 Supports the natural process of pregnancy and childbirth;
  - 2.3.2 Provides continuous care, when possible, to protect the integrity of the woman's experience and the birth and to bring a broad range of skills and services into each woman's care;
  - 2.3.3 Bases her choices of interventions on empirical and/or research evidence, verifying that the probable benefits outweigh the risks;
  - 2.3.4 Strives to minimize technological interventions;
  - 2.3.5 Demonstrates competency in emergencies and gives priority to potentially life-threatening situations;
  - 2.3.6 Refers the woman or baby to appropriate professionals when either needs care outside her scope of practice or expertise;
  - 2.3.7 Works collaboratively with other health professionals;
  - 2.3.8 Continues to provide supportive care when care is transferred to another provider, if possible;
  - 2.3.9 Maintains her own health and well-being to optimize her ability to provide care.
- 2.4 The midwife supports each woman's right to plan her care according to her needs and desires. The midwife:
- 2.4.1 Shares all relevant information in language that is understandable to the woman;
  - 2.4.2 Supports the woman in seeking information from a variety of sources to facilitate informed decision-making;
  - 2.4.3 Reviews options with the woman and addresses her questions and concerns;
  - 2.4.4 Respects the woman's right to decline treatments or procedures and properly documents her choices;
  - 2.4.5 Develops and documents a plan for midwifery care together with the woman;
  - 2.4.6 Clearly states and documents when her professional judgment is in conflict with the decision or plans of the woman;
  - 2.4.7 Helps the woman access the type of care she has chosen;
  - 2.4.8 Shall refuse to provide or continue care and refer the woman to other professionals if she deems the situation or the care requested to be unsafe or unacceptable;
  - 2.4.9 Has the right and responsibility to transfer care in critical situations that she deems to be unsafe;
  - 2.4.10 She refers the woman to other professionals and remains with the woman until the transfer is complete.
- 2.5 The midwife concludes the caregiving partnership with each woman responsibly. The midwife:
- 2.5.1 Continues her partnership with the woman until that partnership is ended at the final postnatal visit or until she or the woman ends the partnership and the midwife documents same;
  - 2.5.2 Ensures that the woman is educated to care for herself and her baby prior to discharge from midwifery care;
  - 2.5.3 Ensures that the woman has had an opportunity to reflect on and discuss her childbirth experience;
  - 2.5.4 Informs the woman and her family of available community support networks and refers appropriately.
- 2.6 The midwife collects and records the woman's and baby's health data, problems, decisions and plans comprehensively throughout the caregiving partnership. The midwife:
- 2.6.1 Keeps legible records for each woman, beginning at the first formal contact and continuing throughout the caregiving relationship;
  - 2.6.2 Does not share the woman's medical and midwifery records without her permission, except as legally required;
  - 2.6.3 Reviews and updates records at each professional contact with the woman;
  - 2.6.4 Includes the individual nature of each woman's pregnancy in her assessments and documentation;
  - 2.6.5 Uses her assessments as the basis for on-going midwifery care;
  - 2.6.6 Documents the woman's decisions regarding choices for care, including informed consent or refusal of care;
  - 2.6.7 Makes records and other relevant information accessible and available at all times to the woman and other appropriate persons with the woman's knowledge and consent;
  - 2.6.8 Files birth and death certificates or records as required by law.
- 2.7 The midwife continuously evaluates and improves her knowledge, skills and practice in her endeavor to provide the best possible care. The midwife:
- 2.7.1 Continuously involves the women for whom she provides care in the evaluation of her practice;
  - 2.7.2 Uses feedback from the women she serves to improve her practice;

- 2.7.3 Collects her practice statistics and uses the data to improve her practice;
- 2.7.4 Informs each woman she serves of mechanisms for complaints and review;
- 2.7.5 Participates in continuing midwifery education and peer review;
- 2.7.6 May identify areas for research and may conduct and/or collaborate in research;
- 2.7.7 Shares research findings and incorporates these into midwifery practice as appropriate.

### **3.0 Midwifery Record Keeping**

- 3.1 Every midwife shall:
  - 3.1.1 Document completely and accurately the client's history, physical exam, laboratory test results, prenatal visits, consultation reports, referrals, labor and birth care, postpartum care and visits, and neonatal evaluations at the time midwifery services are delivered and when reports are received;
  - 3.1.2 Complete birth and death certificates as required by state law;
  - 3.1.3 Facilitate clients' access to their own records;
  - 3.1.4 Maintain the confidentiality of client records;
  - 3.1.5 Retain records for a minimum of seven years;
  - 3.1.6 Clearly state and document when a woman's choices fall outside the midwife's legal scope of practice or expertise;
  - 3.1.7 Provide infant medical records for newborns either to mother or the infant health care provider.
- 3.2 Client records must clearly document objective findings, decisions and professional actions, and must contain the following information:
  - 3.2.1 Patient name;
  - 3.2.2 Patient date of birth;
  - 3.2.3 Patient address;
  - 3.2.4 Past pregnancy history, including gravidity, parity, dates, methods of deliver, outcomes, and any complications;
  - 3.2.5 Past medical history, including hypertension, cardiac disease, renal disease, neurological disease, psychiatric illness, diabetes, pulmonary disease, gastrointestinal disease, thyroid or endocrine disorder, gynecologic disease, cancer, hematologic disease, infectious disease, sexually transmitted disease, HIV, musculoskeletal disorder;
  - 3.2.6 Allergies;
  - 3.2.7 Past surgical history including dates, type, outcomes, and any complications;
  - 3.2.8 Social history, including alcohol use, smoking, drug abuse, domestic violence, occupation;
  - 3.2.9 Family history, including medical diseases, genetic disorders, congenital anomalies, multiple gestations;
  - 3.2.10 Physical exam to include vital signs, height, weight, basic exam;
  - 3.2.11 Estimated date of delivery and how calculated;
  - 3.2.12 Number of visits;
  - 3.2.13 Prenatal lab results;
  - 3.2.14 Special test results, such as ultrasound, genetic testing or screening, biophysical profile, and non-stress test;
  - 3.2.15 Maternal complications;
  - 3.2.16 Fetal complications;
  - 3.2.17 Fetal anomalies;
  - 3.2.18 Intrauterine growth restriction, large for gestation, oligohydramnios, polyhydramnios;
  - 3.2.19 Estimated gestational age;
  - 3.2.20 Date and time of birth of infant;
  - 3.2.21 Date and time of delivery of placenta;
  - 3.2.22 Length of each stage of labor;
  - 3.2.23 Date and time of rupture of membranes;
  - 3.2.24 Fetal heart rate during labor;
  - 3.2.25 Documentation of labor progress;
  - 3.2.26 Method of delivery;
  - 3.2.27 Whether the delivery was at home;
  - 3.2.28 Whether transfer to the hospital was necessary and if so, for what reason;

- 3.2.29 Estimated blood loss;
- 3.2.30 Administration of any medications;
- 3.2.31 Intrapartum, delivery, or postpartum complications including but not limited to meconium, shoulder dystocia, hemorrhage, atony, tears or lacerations, arrest disorder, infection, prolapsed cord, bradycardia, fetal distress;
- 3.2.32 Date and time of birth;
- 3.2.33 APGAR score;
- 3.2.34 Gender of infant;
- 3.2.35 Weight, length, heart rate of infant;
- 3.2.36 Newborn physical exam and screening;
- 3.2.37 Medications given, including vitamin K;
- 3.2.38 Neonatal complications including infection, apnea, bradycardia, hyperbilirubinemia, anomalies, hypoglycemia;
- 3.2.39 Breastfeeding or not;
- 3.2.40 Postpartum complications, if any;
- 3.2.41 Birth control method.

#### **4.0 Home Birth**

- 4.1 A midwife offering home birth services shall only accept and provide care to those women who are classified as being low risk pregnancy, labor, and delivery. Low risk pregnancy, labor, and delivery means:
  - 4.1.1 There is no preexisting maternal disease or condition likely to affect the pregnancy, including but not limited to:
    - 4.1.1.1 Prior cesarean procedures;
    - 4.1.1.2 Significant cardiac disease;
    - 4.1.1.3 Active tuberculosis;
    - 4.1.1.4 Asthma, if severe or uncontrolled by medication, or other chronic pulmonary disease;
    - 4.1.1.5 Preexisting renal disease;
    - 4.1.1.6 Hepatic disorders;
    - 4.1.1.7 Untreated or uncontrolled endocrine disorders;
    - 4.1.1.8 Significant hematological disorders;
    - 4.1.1.9 Preexisting/uncontrolled neurologic disorders;
    - 4.1.1.10 Essential hypertension;
    - 4.1.1.11 Active cancer;
    - 4.1.1.12 Pre-gestational diabetes mellitus;
    - 4.1.1.13 History of newborn with group B strep disease;
    - 4.1.1.14 Current substance addiction or abuse;
    - 4.1.1.15 Current severe psychiatric illness;
    - 4.1.1.16 History of Rh red cell isoimmunization;
    - 4.1.1.17 Positive for HIV antibody or hepatitis B;
    - 4.1.1.18 Primary or uncontrolled infections;
    - 4.1.1.19 History of uterine surgery involving breach of the uterine wall;
    - 4.1.1.20 Prior neonatal death related to an intrapartum event;
    - 4.1.1.21 Primary post-partum hemorrhage requiring surgery.
  - 4.1.2 There is no significant disease or condition arising from the pregnancy, including:
    - 4.1.2.1 Onset of labor before the 37th week of gestation with a positive GBS or GBS status unknown;
    - 4.1.2.2 Lie other than vertex at term;
    - 4.1.2.3 Multiple gestations;
    - 4.1.2.4 Significant vaginal bleeding;
    - 4.1.2.5 Significant gestational hypertension;
    - 4.1.2.6 Gestational diabetes mellitus, uncontrolled by diet;
    - 4.1.2.7 Hemoglobin less than 10 mg/dl, not responsive to treatment;
    - 4.1.2.8 Evidence of pre-eclampsia;

- 4.1.2.9 Consistent size/date discrepancy;
- 4.1.2.10 Deep vein thrombosis or other significant hematologic syndrome;
- 4.1.2.11 Known fetal anomalies or conditions that would render a home birth unsafe;
- 4.1.2.12 Threatened or spontaneous abortion in the second trimester or later;
- 4.1.2.13 Abnormal ultrasound findings requiring a higher level of care;
- 4.1.2.14 Red cell isoimmunization with rising titer;
- 4.1.2.15 Documented placental anomaly or late term previa;
- 4.1.2.16 Rare diseases or disorders outside of the midwife's scope of care;
- 4.1.2.17 Postdates pregnancy;
- 4.1.2.18 HIV infection;
- 4.1.2.19 Primary or uncontrolled infections;
- 4.1.2.20 Significant decreased fetal responsiveness or evidence of non-reassuring fetal status.
- 4.1.3 There is a singleton fetus.
- 4.1.4 There appears to be a cephalic presentation prior to delivery.
- 4.1.5 The onset of labor occurs when the fetus has a gestational age greater than 37 and 0/7 weeks and less than 42 completed weeks, unless GBS positive or GBS status unknown.
- 4.1.6 Labor is most likely to be spontaneous.
- 4.2 The following equipment must be present at every home birth and the midwife must be properly trained on the use of each piece of equipment:
  - 4.2.1 Equipment for assessing maternal well-being:
    - 4.2.1.1 Blood pressure cuff;
    - 4.2.1.2 Stethoscope;
    - 4.2.1.3 Thermometer;
    - 4.2.1.4 Time keeping device with the ability to track seconds.
  - 4.2.2 Equipment for assessing fetal well-being:
    - 4.2.2.1 Doppler and Fetoscope.
  - 4.2.3 Equipment for assessing newborn well-being:
    - 4.2.3.1 Stethoscope;
    - 4.2.3.2 Thermometer;
    - 4.2.3.3 Blood glucose monitor;
    - 4.2.3.4 Pulse oximeter;
    - 4.2.3.5 Time keeping device with the ability to track seconds.
  - 4.2.4 Supplies to maintain asepsis:
    - 4.2.4.1 Sterile gloves;
    - 4.2.4.2 Antiseptic hand cleanser;
    - 4.2.4.3 Paper towels;
    - 4.2.4.4 Protective gowns;
    - 4.2.4.5 Eye shields;
    - 4.2.4.6 Surgical face masks;
    - 4.2.4.7 Protective fluid-resistant barrier;
    - 4.2.4.8 Sterile cord occlusive device;
    - 4.2.4.9 General purpose antiseptic;
    - 4.2.4.10 Sterile gauze;
    - 4.2.4.11 Speculum;
    - 4.2.4.12 Scissors;
    - 4.2.4.13 Hemostats;
    - 4.2.4.14 Ring forceps;
    - 4.2.4.15 Sterile barrier;
    - 4.2.4.16 Needle holder;
    - 4.2.4.17 Sutures.
  - 4.2.5 Maternal emergency resuscitation equipment:
    - 4.2.5.1 Ammonia inhalants;

- 4.2.5.2 Suction catheter;
- 4.2.5.3 Cuffless oral/nasal tube;
- 4.2.5.4 Benadryl;
- 4.2.5.5 Pepcid;
- 4.2.5.6 Epinephrine;
- 4.2.5.7 Dextrose;
- 4.2.5.8 0.9% Sodium Chloride;
- 4.2.5.9 Needles;
- 4.2.5.10 Angiocath;
- 4.2.5.11 10 cc syringe;
- 4.2.5.12 1 cc syringe;
- 4.2.5.13 Alcohol swabs;
- 4.2.5.14 Gauze;
- 4.2.5.15 Nasal cannula or mask;
- 4.2.5.16 Lactated ringers.

4.2.6 Newborn emergency resuscitation equipment:

- 4.2.6.1 Suction device;
- 4.2.6.2 Neo-natal resuscitation bag, mask, and board;
- 4.2.6.3 Feeding tube;
- 4.2.6.4 Endotracheal tube laryngoscope;
- 4.2.6.5 Meconium aspirator;
- 4.2.6.6 Epinephrine;
- 4.2.6.7 Needles;
- 4.2.6.8 1 cc syringe;
- 4.2.6.9 Alcohol swabs;
- 4.2.6.10 Gauze;
- 4.2.6.11 Oxygen.

4.3 A midwife must ensure that every location where a homebirth will occur is equipped with all of the following:

- 4.3.1 Running water;
- 4.3.2 A room with heat.

4.4 Administration of Prescribed Medications and Authorized Tests:

- 4.4.1 Upon the administration of any prescribed medication, the Midwife shall document in the client's chart the type of prescribed medication administered, name of prescribed medication, expiration date, lot number, dosage, method of administration, site of administration, date, time, and the prescribed medication's effect.

4.4.2 Administration of Approved Prescribed Medications by a Midwife includes:

- 4.4.2.1 Rh-immune globulin to Rh negative, antibody negative mothers, for the prevention of isoimmunization in Rh (D) negative women. One 300 microgram dose (or as recommended by the manufacturer) at 26-28 weeks gestation via intramuscular injection. In addition, one 300 microgram dose (or as recommended by the manufacturer) administered via intramuscular injection to the mother within 72 hours of delivery of an Rh positive infant (or an infant with unknown blood type) to an Rh negative, antibody negative mother. If mother does not deliver by 12 weeks after the dose is administered, mother must be administered another dose of Rh-immune globulin.
- 4.4.2.2 Oxytocin (Pitocin) for postpartum hemorrhage or, following delivery of the newborn to prevent postpartum hemorrhage. One or two doses of 10 units/ml may be administered via intramuscular injection. If a second dose is administered, for any reason, transport must be initiated in accordance with the emergency plan.
- 4.4.2.3 Methylergonovine (Methergine) for postpartum hemorrhage only; one 0.2 mg per 1 ml dose ampule administered via intramuscular injection. Every six hours, may repeat 3 times. Contraindicated in hypertension and Raynaud's Disease. If Methylergonovine (Methergine) is administered more than 3 times, transport must be initiated in accordance with the emergency plan.
- 4.4.2.4 Misoprostol (Cytotec) for postpartum hemorrhage only. Rectal or sublingual, or may be used as ½ rectally and ½ sublingually. 800 mcg dose (four 200 mcg tabs) administered rectally or a 400-600

mcg dose (two or three 200 mcg tabs) administered sublingually. 1-2 doses; not to exceed 800 mcg total. Transport to hospital required if more than 2 doses are administered.

4.4.2.5 Oxygen 10-12 L/min. for maternal /fetal distress; bag or bag and mask until stabilization is achieved or transfer to a hospital is complete.

4.4.2.6 Erythromycin Ophthalmic Ointment to a newborn, for prophylaxis of neonatal ophthalmia, as provided by Delaware law. A single topical dose of Erythromycin Ophthalmic, Ointment USP (0.5%) is to be administered within two (2) hours after birth via topical application of a ribbon of ointment approximately 1 cm in length into each eye.

4.4.2.7 Vitamin K1 (phyloquinone, phytonadione) to a newborn, as prophylaxis for vitamin K deficiency bleeding. One 1 mg dose of 2 mg / ml concentration vitamin K1 via intramuscular injection.

4.4.2.8 Lidocaine HCl 1% or 2% Local anesthetic for use during postpartum repair of lacerations Maximum 50 ml (1%), Maximum 15 ml (2%) percutaneous infiltration only.

4.4.2.9 Epinephrine HCl 1:1000 (Epi-Pen Twin Jet® auto injector adult ≥66 lbs.) Treatment or post exposure prevention of severe allergic reactions. 0.3 ml-1.5 mg pre-metered dose as directed. Administer first dose then immediately request emergency services. Thereafter, administer every 20 minutes or until emergency medical services arrive.

4.4.2.10 If IV therapy is initiated for blood loss, transport must be initiated in accordance with the emergency plan. The preferred drug list of IV fluids necessary to restore fluid volume lost due to postpartum hemorrhage consists of:

4.4.2.10.1 Lactated Ringers (LR); 1 - 2 liter bags - first liter run in at a wide open rate, via intravenous catheter, the second liter titrated to client's condition.

4.4.2.10.2 Lactated Ringers solution (D5LR); 500 ml - may run in at a wide open rate, via intravenous catheter, and then titrated to client's condition.

4.4.2.11 Clients found to have a culture indicated Group B Streptococcal Infection should be treated with appropriate antibiotics during labor according to CDC guidelines.

4.4.2.11.1 0.9% sodium chloride in sterile water (NS) for reconstitution of the antibiotic.

4.4.2.11.2 Penicillin G: 5 million units initial dose then 2.5 million units every four hours until birth IV in >100 ml LR or NS; or Ampicillin sodium: 2 grams initial dose, then 1 gram every four hours until birth IV in > 100 mg LR, NS or D5LR.

4.4.2.11.3 For clients found to have Group B Streptococcal infection with a history of penicillin allergy, antibiotics to which the strain of Group B Streptococcus carried by the client is sensitive must be determined prior to labor and the client must be treated with those antibiotics during labor as outlined by the CDC guidelines.

4.5 Emergency Care: The following procedures may be performed by the Midwife, only in an emergency situation in which the health and safety of the mother or newborn are determined to be at risk.

4.5.1 Administration of oxygen

4.5.2 Episiotomy

4.5.3 Administration of Pitocin, Methergine or Cytotec to control postpartum bleeding

4.5.4 If any of the following conditions arise during intrapartum or postpartum care, the midwife must immediately engage emergency medical services, and may continue to assist in the emergency:

4.5.4.1 Persistent abnormal bleeding;

4.5.4.2 Signs or symptoms of maternal or fetal infection;

4.5.4.3 Transverse lie or any other unresolvable malpresentation;

4.5.4.4 Visualization of active genital herpetic lesion;

4.5.4.5 Development of pre-eclampsia or gestational hypertension;

4.5.4.6 Abnormal findings on rupture of membranes;

4.5.4.7 Seizure;

4.5.4.8 Significant hemorrhage, greater than 1,000 cc with symptoms, not responsive to treatment;

4.5.4.9 Adherent or retained placenta;

4.5.4.10 Sustained maternal vital sign instability;

4.5.4.11 Suspected uterine prolapse;

4.5.4.12 Repair of laceration or episiotomy beyond the midwife's level of expertise;

4.5.4.13 Anaphylaxis;

4.5.4.14 Need for cardiopulmonary resuscitation of the mother or newborn with a bag and mask;

- 4.5.4.15 Need for manual exploration of the uterus for placental extraction to control severe bleeding.
- 4.5.5 A second attendant, certified in neonatal resuscitation, must be present at every home birth.

## **5.0 Prohibitions in the Practice of Midwifery**

- 5.1 The Midwife shall not administer any prescribed medications or injections of any kind, except as indicated in these regulations.
- 5.2 The Midwife shall not use synthetic prostaglandin compounds for the induction of labor for out-of-hospital use, even when prescribed by a physician.
- 5.3 Intrapartum (first and second stages of labor) use of oxytocics, such as Pitocin and Methergine, is prohibited through all routes of administration.
- 5.4 Surgical Procedures. The Midwife shall not perform any operative procedures or surgical repairs other than:
- 5.4.1 Sterile artificial rupture of membranes (AROM);
  - 5.4.2 Aseptic performance and repair of episiotomy;
  - 5.4.3 Perineal/vaginal repair if within the midwife's abilities;
  - 5.4.4 Clamping and cutting of the newborn's umbilical cord.
- 5.5 Instrumental Delivery. The Midwife shall not use forceps or vacuum extraction to assist the birth of the baby.

## **6.0 Prenatal Care**

- 6.1 During prenatal care, the midwife or other licensed health care provider shall follow a regular schedule of prenatal care with increasing frequency towards term. The responsibilities of the midwife during this time include:
- 6.1.1 Initial Prenatal Visit:
- 6.1.1.1 History and assessment of general health;
  - 6.1.1.2 History and assessment of obstetric and psychosocial status;
  - 6.1.1.3 Discussion of current CDC recommendations for immunization during pregnancy;
  - 6.1.1.4 Physical Exam, including:
    - 6.1.1.4.1 Height;
    - 6.1.1.4.2 Weight;
    - 6.1.1.4.3 Blood pressure;
    - 6.1.1.4.4 Pulse;
    - 6.1.1.4.5 Breast exam;
    - 6.1.1.4.6 Abdomen, to include fundal height, fetal heart tones, fetal lie, and presentation;
    - 6.1.1.4.7 Estimation of gestational age;
    - 6.1.1.4.8 Assessment of varicosities, edema, and reflexes.
  - 6.1.1.5 The midwife must complete the following laboratory tests at the initial prenatal visit:
    - 6.1.1.5.1 Hemoglobin or hematocrit or CBC;
    - 6.1.1.5.2 Urinalysis for protein and glucose;
    - 6.1.1.5.3 Syphilis serology;
    - 6.1.1.5.4 Blood group, Rh type, and antibody screen;
    - 6.1.1.5.5 Hepatitis B surface antigen;
    - 6.1.1.5.6 Rubella screen;
    - 6.1.1.5.7 Gonorrhea test;
    - 6.1.1.5.8 Chlamydia test;
    - 6.1.1.5.9 HIV test;
    - 6.1.1.5.10 Urine culture.
  - 6.1.1.6 The midwife must provide appropriate prophylactic antibiotic therapy for GBS positive clients pursuant to CDC guidelines.
  - 6.1.1.7 The midwife should consider genetic testing, urine drug screen, and Hepatitis C testing as indicated.
- 6.1.2 On-going Prenatal Care:
- 6.1.2.1 Assessment of general health;
  - 6.1.2.2 Assessment of psychosocial health;

- 6.1.2.3 Nutritional counseling;
- 6.1.2.4 Physical Exam to include, but not limited to:
  - 6.1.2.4.1 Blood pressure;
  - 6.1.2.4.2 Weight;
  - 6.1.2.4.3 Abdomen, to include fundal height, fetal heart tones, fetal lie, and presentation;
  - 6.1.2.4.4 Estimation of gestational age by physical findings;
  - 6.1.2.4.5 Assessment of varicosities, edema and reflexes.
- 6.1.2.5 The midwife must offer the following laboratory tests:
  - 6.1.2.5.1 Hemoglobin, hematocrit, or CBC between 28 and 32 weeks;
  - 6.1.2.5.2 Gross urinalysis for protein and glucose at each visit;
  - 6.1.2.5.3 Glucose Tolerance Test;
  - 6.1.2.5.4 Group Beta Strep (GBS) cultures, according to CDC guidelines. If penicillin allergic, determine antibiotics to which the strain of GBS carried by the client is sensitive and treat appropriately during labor;
  - 6.1.2.5.5 Herpes (HSV 1 or HSV 2) cultures, if indicated;
  - 6.1.2.5.6 Prophylactic Rh-immune globulin information for Rh negative clients;
  - 6.1.2.5.7 Urine Drug Screen.

## **7.0 Intrapartum Care**

- 7.1 During labor, the midwife shall monitor and support the natural process of labor and birth, assessing mother and baby throughout the birthing process. The responsibilities of the midwife shall include, but are not limited to:
  - 7.1.1 Assess & monitor fetal well-being. While in attendance, assess fetal heart beats:
    - 7.1.1.1 1st Stage of labor: at least once every hour, or more frequently as indicated;
    - 7.1.1.2 2nd Stage of labor: at least every 10 minutes, or more frequently as indicated.
  - 7.1.2 During active labor, assess vital signs at least every 4 hours, or more frequently as indicated;
  - 7.1.3 Monitor the progress of labor;
  - 7.1.4 Assess cervical dilatation, effacement, station, and position during each exam and document in client's chart;
  - 7.1.5 Monitor membrane status for rupture, relative fluid volume, odor, and color of amniotic fluid;
  - 7.1.6 Assist in birth of baby;
  - 7.1.7 Inspect placenta and membranes.

## **8.0 Postpartum Care**

- 8.1 After the birth of the baby, the midwife shall assess, monitor, and support the mother during the immediate postpartum period until the mother is in stable condition and during the on-going postpartum period. The responsibilities of the midwife shall include, but are not limited to:
  - 8.1.1 Immediate Postpartum Care:
    - 8.1.1.1 Assess and monitor overall maternal well-being;
    - 8.1.1.2 Assess and monitor bleeding;
    - 8.1.1.3 Assess and monitor vital signs;
    - 8.1.1.4 Assess abdomen, including fundal height and firmness;
    - 8.1.1.5 Assess and monitor bowel and bladder function;
    - 8.1.1.6 Complete a perineal exam and assessment;
    - 8.1.1.7 Complete suture laceration or episiotomy within the midwife's level of expertise.
  - 8.1.2 On-going Postpartum Care:
    - 8.1.2.1 Assess and monitor overall maternal well-being;
    - 8.1.2.2 Assess and monitor bleeding;
    - 8.1.2.3 Assess abdomen, including fundal height and firmness;
    - 8.1.2.4 Assess and monitor bowel and bladder function;
    - 8.1.2.5 Assess and monitor vital signs;
    - 8.1.2.6 Complete a perineal exam and assessment.

## **9.0 Newborn Care**

9.1 After the birth of the baby, the midwife shall assess, monitor, and support the baby during the immediate postpartum period until the baby is in stable condition and during the on-going postpartum period.

### 9.1.1 Immediate Newborn Care:

9.1.1.1 Assess overall newborn well-being;

9.1.1.2 Monitor vital signs;

9.1.1.3 Assess and monitor color;

9.1.1.4 Assess and monitor tone and reflexes;

9.1.1.5 Assess APGAR scores at 1 and 5 minutes, and at 10 minutes when indicated;

9.1.1.6 Assess and monitor temperature;

9.1.1.7 Monitor feeding;

9.1.1.8 Assess and monitor bowel and bladder function;

9.1.1.9 Assess and monitor breathing;

9.1.1.10 Clamping/cutting of umbilical cord;

9.1.1.11 Newborn physical exam, including weight and measurements;

9.1.1.12 Eye prophylaxis;

9.1.1.13 Administration of Vitamin K, orally, or intramuscularly.

### 9.1.2 Ongoing Newborn Care:

9.1.2.1 Monitor vital signs, including color and temperature;

9.1.2.2 Monitor tone and reflexes;

9.1.2.3 Monitor feeding;

9.1.2.4 Monitor breathing;

9.1.2.5 Monitor bowel and bladder function;

9.1.2.6 Monitor weight gain;

9.1.2.7 Newborn screenings as per Delaware law;

9.1.2.8 Recommend every newborn see a pediatrician within 72 hours of delivery.

## **10.0 Duty to Update Address**

Midwives must provide the Division of Professional Regulation his/her current home mailing address. Any change in home mailing address must be reported to the Division within ten days of such change. All notifications and correspondence pertaining to a Midwife's license that are sent through the mail will be sent only to the most recent address provided by the licensee. The failure to provide the Division with a current home mailing address will not operate to excuse any duty or responsibility of the licensee and confirmed delivery to the most recent address provided by the licensee will be considered proper notice.

## **11.0 Disciplinary Proceedings**

11.1 The license of a Midwife found to have committed unprofessional conduct may be subject to revocation, suspension, probation, denial, non-renewal, fine, censure, or a letter of reprimand.

11.2 Unprofessional conduct includes any act of fraud, deceit, incompetence, negligence, dishonesty or other behavior in the licensee's professional activity which is likely to endanger the public health, safety, or welfare including, without limitation, the following:

11.2.1 Performing acts beyond the scope of authorized practice by a midwife to include violations of 24 Del.C. §1799AA et seq. or of these regulations.

11.2.2 Assuming duties and responsibilities within the practice of midwifery without adequate preparation or supervision or when competency has not been maintained.

11.2.3 Performing new midwifery techniques or procedures without adequate education and practice or without proper supervision.

11.2.4 Failing to take appropriate action or follow policies and procedures in the practice situation designed to safeguard the patient from incompetent, unethical or illegal health care practices.

11.2.5 Inaccurately recording on, falsifying or altering a patient record.

11.2.6 Committing verbal, physical or sexual abuse or harassment of patients or co-workers.

11.2.7 Allowing unqualified persons to perform the practice of licensed midwives.

- 11.2.8 Delegating midwifery responsibilities to unqualified persons.
- 11.2.9 Failing to supervise persons to whom midwifery responsibilities have been properly delegated.
- 11.2.10 Leaving a patient assignment in circumstances which endangers the patient except in documented emergency situations.
- 11.2.11 Failing to safeguard a patient's dignity and right to privacy in providing midwifery services which shall be provided without regard to race, color, creed or sexual orientation.
- 11.2.12 Violating the confidentiality of information concerning a patient except where disclosure is required by law.
- 11.2.13 Practicing midwifery when unfit to perform procedures and make decisions when physically, psychologically, or mentally impaired.
- 11.2.14 Diverting drugs, supplies, or property of a patient or attempting to do so.
- 11.2.15 Diverting, possessing, obtaining, supplying or administering prescription drugs to any person, including self, except as directed by a person authorized by law to prescribe drugs or attempting to do so.
- 11.2.16 Providing midwifery in this State without a currently valid license or permit and without other lawful authority to do so.
- 11.2.17 Allowing another person to use his/her license to provide midwifery for any purpose.
- 11.2.18 Aiding, abetting and/or assisting an individual to violate or circumvent any law or duly promulgated rule or regulation intended to guide the conduct of a midwife or other health care provider.
- 11.2.19 Resorting to, or aiding in any fraud, misrepresentation or deceit directly or indirectly in connection with acquiring or maintaining a license to practice midwifery.
- 11.2.20 Failing to report unprofessional conduct by another midwife licensee or permit holder.
- 11.2.21 Violating a lawful provision of Title 24, Chapter 17, Subchapter 13, or any lawful regulation established thereunder.

## **12.0 Continuing Education**

### **12.1 Contact Hours Required for Renewal**

- 12.1.1 The midwife shall be required to complete thirty hours of continuing education acceptable to the Council biennially.
- 12.1.2 Proof of continuing education is satisfied with an attestation by the licensee that he or she has satisfied the requirements of this Section.
- 12.1.3 Attestation may be completed electronically at the time of online renewal.
- 12.1.4 The midwife shall retain all certificates and other documented evidence of participation in an approved continuing education program for a period of at least three years. Upon request, such documentation shall be made available to the Council for random audit and verification purposes.
- 12.1.5 Continuing education hours shall be prorated for new licensees in accordance with the following schedule: Two years remaining in the licensing cycle requires thirty hours. One year or more, but less than two years, remaining in the licensing cycle requires fifteen hours. Licensees obtaining initial licensure with less than one year remaining in the licensing cycle are exempt from the continuing education requirement.

### **12.2 Exemptions and Extensions**

- 12.2.1 A licensee who because of a physical or mental illness during the license period could not complete the continuing education requirement may apply to the Council for a waiver. A waiver may provide for an extension of time or an exemption from some or all of the continuing education requirements for one renewal period. A separate request must be submitted for every renewal period during which a waiver is requested.
- 12.2.2 A request for a waiver must be submitted sixty days prior to the license renewal date.
- 12.2.3 Requests for Extension - Extenuating Circumstances. A licensee applying for renewal may request an extension and be given up to an additional twelve months to make up all outstanding required hours providing he/she can show good cause why he/she was unable to comply with such requirements at the same time he/she applies for renewal. The licensee must state the reason for such extension along with whatever documentation he/she feels is relevant. The Council shall consider requests such as extensive travel outside the United States, military service, extended illness of the licensee or his/her immediate family, or a death in the immediate family of the licensee. The written request for extension must be received prior to the renewal deadline. The Council shall issue an extension when it determines that one or more of these criteria have been met or if circumstances beyond the control of the licensee have rendered it impossible for the licensee to obtain the required hours. A licensee who has successfully applied for an extension under this paragraph shall make up all outstanding hours of continuing education within the extension period approved by the Council. Make-up credits may not be used in the next renewal period.

12.3 Acceptable Continuing Education. The overriding consideration in determining whether a specific program qualifies as acceptable continuing education is whether the program is a planned program of learning that contributes directly to the professional competence of the midwife. Continuing education contact hours awarded for activities or programs approved by the following are appropriate for fulfilling the continuing education requirements pursuant to these regulations, all other contact hours must be submitted to the Council for approval:

12.3.1 North American Registry of Midwives

12.3.2 Accreditation Commission for Midwifery Education

12.3.3 The Delaware Board of Medical Licensure and Discipline

12.3.4 The Delaware Board of Nursing

12.3.5 Other professional or educational organizations as approved periodically by the Council.

12.4 Audit of Continuing Education Hours

12.4.1 Audit. Each biennium, the Division of Professional Regulation shall randomly select from the list of renewed licensees a percentage of licensees, determined by the Council, to be audited. The Council may also audit based on complaints or charges against an individual license, relative to compliance with continuing education requirements or based on a finding of past non-compliance during prior audits.

12.4.2 Documentation. When a licensee is selected for audit, the licensee shall be required to submit documentation showing detailed accounting of the various hours claimed by the licensee. Licensees selected for random audit are required to supplement the attestation with supporting materials which may include a syllabus, agenda, itinerary or brochure published by the sponsor of the activity and a document showing proof of attendance (i.e., certificate, a signed letter from the sponsor attesting to attendance, report of passing test score). The Council shall attempt to verify the hours shown on the documentation provided by the licensee. Upon completion of the review, the Council will determine whether the licensee's hours meet the requirements of these regulations.

12.4.2.1 Any continuing education not meeting all provisions of these regulations shall be rejected in part or in whole by the Council.

12.4.2.2 Any incomplete or inaccurate documentation of continuing education may be rejected in part or in whole by the Council.

12.4.2.3 Any continuing education that is rejected must be replaced by acceptable continuing education within a reasonable period of time established by the Council. This continuing education will not be counted towards the next renewal period.

12.4.3 Council Review and Hearing Process. The Council shall review all documentation requested of any licensee shown on the audit list. If the Council initially determines the licensee has not met the requirements, the licensee shall be notified and a hearing will be held pursuant to the Administrative Procedures Act. This hearing will be conducted to determine if the licensee has met the requirement and if not, if there are any extenuating circumstances justifying the noncompliance with these requirements. Unjustified noncompliance with these regulations shall be considered unprofessional conduct in the practice of midwifery and subject to discipline.

### **13.0 Application for a License**

13.1 Application. An application for a license to practice Midwifery must be completed on a form provided by the Council and returned to the Division of Professional Regulation with the required, non-refundable fee.

13.2 An application for a license to practice midwifery shall be considered completed when the Division has received the following documentation:

13.2.1 Non-refundable application fee;

13.2.2 Completed application for licensure;

13.2.3 Copy of either a high school transcript or diploma, or evidence of completion of a higher level of education;

13.2.4 Credential from either NARM or AMCB;

13.2.5 Verification of Basic Life Support and Neonatal Resuscitation certifications;

13.2.6 Letters of good standing from all other states where the applicant is licensed, if applicable;

13.2.7 Copy of either the applicant's birth certificate, passport, driver's license, or identification card issued by the applicant's state of residence;

13.2.8 Documentation of completion of a course in pharmacology and IV therapy acceptable to the Council:

13.2.8.1 A course in pharmacology acceptable to the Council is offered by a postsecondary educational institution accredited by an accrediting board recognized by the Council for Higher Education

Accreditation of the American Council on Education or is a program or course approved by the Midwifery Education and Accreditation Council ("MEAC"); or;

13.2.8.2 Is, at a minimum, eight clock hours in length and includes basic pharmacotherapeutic principles and administration of medications and includes the following elements:

13.2.8.2.1 Mechanism of Pharmacological Action;

13.2.8.2.2 Indications;

13.2.8.2.3 Therapeutic Effects;

13.2.8.2.4 Side Effects/Adverse Reactions;

13.2.8.2.5 Contraindications;

13.2.8.2.6 Incompatibilities/Drug Interactions;

13.2.8.2.7 Drug administration including:

13.2.8.2.7.1 Dosage;

13.2.8.2.7.2 Dosage Form and Packaging;

13.2.8.2.7.3 Routes of Administration;

13.2.8.2.7.4 Onset of Action;

13.2.8.2.7.5 Peak Effect;

13.2.8.2.7.6 Duration of Action.

13.2.8.2.8 Appropriate injection sites;

13.2.8.2.9 Procedures for drawing up and administering drugs;

13.2.8.2.10 Proper disposal of hazardous and other contaminated materials;

13.2.8.2.11 Administration of medications through injection, which includes:

13.2.8.2.11.1 Universal precautions including the use and disposal of sharps;

13.2.8.2.11.2 Safe injection practices.

13.2.8.2.12 Equipment, including:

13.2.8.2.12.1 Needles;

13.2.8.2.12.2 Filter Needles (for use with glass ampules);

13.2.8.2.12.3 Syringes;

13.2.8.2.12.4 Skin surface disinfectants;

13.2.8.2.12.5 Medication containers (ampules, single use vials);

13.2.8.2.13 Student demonstration of competence in administering medications.

13.2.8.3 A course in IV therapy acceptable to the Council is offered by a post-secondary educational institution accredited by an accrediting board recognized by the Council for Higher Education Accreditation of the American Council on Education, is a program or course approved by the Midwifery Education and Accreditation Council ("MEAC"), or;

13.2.8.4 Is at least at least six clock hours in length and includes basic principles of the administration of medications intravenously and includes the following elements:

13.2.8.4.1 Basic principles of intravenous therapy, including when to initiate and when to discontinue IV therapy;

13.2.8.4.2 Purpose of IV fluid therapy;

13.2.8.4.3 Safe infusion and infection control practices;

13.2.8.4.4 Equipment;

13.2.8.4.5 Appropriate sites;

13.2.8.4.6 Procedure and technique;

13.2.8.4.7 Rate of administration;

13.2.8.4.8 Care of equipment;

13.2.8.4.9 Proper disposal of hazardous and other contaminated materials;

13.2.8.4.10 Student demonstration of competence in the ability to administer IV fluids.

## **14.0 Renewal of Licenses**

14.1 Each license shall be renewed biennially. The failure of the Council/Board to notify a licensee of his/her expiration date and subsequent renewals does not, in any way, relieve the licensee of the requirement to renew his/her certificate.

14.2 Renewal may be effected by completing all of the following:

- 14.2.1 Filing a renewal application online at [www.dpr.delaware.gov](http://www.dpr.delaware.gov);
- 14.2.2 Attesting on the renewal application to completing the continuing education as required by these regulations;
- 14.2.3 Paying fees determined by the Division of Professional Regulation;
- 14.2.4 Attesting on the renewal application to possession of credential from either NARM or AMCB;
- 14.2.5 Attesting on the renewal application that Basic Life Support and Neonatal Resuscitation certifications are current.
- 14.3 Failure of a licensee to renew his/her license shall cause his/her license to expire.
  - 14.3.1 A licensee whose license has expired may renew his/her license within sixty days after the expiration date upon fulfilling the requirements in subsection 14.2 above, certifying that he/she has not practiced midwifery in Delaware while his/her license was expired, and paying the renewal fee and a late fee as determined by the Division of Professional Regulation. All late renewals shall be audited for compliance with CE renewal requirements.
- 14.4 A license may be placed on inactive status at the request of a licensee for no more than five years. An inactive license will convert to expired if it is not reinstated within five years.
  - 14.4.1 An inactive license may be reinstated if the licensee provides all of the following:
    - 14.4.1.1 Payment of the reinstatement fee established by the Division of Professional Regulation;
    - 14.4.1.2 Documentation of thirty hours of continuing education completed within the six months immediately preceding the request for reinstatement;
    - 14.4.1.3 Documentation of current credential from either NARM or AMCB;
    - 14.4.1.4 Documentation of current Basic Life Support and Neonatal Resuscitation certifications.

## **15.0 Community Peer Review**

- 15.1 A midwife must participate in peer review with midwives, physicians, or nurses at least every six months.
- 15.2 A midwife must encourage her midwifery students to participate in peer review.
- 15.3 Peer review must include, at a minimum, a discussion of all of a midwife's transfers and adverse outcomes since the time of the last peer review.

## **16.0 Students**

- 16.1 A midwifery student may only practice under the direct supervision of a licensed midwife.
- 16.2 Direct supervision means that a licensed midwife will be personally present and immediately available within the treatment area to provide aid, direction, and instruction when procedures are being performed. All evaluations, progress notes, or chart entries must be co-signed by a licensed midwife.

## **17.0 Voluntary Treatment Option for Chemically Dependent or Impaired Professionals – The Delaware Professionals' Health Monitoring Program**

- 17.1 If information regarding a suspected chemically dependent or impaired licensee is received by the Council, the Council shall immediately notify the Division of Professional Regulation.
- 17.2 Upon receipt of information concerning a suspected chemically dependent or impaired licensee, the Division of Professional Regulation or its designee shall contact the licensee and inform him or her of the report, provide the licensee information describing the Delaware Professional Health Monitoring Program (DPHMP), and give him or her the opportunity to enter the DPHMP.
- 17.3 In order for the licensee to participate in the DPHMP, he/she shall execute a monitoring agreement.
- 17.4 A regulated professional with chemical dependency or impairment due to addiction to drugs or alcohol may enter into the DPHMP and continue to practice, subject to any limitations on practice imposed by either the DPHMP or the Board following a determination that disciplinable conduct has occurred.
- 17.5 Failure to cooperate fully with the DPHMP, the Division, or any employee of the same, or to comply with their requests for evaluations and screens may disqualify the licensee from the provisions of the DPHMP and there may be activated an immediate investigation and institution of disciplinary proceedings, if appropriate.
- 17.6 The DPHMP may require a licensee to execute a monitoring agreement that includes, but is not limited to, the following provisions:
  - 17.6.1 Evaluation and entry into a treatment program.
  - 17.6.2 Consent of the licensee, in accordance with applicable law, to the release of any treatment information from anyone within the approved treatment program.

- 17.6.3 Agreement by the licensee to be personally responsible for all costs and charges associated with the DPHMP and any associated treatment programs.
- 17.6.4 Agreement by the licensee that failure to satisfactorily progress shall be reported to the Division of Professional Regulation for investigation and the institution of disciplinary proceedings.
- 17.6.6 Compliance with any terms or restrictions placed on professional practice as outlined in the monitoring agreement under the DPHMP.
- 17.7 The licensee's records of participation in the DPHMP will not reflect disciplinary action if the licensee voluntarily entered the Program and shall not be considered public records open to public inspection. However, the Board may consider such records in setting a disciplinary sanction in any future matter in which the regulated professional's chemical dependency or impairment is an issue.
- 17.8 Any licensee who complies with all of the terms and completes the DPHMP shall have his/her confidentiality protected.

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