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PRACTICE STANDARD

Midwives: Practice Protocols

Introduction

A practice protocol is a written plan that explains how client care is coordinated. It describes how the practice manages specific areas of care during pregnancy, birth, and postpartum. Protocols can be community specific and adopt guidance from evidence-based sources. They promote transparency, informed choice for clients, and consistency among midwives sharing care. Protocols must align with the Regulation, BCCNM bylaws, and BCCNM standards, and should be based on current evidence.

Standards

1. Each practice is required to have the following written protocols:
    a. A protocol describing how care of clients and their newborns is coordinated in the practice. This practice protocol must include:
        i. a way for current information on each client to be communicated to the on-call midwife;
        ii. regular review of each client's chart to ensure that an appropriate schedule of visits is maintained and clinical concerns are followed up in a timely manner; and
        iii. a process for evaluating the system's effectiveness.
    b. Clear protocols around the use of social media in midwifery practice, and the use of email, fax and text message with regard to communication with clients and the sharing of client information.
    c. A protocol for outlining responsibility for confidential and secure record storage and retention. Records must be accessible to all midwives who were involved with the provision of care. This practice protocol must include:
        i. where and how original client records or unalterable copies of those records are securely stored;
        ii. how the midwife or the client can access or obtain a copy of those records;
        iii. how original records and/or copies will be made available to all midwives who provided care to the clients in the event of a midwife leaving the practice or the practice closing;
        iv. in the event a midwife ceases to practice or resigns from practice, how records will be stored, shared and retained for the duration of the legal retention period;
        v. an outline of any fee charging process.

2. Protocols should be accessible to all practice members, including locums, and to clients upon request, reviewed regularly to ensure currency, and revised as necessary using available evidence, relevant community standards and client feedback.
3. Practices should maintain a written record of the protocols that are or have been followed by the practice for at least the previous five years. Any of the following systems is acceptable:
    a. A record of protocols that includes the date that each protocol came into effect within the practice, or
    b. A list of protocols, along with the dates that they were in effect within the practice, and an indication of where the protocol is located.
4. Practice protocols should be reviewed at least every three years to ensure compliance with best practices.

Revision history

Version #	Approved by board	Bylaw in-force	Description
1.0	March 1, 2026	April 1, 2026	Initial publication

Effective April 1, 2026, this practice standard, and any amendments to it, is made a bylaw under the authority of the *Health Professions and Occupations Act, B.C.*

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