

November 2006

COLLEGE OF
MIDWIVES
OF ONTARIO



ORDRE DES
SAGES-FEMMES
DE L'ONTARIO

CMO Discussion Paper: Conditions for Safe Practice

Background

The CMO has decided that due to the model of midwifery care that requires members to provide 24-hour on-call availability and continuity of care, it is appropriate to address with members issues of balancing professional obligations to delivery of on-call care with client safety concerns created by a demanding model of care. The College has prepared this discussion paper to assist midwives to develop strategies to support conditions for safe practice. The Council has also approved that “Conditions for Safe Practice” be added to the list of required protocols (see attached “Policy on Practice Protocols, revised Nov 06).

The Ontario model of midwifery care has shown that it is safe and provides high levels of client satisfaction; however, it is physically and emotionally demanding of the practitioners. The success of midwifery in Ontario is certainly due, in part, to the conscientious efforts of midwives to balance their professional obligations to a demanding model of care with their own needs to avoid stress and burn-out. We recognize that providing continuity of care and 24 hour availability is a requirement of the model of care; it is also important to recognize the significance of safe boundaries to the provision of care.

Rationale

It is in the best interests of both clients and midwives that the College is providing this Discussion Paper and adopting a policy requiring midwives to develop a practice protocol. The requirement for a practice protocol provides midwives with flexibility to establish strategies appropriate to their practice’s specific characteristics while ensuring that this issue is given the proper emphasis in the provision of safe midwifery care.

High Reliability Organizations

Over the last decade, there has been increasing discussion and research on the reduction of error, both human and system, in professions and workplaces where there is potential for grave consequences. The profession of midwifery, as it is practiced in Ontario, is one such profession.

Without providing an in-depth analysis of High Reliability Organizations (HRO) theory and all its complexities, a high reliability organization can be broadly defined as one that has fewer than normal accidents despite an inherently "risky" environment. The air traffic control industry was the first to use this type of identification, in an attempt to identify the optimal approach to risk management related to the consequences of human or system error. The recent literature with respect to medical error and risk management indicates that the HRO model is being applied in health care, both at the overall system level, as well as in individual components such as emergency medicine.

Many of the key characteristics of high reliability organizations' structures and practices can be found in the structures and practices of the Ontario midwifery profession. Below is a comparison of the HRO and Ontario Midwifery (OM).

High Reliability Organizations (HRO)	Ontario Midwifery (OM)
<u>Systems, structures and procedures</u> conducive to safety and reliability are in place	On/off call schedules, practice protocols, group practice
<u>Intensive training</u> of personnel and teams takes place during routine operations, drills and simulations.	Continuing competencies such as CPR, NRP, and emergency skills
<u>Safety and reliability</u> are examined <u>prospectively</u> for all the organization's activities, and <u>organizational learning</u> by <u>retrospective analysis</u> of accidents and incidents is aggressively pursued.	Peer review, perinatal morbidity and mortality review
<u>A culture of safety</u> permeates the organization.	The primary purpose of regulating midwifery is the provision of safe care; the primary motivation of regulated midwives is the same.

The College believes it is in keeping with our profession's preventive and proactive approach to risk reduction that midwives be required to consider the best way to foster conditions for safe practice within their own circumstances.

Fatigue and Medical Error

The work situation for midwives in Ontario, such as the extended periods of being awake (>24 hours), extended periods of being on-call, the highly stressful environment, the long hours worked each week (may be >80 hours/wk) as well as the fact that our profession is young (both in experience level of practitioners and integration) makes it very similar to the working conditions for medical residents.

There is a substantial amount of literature on fatigue, medical error and risk reduction strategies in medical residencies, much of this information is applicable to practice issues for midwives. There are now many researchers making arguments for adequate attention to fatigue.

A national survey conducted in 1999 of U.S. medical residents correlated work hours with a variety of measures. Total work hours significantly correlated with perceived levels of stress, total sleep hours, satisfaction with learning, inadequate supervision, working while ill, observations of self and others working in an "impaired condition," and perceptions of humiliation and belittlement. Residents working more than 80 hours a week were more likely to be in a personal accident or injury, a serious conflict with other staff, and make a serious medical error.

Research shows that performance declines after 24 hours of sustained wakefulness to a level roughly equivalent to that of alcohol intoxication with a 0.1% blood alcohol level. It is argued that sleep deprivation, in addition to endangering patient safety, has a negative impact on professionalism, provoking resentment towards patients and the medical system. Working while impaired, while typically construed as alcohol or drug induced impairment, is considered a breach of ethics and professional duty by all health professions. Although the definition of impaired for the purposes of professional regulation has not yet been expanded to include sleep deprivation; it is responsible and prudent to consider the evidence with respect to this issue.

Structures and Practices for Consideration by Midwives

The following strategies, based on the literature with respect to medical error reduction, fatigue and stress, are provided for consideration by midwives and their practices.

- Put structures in place to minimize prolonged work (> 24 hours of clinical duties without sleep) such as group practice call schedules, use of second attendants
- Protect periods designed to address sleep debt (i.e. minimum time period each week free from all clinical responsibilities, required rest following prolonged work days)
- Reduce non-essential tasks during periods of work
- Reduce interruptions during designated rest
- Identify and immediately address co-existent medical issues which impair sleep (i.e. undiagnosed sleep disorder, depression, stress)
- At regular intervals, critically appraise the best way to implement call schedules.
- Consider/develop napping resources, and napping prior to call periods
- Put structures in place to return home safely after a long period of being awake (i.e. get a ride, call a cab, sleep before leaving)

Further Readings

Baldwin DC Jr, Daugherty S, Tsai R, Scotti MJ Jr. **A national survey of residents' self-reported work hours: thinking beyond specialty.** *Acad Med* 2003;78(11):1154-63.

Dawson and Reid **Fatigue, alcohol and performance impairment.** (*Nature* 1997;388(6639):235.)

Hill **Sleep deprivation** *Lancet* 2004;363(9413):996 Landrigan CP, Rothschild JM, Cronin

JW, et al. **Effect of reducing interns' work hours on serious medical errors in intensive care units.** *N Engl J Med* 2004;351(18):1838-48.

Mukherjee S. **A precarious exchange.** *N Engl J Med* 2004;351(18):1822-4.