POLICY STATEMENT:
In accordance with the philosophy of ACNM, nurse-midwifery, as an autonomous profession, bears the responsibility for maintaining and documenting high standards of care among its practitioners. Quality improvement programs that meet the ACNM’s standards must incorporate peer review and documentation mechanisms into their plans for external regulation and should include, but not be limited to, the following: ongoing review of the credentialing process; case review and chart audits; data collection and interpretation; continuing education; development and periodic review of philosophy, mission statements, policies, and practice guidelines; and peer review.

The goal of quality improvement programs is to enable practitioners to continually improve in their role as providers and thus offer quality service.

FUNCTION: Administration of Practice

POINTS OF EMPHASIS:
Practice Guidelines
Evidence-based practice combines the wisdom derived from a variety of credible resources. The overall goal has been to determine, according to current scientific evidence (rather than opinion), which therapies work the best.

*Standards* refer to a defined minimum level of professional performance that unify a profession and delineate the professional behaviors for which the practitioner is accountable; they are usually stable over time because they reflect the philosophic underpinnings of the profession.

*Practice guidelines* are best described as clinical parameters that are agreed upon by the participants in the agency, professional organization, policy group, or practice. For example, written general practice guidelines developed or agreed upon by CNMs and CMs upon entry into practice should speak to the philosophy of care, the purposes or goals of the practice, and the general maternity, gynecologic, and primary care functions and responsibilities of the midwife and consultant physician in a specific practice setting.

*Policies and procedures*, which describe a line or course of action, are included in the practice guidelines document. Policies refer more to administrative practices, while procedures refer more to clinical matters.

*Protocols*, which can be viewed as clinical decision trees or algorithms, may also be a part of the practice guidelines, although they are in need of more frequent update, as clinical knowledge unfolds or changes. Protocols focus on the diagnosis and management of specific clinical situations, such as postdates pregnancy or premature rupture of membranes, where accurate clinical decision-making is critical both in terms of client outcome and cost of care.

Ultimately it must be understood that no guideline or protocol can replace individual clinical judgment. Evidence-based practice requires the integration of individual clinical expertise with the best available external clinical evidence from a systematic review and evaluation of the research. Clinical expertise involves effective and efficient diagnosis and treatment, as well as a thoughtful and compassionate approach to the client/family with respect for individual rights and preferences.

In the United States, individual professional societies and national groups maintain collections of guidelines specific to a particular practice, professional specialty, disease screening, prevention, or management. The ACC and the AHA have joint guideline panels and publish their guidelines in a variety of formats ([www.acc.org/qualityandscience/clinical/statements.htm](http://www.acc.org/qualityandscience/clinical/statements.htm)). The American Cancer Society also convenes multidisciplinary panels to develop cancer-related guidelines and to make the guidelines available on the Internet ([www.cancer.org](http://www.cancer.org)). The U.S. Preventive Services Task Force (USPSTF) provides evidence-based guidelines for disease screening and prevention, including behavioral counseling ([www.ahrq.gov/clinic.uspstattf.htm](http://www.ahrq.gov/clinic.uspstattf.htm)).
PRACTICE GUIDELINE

The National Guideline Clearinghouse was developed in partnership with the American Medical Association and the American Association of Health Plans. The database is updated at least weekly with new content and provides guideline comparison features so that users can explore differences among guidelines, facilitating critical appraisal. A newer feature to the NGC is the guideline synthesis, which enables users to access comprehensive information with the best available evidence to support recommendations. Users can register to receive weekly emails listing the guideline changes on the site. Of the various guidelines collections and databases, the NGC contains the most descriptive information about guidelines. It is also the most selective about the guidelines that are included in its database.

Peer Review
Peer review is the responsibility of an autonomous profession. “The profession that does not oversee itself will find itself policed by others,” (ACNM, 1994). The essence of peer review is the safeguarding of mother and infants through improvement of midwifery practice. Secondary goals include the safeguarding of the autonomy of midwifery practice through the documentation of profession self-surveillance as well as the reduction of potential liability through prospective risk management (ACNM, 1994).

Discipline is not the goal of peer review. Peer review is a prospective method of quality surveillance, designed to document sound practice and identify areas for improvement before consumer safety is compromised. Mentorship, constructive critique, and remediation are the bywords (ACNM, 1994).

Peer review is not an interdisciplinary process, per definition. Meaning only nurse-midwives can conduct a peer review of another Nurse Midwife and/or only a physician reviews a physician and/or a non-Nurse midwife, a non-Nurse Midwife. However, Believe Midwifery Service appreciates the professional knowledge and experience of all providers with the same philosophy of care is invaluable and therefore, encourages an interdisciplinary process.

CNMs are mandated as of 1985 to participate in peer review. This mandate was incorporated into the Standards for the Practice of Nurse Midwifery in 1987. The publication of the Guide to Peer Review in Nurse Midwifery in 1994 provides guidance for initiating the process. Various peer review models have been explored and while challenging to organize and maintain, Believe Midwifery Services, LLC favors the site review model.

PROCEDURE:
Believe Midwifery Services, LLC will:

1. Revise, update and delete documents on a bi-annual basis. These include administrative documents, both legal and ACNM documents, in addition to documents for charting healthcare, informed consents and hand-outs for client education.
2. Review the philosophy, mission and vision statements to assure their reflection on the practice is current and in relation to the profession as a whole.
   a. The philosophy statement should communicate the particular values, beliefs, and goals of the CNMs in the practice.
   b. The mission statement should convey the purpose of the practice –why it exists.
   c. The vision statement should declare the goals of the practice, including a projection of what the practice will look like in five years. Details such as the desired number of clients and CNMs/RNs, the developing role in the community, planned activities or public education goals, location of office, etc. should be discussed.
   d. The philosophy might be directed specifically at the client, while the mission and vision might be more directly focused on the administrative purposes and goals of the practice.
3. Documents describing general CNM practice should be made available to interested parties. However, the clinical practice guidelines should ordinarily be available only to the CNM and collaborating physicians.
4. A public relations package on nurse-midwifery should be developed, revised, and up-dated on a bi-annual basis. This package is a subset of the essential documents for practice. It should include the following:
   a. Mission statement
   b. Vision statement
   c. Quality improvement statements
   d. Consultation and transfer arrangements
5. Licensure and certification of all employed and contracted personnel must remain at 100% compliance. Documentation will remain on file within the office of Believe Midwifery Services, LLC.

6. Practice statistics/clinical indicators will be reviewed and up-dated annually.

7. Chart audits should be conducted monthly by each Believe Midwifery Service, LLC midwife. Support staff should submit a minimum of one complete chart audit each quarter. A coordinator for chart audits should be appointed to maintain accountability and for compiling information for recommendations and outcome assessment.

8. Peer review is a professional responsibility.
   a. Each sentinel event and each critical indicator exceeding 10% shall meet with review on an annual basis.

9. State Statute
   a. The CNM shall complete all required birth registration information with appropriate prenatal data in accordance with Indiana law for Vital Statistics Reporting to the Indiana Department of Health. This includes newborn screening and referral for hearing screening.

Evidence alone is never sufficient to make clinical decisions. one must weigh the evidence in context, always accounting for the values and preferences of patients, with the goal to achieve optimal shared decision making.

SELECTED GUIDELINE DATABASES:
NGC: www.guideline.gov
Primary Care Clinical Practice Guidelines: http://medicine.ucsf.edu/education/resed/ebm/practice_guidelines.html
RNAlO: www.rnao.org
CMA Infobase: http://mdm.ca/cpgsnew/cpgs/index.asp
Guidelines Advisory Committee (GAC): http://www.gacguidelines.ca
SIGN: http://www.sign.ac.uk/guidelines/index.html
NICE: www.nice.org.uk
NZGG: www.nzgg.org.nz

American College of Physicians: www.acponline.org/clinical_information/guidelines
American Cancer Society: www.cancer.org/docroot/home/index.asp
American College of Cardiology: www.acc.org/qualityandscience/clinical/statements.htm
American Association of Clinical Endocrinologists: www.aace.com/pub/guidelines/
American Association of Respiratory Care: http://www.aarc.org/resources
American Academy of Pediatrics: http://aappolicy.aappublications.org
American Psychiatric Association: www.psych.org/psych_pract/treatg/pg/prac-guide.cfm
Ministry of Health Services, British Columbia, Canada: www.gov.bc.ca/health/
Veterans Administration: www.va.gov/health/index.asp
American Medical Directors Association: www.amda.com
Association of Women’s Health, Obstetric, and Neonatal Nurses: http://awhonn.org
National Association of Neonatal Nurses: http://www.nann.org
Oncology Nursing Society: http://www.ons.org
University of Iowa Gerontological Nursing Interventions Research Center: www.nursing.uiowa.edu/excellence/nursing_interventions

REFERENCES:


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<td>Penny Lane MSN, CNM, IBCLC</td>
<td>10/27/2013</td>
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<tr>
<td>January Gilley</td>
<td>9/1/2011</td>
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<tr>
<td>Holly Hopkins MSN, CNM</td>
<td>9/1/2011</td>
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<tr>
<td>Michelle Burton</td>
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