

Canadian Midwifery Registration Examination

Technical Report 2008

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Introduction

Each province and territory is responsible for ensuring that all applicants for registration as midwives meet an acceptable level of competence before they begin to practise in Canada. This level of competence is measured, in part, by the Canadian Midwifery Registration Examination (CMRE).

The CMRE is a national written examination designed to assess internationally educated and Canadian-educated applicants for midwifery registration to ensure that they meet entry-level competency standards set out in the Canadian Competencies for Midwives. Its goal is to ensure that midwives gaining registration are competent and safe practitioners providing a consistent standard of care across Canada.

The examination consists of between 210-230 multiple-choice questions. The majority of questions on the exam are case-based. Exam questions come from the CMRE exam databank according to the CMRE Blueprint (Appendix A). The exam content is based on the Canadian Competencies for Midwives (Appendix B). In order to represent the range of care a Canadian midwife is expected to provide, slightly more than half of the questions are set in an out-of-hospital setting with the remainder in a hospital setting. Slightly more than half of the questions represent normal midwifery situations and the remainder, abnormal situations.

This technical report begins with an overview of the history of the examination development, then covers the construction and administration of the May and September 2008 administrations.

History of the Examination Development

In 2003, the Canadian Midwifery Regulators Consortium launched the HRSDC funded National Midwifery Assessment Strategy (NAS) project, an initiative designed to determine the best strategy for assessing the skills and abilities of internationally-educated midwives applying for registration in Canada. NAS research involved consultation with a wide variety of stakeholders. One of its results was a clear directive to create a national registration exam to ensure a consistent evaluation of midwives' competence to practise in Canada. Initial development of the examination took place in 2005 and 2006. The participants involved in the exam development are provided in Appendix C. It was led by the exam committee (formerly known as the NAS project steering committee) with support and guidance from the NAS project coordinator and Assessment Strategies Inc. More than 45 content experts (mostly practicing midwives) participated directly in the development activities outlined below in this report. This represents approximately 8% of the registered midwives in Canada.

The examination was first offered to internationally-educated applicants in some provinces in May and September 2006. In 2007, the exam was again offered internationally-educated candidates in May and September. The 2007 administrations took place in three provinces: British Columbia, Alberta and Manitoba. The CMRE is now required for Midwifery registration in Canada for Canadian graduates and internationally-educated applicants in all jurisdictions where legislation permits.

Canadian Competencies for Midwives

Standards dictate that a credentialing examination must be based on clearly defined competencies that fit the purpose of the exam. In keeping with this, the exam committee started exam development in 2004 with the creation of a document that details the knowledge and skills expected of an entry-level midwife in Canada.

The first step in this process was a comparative analysis of provincial competency documents resulting in a spreadsheet providing a detailed comparison competency-by-competency. The first draft of the Canadian Competencies for Midwives document was then created based on common competencies. A 12- person working committee

composed of CMRC representatives and midwifery educators from 6 jurisdictions reviewed these documents extensively at an all-day in-person meeting in Calgary, Alberta. While the group functioned mainly in English, whisper interpretation was available and the French translation was reviewed as well. Extensive revisions were made to both English and French versions based on feedback from the meeting and this revised draft was circulated to the working group for confirmation. Feedback was then solicited from the CMRC representatives and from board/council members of each midwifery regulator. After several more drafts, the final document was approved in May 2005.

In carrying out this work, it became clear that there was a high degree of commonality in midwifery practice across Canada. In fact, the group identified only a short list of competencies required in only one or some of the provinces. This list became known as “advanced competencies” since they were specialized to specific regions. It was confirmed that the basic model of midwifery practice is the same across Canada, thus the approved Canadian Competencies for Midwives includes a brief description of the Canadian model of midwifery practice as well as the detailed list of competencies required for safe practice.

CMRE Blueprint

It is critical that a credentialing exam be standardized in format and content. Assessment Strategies Inc. (ASI), a high stakes exam development consulting firm, was contracted to coordinate the initial exam development, including the development of the CMRE Blueprint. A written survey sent to exam committee members enabled ASI to identify the relative importance of each competency so that the blueprint could define the number of questions on each competency. Several teleconferences with the exam committee were held to discuss and refine survey results and to make decisions regarding the exam structure (e.g. item type, length of exam), contextual issues (e.g. the fact that both hospital and out-of-hospital settings should be included), and standards to be used (e.g. metric measurement). The resulting exam blueprint approved in June 2005 provides a detailed description of the CMRE.

Item Writing

In order to create as many items (questions along with a correct response and distracters) as possible for the CMRE, regulators and educators were asked if they would contribute questions from provincial examinations that the CMRE would be replacing. The CMBC, the CMO, and the Alberta MHDC contributed their PLEA written examinations to the process. Assessment Strategies Inc coordinated and facilitated the process of revising and creating items in two item-writing workshops. The first step was to map all the items from previous exams to the competencies; this was accomplished by an experienced midwife who received training and direction from ASI. Next, item-writing workshops were organized. Research indicates that for a truly bilingual exam, it is best to create items in both languages, rather than creating items all in one language and then translating them. Thus one workshop took place in English and one in French. Participants were selected by provincial regulators based on the following criteria: amount and type of experience practising in Canada, knowledge of provincial standards, past experience writing or marking exams, and ability to work well as part of a team. Item writing teams included participants from as many jurisdictions as possible and ensured a balance of experience and perspectives.

The initial English-language workshop took place in August 2005 in Ottawa, Ontario and involved five experienced, practising midwives from four jurisdictions. This five-day workshop commenced with training by ASI staff on the process of item writing as well as pointers on how to create good exam items. Participants began by revising the “old” questions, ensuring that each question was up-to-date, relevant in all jurisdictions, accurate, followed CMRE standards, and was referenced to two appropriate reference sources (e.g. midwifery textbook). The last few days of this workshop consisted of writing new items. Participants wrote and revised items independently and then reviewed each one as a full group to further refine it. The workshop resulted in 128 potential items for the CMRE.

The initial French-language workshop took place in October 2005 in Laval, Quebec and involved five midwives from two jurisdictions. This three day workshop was facilitated by ASI and it focused on the creation of new items. The workshop commenced with training and then involved independent item-writing and group review of each item. It was challenging to find appropriate reference texts in French so participants were asked to use at least one French and one English reference (unless two French references were readily available). As in the English

workshop, items had to be reflective of current practice across Canada and adhere to standards laid out in the CMRE blueprint and by the ASI facilitator. Forty-seven items were developed in this workshop.

In February 2007, two in-person workshops were held for the purpose of creating new exam items for the CMRE. One workshop was held in English and one in French. Both were two full-days in length. Six practicing midwives participated in each workshop. The participants represented a diverse group:

- From across Canada (3 BC, 1 AB, 2MB, 1 ON, and 5 from QC);
- Educated via direct entry, apprenticeship, and post-nursing programs;
- Educated in Canada, France, Switzerland, Tunisia, Belgium, UK, and USA;
- Registered via PLEA, graduation from approved Canadian program, or via initial registration processes;
- Very experienced practitioners and relatively new practitioners.

The (Anglophone) NAS Project Coordinator facilitated the English session. In order to ensure there were no language issues at the French session, the Quebec member of the Exam Committee was brought on as a co-facilitator.

Pilot

Due to the small numbers of potential participants in the exam pilot, ASI recommended a qualitative, rather than quantitative, pilot of the exam. In addition to being more valid than interpreting statistics from a pilot with small numbers of participants, it allowed for detailed feedback to be received on each item. A posting was circulated to registered midwives in all regulated jurisdictions for twenty volunteers to take part in the pilot for a small honorarium. More than twenty expressions of interest were received. The committee selected twenty applicants that together ensured a balance of types of midwifery experience (e.g. rural/remote, urban), education (e.g. internationally-educated, Canadian educated), length of time working as a midwife, and first language. As well, the committee ensured there were as many participants with backgrounds in exam development/marking as possible and that each regulated jurisdiction was well represented.

Eighteen participants took part in the exam pilot in November 2005 in Halifax, Nova Scotia. The pilot took place in English and all items that had been created in French were translated by ASI's professional translation team into English in preparation for this pilot. The pilot was organized by ASI and facilitated by the NAS Project Coordinator. There were two sittings of four hours each.

Each participant reviewed half of the more than 250 items that were available to the CMRE. Participants were asked to answer each item without reference to the answer key, and then to review the answer key and provide written feedback on each item regarding its clarity, currency, and accuracy. Participants were asked to pay special attention to ensuring the item represented current practice in their community and province or territory. Following the pilot, the written feedback was incorporated into the LXR-Test exam databank by ASI staff in preparation for the validation meeting.

Validation

A four-day in-person exam committee meeting was held in English in November 2005 to review the feedback from the exam pilot and to confirm the exam items. This "validation meeting" was facilitated by an ASI staff member and it involved reviewing each item and revising them as appropriate.

A 10-hour session was held in March 2007 for the purpose of validating newly created examination questions (early 2007) for the CMRE. The process was planned and facilitated by the project coordinator. The validation took place via web-conferencing. The validation process involved committee members ensuring that each of the new questions was appropriate for all Canadian jurisdictions, that it was relevant to the competency selected, and that it read clearly. Five exam committee members took part, representing British Columbia, Alberta, Manitoba, Ontario and Quebec. Three were practicing midwives and all were involved in the regulation of midwifery. Each item was reviewed and discussed. Revisions were made, as required, to the items and to references. In a few cases, items were flagged for more extensive revisions at a later date.

Translation

ASI's professional translation team translated the 2005 items into French. In order to ensure that the midwifery language used in the translation is correct, a team of two bilingual midwives then reviewed each item in detail in a three day in-person meeting in Ottawa, Ontario. This session was organized and facilitated by ASI staff and translators.

In March 2007, all exam items originally written in French were translated professionally into English for the validation and standard setting processes. Following these sessions, all final items were translated into French. All translators were professionally certified and experienced.

A one-day session was held in April 2007 for the purpose of reviewing the final translation. Two bilingual midwives previewed the translations in detail and then participated in a translation verification meeting with the translator and a facilitator. This team of four reviewed each question in turn to ensure that the meaning of each question is the same in both languages. Additionally translations were obtained of the various documents and materials needed for each stage of the item writing process.

Cut-Score Setting

It is critical that the pass score set for a credentialing exam be done through careful analysis to determine the level of skills and knowledge needed for safe, entry-level practice. In order to accomplish this, a standard setting procedure was used to determine an administration specific cut-score (pass score). The initial process was organized and facilitated by the NAS project coordinator. Based on a recommendation from ASI and further research, the Angoff method was used.

In 2005, six participants from four jurisdictions participated in a four-day workshop held in Winnipeg, Manitoba. Due to funding limitations participants included exam committee members from four jurisdictions (who were meeting for other reasons as well) plus two local, experienced midwives. Participants reviewed each exam item to estimate the probability that an entry-level candidate would get it correct. Several "rounds" ensured that the group considered all aspects (e.g. how often the competency is used, type of language used in the items, quality of distracters, etc.). A provisional cut-score resulted from this workshop. The group also confirmed that cut-scores for the CMRE will range from 70-80%. A follow-up teleconference with

the exam committee was held to review item statistics following the first offering of the exam and revisions were made as appropriate.

The Angoff method was used again in March 2007. The process was planned and facilitated by project coordinator Wendy Martin. A 6-hour session was held to identifying a standard score for each new item in the bank. This ensured the ability to set an appropriate cut-score for new exam forms. Five exam committee members took part. Panelists were all educated as midwives and had experience working as a midwife in Canada. They came from five different jurisdictions in Canada, including both English and French language areas. Four were actively practising; the remaining two were actively involved in Canadian midwifery although not currently practising. All new items were successfully reviewed and assigned an Angoff score.

Policies & Procedures

The NAS Project Coordinator engaged in research to determine the policies and procedures that would best protect the security of the exam, ensure the effectiveness of the exam, and be most fair to exam candidates. Based on this research, the Coordinator drafted policies, procedures, manuals, and forms for review by exam committee members and other relevant stakeholders. This process resulted in the following documents available in both English and French that outline approved policies and procedures:

- Candidate information sheets posted to the website (also available by PDF to candidates).
- Proctor Manual, and associated forms.
- Marker Manual, and associated form (not required for the September 2007 administration).

Examination Committee

The Exam Committee was launched initially as the NAS Steering Committee. It includes representatives of midwifery regulators in the five jurisdictions that assess applicants for registration directly. (The Northwest Territories accepts registrants who have been assessed in the other Canadian regulated jurisdictions). Committee members were appointed by their provincial regulatory authority and they have worked closely together since 2003. The committee reports to the larger CMRC where all major decisions are made, sometimes after explicit consultation with boards and councils of each regulatory authority. The committee provides guidance to the Exam Manager and is the decision-making authority. The current examination committee members are listed in Appendix D. The committee currently operates under the Exam Committee Terms of Reference (Appendix E) for the purpose of overseeing the CMRE.

Confidentiality and Security

The examination and all associated materials are protected by copyright law. Stringent measures were in place throughout examination development to protect the examination before, during, and after the administration. All those with access to exam materials (e.g. item writers, pilot participants, and others) were required to sign affidavits of non-disclosure. Exam materials were kept locked and/or password protected at all times when not in use. Additional security measures were used during the administration and marking of the exam in order to ensure its protection.

Examination Standards

The CMRE development was guided by research into exam standards and the resulting exam adheres as much as is feasible to generally accepted examination standards. These standards can be found in resources such as Standards for educational and psychological testing; Development, Administration, Scoring, and Reporting of Credentialing Examinations; and Principles of Fairness: An Examination Guide for Credentialing Boards. Specific references used in the exam development and as Midwifery content resources are provided in the reference section of this document.

The Canadian Midwifery Registration Examination 2008

Examination forms, based on the CMRE blueprint, are changed each year in order to maintain the security of the examination items. Comparability of these examination forms across administration is essential for fairness. In other words, no version of the CMRE administered at a particular sitting should be harder than a different version administered at a different sitting. Adherence to the examination blueprint ensures, as much as is reasonably possible, that the examination forms tap the same construct (midwifery proficiency) in the same way (across specified competencies of a specified weight and across specified conditions within specific proportions). Construction of these examination forms requires that the CMRE item bank be continually refreshed. The construction and administration of the May and September 2008 forms is outlined here.

Form Construction

In order to build up the CMRE item bank while the total number of candidates writing the CMRE is still relatively small, and in consideration of financial realities the CMRE committee decided to make minimal changes from the September 2007 sitting to the May 2008 sitting. The item order and presentation of the multiple choice options from the September 2007 sitting were both randomly scrambled to create the May 2008 form of the CMRE.

After the May 2008 sitting, 72 previously used items were pulled from the item bank and donated to the developing Bridging project for the construction of an on-line practice examination (Pre-Exam Self Assessment; PESA). In return, the Bridging project, using the procedure identical to the CMRE item writing procedure (outlined in History) and the CMRE competency descriptions to create new items for the CMRE item bank.

A new examination form was constructed for the September 2008 sitting of the CMRE. The September 2008 CMRE was created using 33.8% of the items that were either a) previously unused items in the CMRE data bank or b) items that were newly generated through PESA item writing. The remaining 66.2% of the items appeared in the September 2007 and May 2008 assessments. These crossover items may be used as linking items for the purpose of establishing comparability.

Comparability is an essential component of validity. It is important to maintain items from previous assessments in order to do the necessary linking of the assessment forms for the purpose of comparability of examination forms. Items that are common to examination forms may be used as anchor items for linking (placing different forms of an assessment on the same scale). To further bolster comparability of scores across administrations, the examination format remained constant across all forms of the CMRE from September 2007 through to September 2008. Each form of the examination contained 216 items broken into two parts of 108 items each. Case studies were followed by independent questions in each part. By establishing comparability of scores in these ways, the Midwifery Consortium may track exam results over time, calculate accurate statistics, combine scores across time and monitor changes.

Administration

A total of 30 candidates wrote the CMRE in 2008. In May 2008, 20 candidates sat the CMRE in British Columbia and Alberta. In September the CMRE was administered to 10 candidates at sites in Alberta, Saskatchewan and Manitoba. This was the first time that Saskatchewan took part in the CMRE.

Both internationally-educated midwives taking part in provincial PLEA processes and candidates from approved Canadian Midwifery education programs were represented. The exam was administered in a paper-based format. In total, 28 of the 30 candidates who took the CMRE in 2008 were within the passing range.

The 2008 administrations were managed by the CMRE Examination Manager. Given a set of site requirements and guidelines, provincial registrars arranged for the examination sites. Proctors were also engaged at the local level. The Exam manager vetted the recommended proctors. In order to ensure consistency (and comparability) across site locations the proctors adhered to a set of written protocols and used a proctor script to provide directions to the candidates. The Examination Manager held a telephone instruction session with each of the proctors.

Scoring

All candidate responses were subject to automated scoring using a LXR-Test software compatible Optical Mark Reader Scanner. In May, 5 of the 25 response forms were also randomly selected for hand re-scoring in order to check the accuracy of the automated scoring. The hand re-scored results matched the results generated through automated scoring 100%. Automated scoring was again used for the September 2008 administration. In September, 3 of the 10 candidate response forms were checked via hand scoring. The match to the automated scores was 100%. A request for re-scoring led to 2 additional response forms being re-scored (all assessments that received a Fail mark were re-scored). The hand re-scoring of these 2 additional response forms confirmed the automated scoring results.

Data Analysis

Descriptive statistics based on results from the May and September 2008 sittings were generated from the LXR-Test software. Descriptive exam statistics generated included: high and low scores, mean score, number of candidates passing and failing the entire exam and each major competency, standard deviation, and a summary of candidate response patterns. The internal consistency of the exam (reliability) was calculated with SPSS. Exploratory analyses included the identification of outlier scores and a distracter analysis, conducted for the purpose of identifying aberrant response patterns.

After each sitting, the candidates are asked to provide feedback on their examination experience and to comment on specific items on the exam. Candidate comments are summarized and discussed by the examination committee. Items identified as potentially aberrant are checked. If any question remains as to the adequacy or accuracy of any candidate identified item, the item is reviewed by the examination committee and may be adapted or removed from analysis (and scoring).

Reporting

Secure examination committee web/teleconferences were held to review CMRE candidate scores, statistics, candidate feedback, and aberrant items along with construction and administration procedures on June 10 for the May sitting and on October 6 for the September sitting. There were 4 items were flagged for review from the May form. The distracters on one of the items were ordered incorrectly. However, the incorrect ordering of the distracters did not affect examinee responses. Most candidates made a written note of the error and selected the corrected response. The error was of such a nature that it could not have inadvertently led the candidates to select an incorrect response. As such, the scores were retained. The item was pulled from the data bank for correction. The remainder of the flagged items were assessed by the examination committee and found to be functioning as designed. Candidate comments and a distracter analysis on the September form of the CMRE led to 8 items being flagged for review. Although suggestions were made for minor changes to items, none of the items were concerning enough to be removed from the item bank, nor from the exam itself. One item that was flagged on the May 08 form of the CMRE was flagged again on the September form. This item was discussed by the examination committee. The item was found to be functioning as designed and the Angoff score was found to accurately represent the probability of a correct response given the currently available data.

CMRE results were reported to provincial regulators and all correspondence with candidates was via their provincial regulator. Regulators received information regarding their candidates' pass/fail status and general weak areas, as well as summary comparisons with other candidates at this sitting (without candidate names). Candidates received reports with their pass/fail status, and with general feedback of strong and weak areas vis-à-vis the competency categories (ex. intrapartum, newborn, etc.). Analyses were conducted on scores collected from September 2007 through to September 2008 (3 sittings) for the purpose of informing future examination construction decisions and providing valuable information to education programs as more data is collected over the years. Due to the low number of candidates who contributed to the existing data set results may not be generalized and are not being released at this time.

Examination Development Resources

(Compiled and presented by Wendy Martin and Dena Morgan)

Below is a list of the key reference materials consulted by the NAS project coordinator and/or the exam committee during the development of the CMRE. Additional materials were used by Assessment Strategies Inc, the consulting firm that was contracted to guide the development of this exam.

Bugbee Jr., Alan, Anne H. Browning, Meredith Mullins (Editors). *Certification: A NOCA Handbook*. National Organisation for Competency Assurance, 1996.

Bunch, Michael, Gregory Cizek, and Heather Koons "Setting Performance Standards: Contemporary Methods". An NMCE Instructional Module, Winter 2004. Madison, USA: National Conference on Measurement for Education, 2004.

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Newman, Larry S., Ning Wang and Randall F. Wisler. *Setting Passing Standards for Performance-Based Certification and Licensure Examinations*. Washington, DC: National Association for Competency Assurance, © 2000.

Perie, Marianne and Michael Zieky. *A Primer on Setting Cutscores on Tests of Educational Achievement*. USA: Educational Testing Service, 2006.

Perrie, Marianne, Mary Pitoniak and Michael Zieky. "Setting Cutscores", Powerpoint presentation slides. National Conference on Measurement for Education, 2006.

Midwifery Resources

(Compiled and presented by Wendy Martin and Dena Morgan)

Item writers used the following reference materials as key resources when creating and revising questions. These texts were also consulted by the exam committee when validating questions.

Alberta Midwifery Health Disciplines Committee. *Registrants Handbook*. MHDC, 2005.

Association of Ontario Midwives. *Emergency Skills Workbook*. AOM, 2004.

Bickley, Lynn S. *Bates' Guide to Physical Examination & History Taking* (8th Edition), Lippincott, Williams and Wilkens Publishers, 2002.

Canadian Pharmacists Association. *Compendium of Pharmaceutical and Specialties: The Canadian Drug Reference for Health Professionals*. Canadian Pharmacists, 2005. Association

College of Midwives of British Columbia. *Registrant's Handbook*. CMBC, 2005.

College of Midwives of Manitoba. *Registrants Handbook*. CMM, 2005.

College of Midwives of Ontario. *Registrants Handbook*. CMO, 2005.

Cunningham, F. et al. *Williams Obstetrics* (22nd Edition). McGraw-Hill Professional Publishers, 2005.

Enkin, M., Keirse, M., Neilson, J., Crowther, C., Duley, L., Hodnett, E., Hofmeyr, J. *A Guide to Effective Care in Pregnancy and Childbirth* (3rd Edition). Oxford University Press, 2000.

Fraser, Diane M., Cooper, Margaret A., eds. *Myles Textbook for Midwives* (14th Edition). Churchill Livingstone Publishers, 2003.

Francoval, C., Bouillie, J., & Huraux-Rendu, C. *Pédiatrie en maternité* (3ième édition). Paris: Flammarion Médecine-Sciences, 1999.

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Sawchuk, Diane et al., eds. *Fetal Health Surveillance in Labour* (3rd Edition). BCRCP, 2002.

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Society of Obstetricians and Gynaecologists of Canada. *SOGC Clinical Practice Guidelines*. SOGC, 2005.

Tappero, E.P., Honeyfield, M.E. *Physical Assessment of the Newborn* (3rd Edition). NICUInk Publishers, 2003.

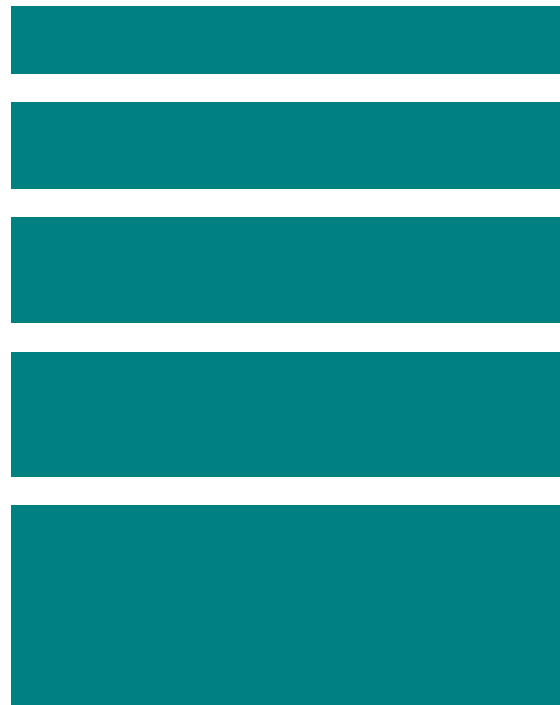
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Tucker, Blackburn S. *Maternal, Fetal, & Neonatal Physiology: A Clinical Perspective*. Saunders Publishing, 2003.

Varney, Helen, Kriebs, Jan M., Gegor, Carolyn L. *Varney's Midwifery* (4th Edition). Jones & Bartlett Publishers, 2004.

APPENDIX A
BLUEPRINT FOR CANADIAN MIDWIFERY REGISTRATION EXAM

BLUEPRINT FOR THE CANADIAN MIDWIFERY REGISTRATION EXAMINATION



A National Assessment of the Entry-Level
Competencies for Canadian Midwives

CANADIAN MIDWIFERY REGISTRATION EXAMINATION BLUEPRINT

INTRODUCTION

Each province and territory is responsible for ensuring that graduates of midwifery programs in Canada, and midwives educated in other countries, applying for registration as a midwife meet an acceptable level of competence before they begin to practise in Canada. This level of competence is measured, in part, by the *Canadian Midwifery Registration Examination (CMRE)*. The CMRE was developed in 2005-06 by the Canadian Midwifery Regulators Consortium, the network of midwifery regulatory authorities in Canada, in conjunction with its examination consultants, Assessment Strategies Inc. Assessment Strategies Inc. provided professional testing services and consultation in the development of the CMRE.. It is anticipated that the development and revision of the CMRE will be an ongoing process, to ensure the continual validity of the examination and to reflect what is expected of an entry-level midwife beginning to practise.

CANADIAN COMPETENCIES FOR MIDWIVES

The CMRE is based on the *Canadian Competencies for Midwives*, a description of entry-level practice that was developed in 2004. This document outlines the knowledge, skills, and professionalism that Canadian midwives are expected to have at an entry-to-practice level, and it provided the basis upon which the CMRE was built.

The *Canadian Competencies for Midwives* was developed via a process that involved a detailed analysis of competency statements from each regulated jurisdiction in Canada; an in-person intensive workshop involving regulators and educators, many of whom were practising midwives, from all regulated jurisdictions; and electronic collaboration and consultation amongst workshop participants and all boards/councils of regulatory authorities. The document is expected to be reviewed regularly to ensure it remains accurate and up-to-date.

EXAM BLUEPRINT

While the Canadian Competencies for Midwives document outlines the competencies that must be assessed, the exam blueprinting process defines how many questions should address each competency, and identifies structural (e.g. length of exam, type of questions) and contextual issues (e.g. the fact that both hospital and out-of-hospital settings should be included). This process was undertaken by the Canadian Midwifery Regulators Consortium's Examination Committee, made up of representatives from each regulated jurisdiction. Assessment Strategies Inc. provided psychometric expertise and guidance to this process.

The resulting exam blueprint provides a detailed description of the CMRE. The details are below.

COMPETENCY WEIGHTING

Competency Groups:

To ensure that the examination accurately reflects the profile of *entry-level* midwifery practice, the competencies are grouped according to their relative importance based on the survey ratings and qualitative review of the Canadian Midwifery Registration Examination (CMRE) Committee.

Competencies were divided into four groups:

1. Group 1 competencies comprising 10-15% of the exam are the least important;
2. Group 2 competencies comprising 70-75% of the exam are of average importance;
3. Group 3 competencies comprising 10-15% are most important; and
4. Group 4 competencies representing 5-10% of the CMRE are both broad and important and require one question per phase in the childbearing year (antepartum, intrapartum, postpartum, and newborn).

Competency Sampling:

Based on the data from the survey and the CMRE Examination Committee guidelines, the sampling scheme presented in Table 1 was developed. The distribution of the weights in this sampling scheme was selected (1) to provide differentiation on the importance ratings, and (2) to

conform with the examination length requirement of 210-230 questions (a maximum of one exam day).

At the beginning of the Blueprinting process, there were 187 midwifery competencies identified by the CMRC. Based on the process, 140 of the 187 competencies were established to be appropriate for testing on the CMRE. The 140 competencies represent entry-level competencies related to safe and effective practice that are common across the Canadian jurisdictions and that can be measured effectively on a multiple-choice and short-answer examination.

The competency grouping and sampling is presented in Table 1. For example, in Group 2, there are 97 competencies. Each of these competencies will be assessed approximately twice, and they represent 70-75% of the questions on the CMRE.

Table 1. Competency Groupings and Sampling

Grouping	Number of Competencies	Approx. Number of Questions per Competency	Percentage of Questions on the CMRE
1	30	1	10-15%
2	97	2	70-75%
3	9	3	10-15%
4	4	4	5-10 %
TOTAL	140		100%

Competency Framework: The framework identifies and organizes the competencies measured by the CMRE. Each of the framework categories contains a different number of competencies that vary in importance. Table 2 presents a list of the competency categories, the number of competencies in each category that are assessed on the examination (the percentage of competencies are found in brackets), as well as the percentage of questions found on the examination for each category. For example, in the Antepartum Category, 24 competencies are assessed, which represents 17.1% of the 140 competencies sampled on the blueprint. Furthermore, the Antepartum Category will represent 25-30% of the questions on the CMRE (i.e., 55-65 questions).

Table 2. Competency Framework

Competency Categories	Competencies Assessed on the CMRE	Percentage of Questions on the CMRE
I. General Competencies	12 (8.6%)	5-10%
II. Education and Counseling	15 (10.7%)	5-10%
III. Antepartum	24 (17.1%)	25-30%
IV. Intrapartum: Care During Labour, Birth, and the Immediate Postpartum Period	38 (27.1%)	25-30%
V. Care of the Woman during the Postpartum Period, Including Breastfeeding	21 (15.0%)	10-15%
VI. Care of the Newborn and Young Infant	18 (12.9%)	10-15%
VII. Well Woman Care, Sexuality and Gynecology	8 (5.7%)	1-5%
VIII. Professional, Inter-Professional, Legal and Other Aspects of the Profession	2 (1.4%)	1-3%
IX. Professional Development	2 (1.4%)	1-3%
X. Advanced Competencies	0 (0%)	0%
TOTAL	140 (100%)	100%

GUIDELINES FOR EXAM FORMAT

Structural Variables: Structural variables include those characteristics that determine the appearance and general design of the examination. They define the length of the examination, the format, and presentation of the examination questions.

1. **Examination Length:** The examination will consist of between 210-230 multiple choice questions.
2. **Question Presentation and Format:** The multiple-choice questions are presented as either case-based scenarios or as independent questions.

The case-based format consists of a set of approximately two to five questions that are associated with a brief midwifery scenario. Independent questions are stand-alone questions that contain all the necessary information without reference to a case. For the 210-230 questions of the CMRE, 65-75% are case-based questions and 25-35% are independent questions.

Contextual Variables: Contextual variables qualify the content domain by specifying the midwifery contexts in which the examination questions will be set.

1. **Health Care Setting:** The CMRE is designed to include questions representing the variety of settings encountered when providing midwifery care in Canada. Thus, for the purpose of the CMRE, the setting is defined as either in Hospital or Out-of-Hospital. Table 3 presents the percentage ranges that serve as the guidelines for the CMRE development.

Table 3. Distribution of questions by health care setting

Type of Health Care Setting	Target Percentage of Questions
Hospital	40-50%
Out-of-Hospital	50-60%

2. **Health Care Situation:** It is recognized that within the context of midwifery care, the client may experience a range of Normal to Abnormal health care situations. Table 4 presents the percentage ranges that served as the guideline for the CMRE test development.

Table 4. Distribution of questions by health care situation

Type of Health Care Situation	Target Percentage of Questions
Normal	50-60%
Abnormal	40-50%

Standardization:

Standardization ensures that exam items are presented consistently and candidates can expect information on the exam to be presented within certain standards. The following standards are adopted for this exam:

- Metric will be used for measurements
- Standard International (SI) Units will be used for drug dosages
- Generic, or common, drug names will be provided. Any trade names provided will follow in brackets.

APPENDIX B
CANADIAN COMPETENCIES FOR MIDWIVES

Canadian Competencies for Midwives

Prepared by: The Canadian Midwifery Regulators Consortium

Le Consortium canadien des ordres
de sage-femmes / Canadian
Midwifery Regulators Consortium

*Projet sur une nationale
d'évaluation de la
pratique sage-femme*

*National Midwifery
Assessment Strategy*

CANADIAN COMPETENCIES FOR MIDWIVES

Please note that while in this document we have used the generic feminine pronouns, the terms "midwife" and "midwives" are meant to include both male and female midwives.

PREAMBLE:

This document, *Canadian Competencies for Midwives* has been developed for two reasons: to provide a base for the development of national assessment processes and to provide information to internationally-educated midwives about what Canadian midwives are expected to know and do. This document outlines the knowledge and skills expected of an entry-level midwife in Canada. Entry level midwives are defined as those who have been assessed as eligible to start practising in Canada, after they meet provincial/territorial requirements, in the full scope of practice and without supervision requirements on their registration.

The *Canadian Competencies for Midwives* is compatible with provincial/territorial competency statements but it does not replace them. Since midwifery in Canada is regulated by province or territory, provincial/territorial competency documents take precedence over this national document and are the ultimate source of information about what a midwife is expected to know and do in any specific province or territory. There is a high degree of similarity in the entry-level competencies required by the various Canadian jurisdictions regulating midwifery. However, some additional competency requirements can be found in provincial and territorial documents.

CANADIAN MODEL OF MIDWIFERY PRACTICE:

While there are provincial/territorial differences in how midwifery is legislated, organized, and practised, the basic model of midwifery practice is the same across all regulated jurisdictions in Canada. Midwives provide care from early pregnancy through to at least six-weeks postpartum to women and their infants. The description below provides context for the competencies outlined in this document.

Health and Well-being

Midwifery care in Canada is based on a respect for pregnancy and childbirth as normal physiological processes. Midwives promote wellness in women, babies, and families, taking the social, emotional, cultural and physical aspects of a woman's reproductive experience into consideration.

Informed Choice

Canadian midwives respect the right of women to make informed choices about all aspects of their care. Midwives actively encourage informed decision-making by providing women with complete, relevant, and objective information in a non-authoritarian manner.

Autonomous Care Providers

Canadian midwives are fully responsible for the provision of primary health services within their scope of practice, making autonomous decisions in collaboration with their clients¹. When midwives identify conditions requiring care that is outside of their scope of practice, they make referrals to other care providers and continue to provide supportive care. Midwives collaborate with other health professionals in order to ensure that their clients receive the best possible care.

Continuity of Care

Canadian midwives are committed to working in partnership with the women in their care. Midwives spend time with their clients in order to build trusting relationships and provide individualized care. Individual or small groups of midwives provide continuity of care to women throughout pregnancy, labour, birth, and up to at least six weeks postpartum. A midwife known to the woman is available on-call throughout her care.

Choice of Birth Setting

Canadian midwives respect the right of each woman to make an informed choice about the setting for her birth. Midwives must be competent and willing to provide care in a variety of settings, including home, birth centres, and hospitals.

Evidence-based Practice

Canadian midwives are expected to stay up-to-date with regard to research on maternity care issues, to critically appraise research, and to incorporate relevant findings into their care.

¹ Clients are women who have contracted to work with and receive care from a specific midwife or midwives.

GENERAL COMPETENCIES

- A. The entry level midwife should have the knowledge and skills to:**
1. provide care and advice to the woman and her family during pregnancy, labour, birth and the postpartum period;
 2. exercise appropriate clinical judgment as an autonomous primary-care provider;
 3. provide culturally appropriate and sensitive care;
 4. provide education, health promotion and counseling related to childbearing, parenthood, and family planning for the woman, her family and the community;
 5. facilitate informed decision making by providing the woman with both time and the necessary information to make choices during pregnancy, labour, birth and the postpartum period;
 6. communicate effectively with the woman, her family and her support people;
 7. develop, implement and evaluate, with the woman, an individualized plan for midwifery care;
 8. provide continuity of care throughout the childbearing cycle;
 9. assist the woman and her family in planning for an appropriate place of birth
 10. provide care in a variety of out-of-hospital and in-hospital settings;
 11. promote normal birth;
 12. conduct births and care for the woman and the newborn on her own responsibility;
 13. identify risk factors before and during pregnancy, labour, birth and the postpartum period; take appropriate action; and/or consult or refer as appropriate;
 14. order, perform and interpret results of screening and diagnostic tests in accordance with provincial/territorial regulations and standards;
 15. prescribe, order and administer pharmacologic agents in accordance with provincial/territorial regulations and standards;
 16. recognize abnormal conditions, recommend and initiate treatment and/or consult or refer as appropriate;
 17. critically review, appraise and apply new information, including research findings, relevant to midwifery practice;
 18. provide information about care alternatives including options, risks and benefits, and assist client decision-making;
 19. use technology appropriately;
 20. use emergency measures when necessary;
 21. limit the spread of disease by using appropriate infection control measures;
 22. establish and maintain comprehensive, relevant and confidential records;
 23. provide care consistent with the philosophy and ethics of midwifery care in Canadian jurisdictions;
 24. assist the woman and her family to access appropriate community resources;
 25. act as an advocate for the client in all aspects of her care.
 26. communicate the scope of practice of a registered midwife, including limitations of practice.

SPECIFIC COMPETENCIES

I. EDUCATION AND COUNSELLING

A. The entry level midwife should have the knowledge of:

1. the principles and processes of informed decision-making;
2. the principles of adult education, communication and counseling;
3. theoretical approaches to prenatal and early parenting education;
4. the impact of life experiences on childbearing and early parenting;
5. historical, social and cultural influences on childbearing and early parenting;
6. issues related to abuse and discrimination;
7. issues related to grief and loss.

B. The entry level midwife should have the ability to:

1. be present with and attentive to the woman throughout her childbearing experience;
2. assess the well-being of the woman in the context of her family and community and provide her with information, education and support according to her needs;
3. facilitate the process of informed decision-making,
4. utilize a broad range of communication skills including reflective listening;
5. provide prenatal and early parenting education to enhance the woman's confidence and competence in childbearing and parenting;
6. assist the woman and her family in planning and preparing for the birth experience and early parenting;
7. facilitate integration of the birth experience(s) for the woman and her family;
8. provide information and resources to the woman and her family regarding self-care, normal postpartum progress, including its emotional and psychological aspects, and signs and symptoms of common postpartum complications;
9. provide information and resources to the woman and her family regarding infant growth, development, behaviour, nutrition, feeding and care, including the benefits and practice of breastfeeding.
10. counsel and support the woman and her family in responding to grief and loss during childbearing.

II. ANTEPARTUM CARE

A. The entry level midwife should have the knowledge of:

1. general anatomy and physiology including detailed knowledge of the reproductive systems;
2. physical, emotional, sexual and social factors and changes associated with pregnancy, including those likely to influence its outcome;
3. genetics, embryology and fetal development and their implications;
4. nutritional requirements during pre-conception and pregnancy;
5. the management of common discomforts of pregnancy;

6. methods for diagnosing pregnancy, establishing due date, and assessing gestational age and the progress of pregnancy;
7. screening and diagnostic tests available during pregnancy;
8. common substances and therapies used during pregnancy and their effects, side-effects and interactions;
9. environmental, occupational, biologic and pharmacologic hazards to the woman and the fetus;
10. variations of normal and abnormalities which may occur during pregnancy;
11. infections prior to and during pregnancy and their implications;
12. principles and procedures for responding to fetal malpresentation, such as external cephalic version.

B. The entry level midwife should have the ability to:

1. obtain a comprehensive health history, including both medical and psychosocial information;
2. assess nutritional intake and provide or recommend counselling as appropriate;
3. address common discomforts associated with pregnancy;
4. recommend appropriate therapies which may be used during pregnancy;
5. perform a complete physical examination of the woman;
6. perform ongoing physical assessments of the woman during pregnancy to detect abnormalities, and initiate treatment and/or consult or refer as appropriate;
7. perform a vaginal exam and assess the soft and bony structures of the pelvis, uterine size, shape, consistency and mobility, and cervical and vaginal health;
8. perform a speculum exam to assess cervical and vaginal health and obtain the necessary specimens to determine the presence of sexually transmitted infections, vaginal infections and cytological changes;
9. perform venipuncture and capillary puncture;
10. confirm pregnancy;
11. perform abdominal palpation and fundal height measurement to assess uterine size, fetal position and presentation, and to estimate fetal size, number, and gestational age;
12. assess fetal well being through such methods as fetal heart auscultation and evaluation of fetal movement.

III. Intrapartum Care –

A. The entry level midwife should have the knowledge of:

1. the normal process of labour including the mechanisms of labour and birth;
2. maternal pelvic anatomy and anatomy of the fetal skull and its landmarks as relevant to assessing fetal position and the progress of labour;
3. physiologic changes associated with the transition from fetus to newborn;
4. indicators of maternal and fetal well-being;
5. requirements for a safe birthing environment;
6. comfort and support measures for labour and birth;
7. physiologic methods to facilitate labour;
8. normal variations and abnormalities of the fetal heart rate and methods of assessing the fetal heart in labour;
9. the principles of clean and aseptic technique and universal precautions;
10. the significance of ruptured membranes and methods for reducing risks of infection;
11. abnormalities of labour, birth and the immediate postpartum period;
12. prevention, assessment and management of exhaustion, dehydration and ketonuria during labour;
13. techniques to prevent and reduce perineal trauma;
14. indications and procedure for episiotomy;
15. indications and procedure for repair of lacerations and episiotomy;
16. prevention, recognition and management of postpartum hemorrhage;
17. pharmacological agents and other substances and therapies used during the intrapartum period;
18. emergency measures, obstetrical procedures and interventions;
19. neonatal resuscitation and stabilization.

B. The entry level midwife should have the ability to:

1. provide emotional and physical support to the labouring woman and her support people;
2. assess the onset and progress of labour and take appropriate actions;
3. recognize variations of normal and abnormal labour patterns and identify probable causes and potential interventions when indicated;
4. assess the fetal heart with a fetoscope, doppler and electronic fetal monitor, interpret findings and take action when appropriate;
5. determine status of the membranes and perform amniotomy when indicated;
6. assess amniotic fluid;
7. assess the bladder and perform urinary catheterization as necessary;

² In this document the CMRC uses the word “immediate” to refer to the hours immediately after the birth when the midwife is providing care until mother and newborn are stable. In some Canadian jurisdictions the word “immediate” is also used in legislation to refer to the complete six-week postpartum period. Use of this definition of the word “immediate” here is not intended to contradict that broader definition.

8. assess the need for pharmacologic and non-pharmacologic measures during labour, birth and the immediate postpartum period;
9. prescribe, order and administer pharmacologic agents as necessary in the intrapartum in accordance with provincial/territorial regulations and standards;
10. administer injections and inhalants, insert intravenous catheters and administer intravenous fluids and medications in accordance with the provincial/territorial regulations and standards;
11. protect the perineum, avoid unnecessary episiotomy and minimize lacerations;
12. perform an episiotomy when indicated;
13. assist and support the spontaneous vaginal birth of the baby;
14. recognize signs of separation of the placenta; assist in the delivery of, and inspect the placenta;
15. collect cord blood samples;
16. examine the perineal and vulval areas for lacerations, hematomas and abrasions and repair lacerations and episiotomies in accordance with provincial/territorial regulations and standards;
17. prevent, recognize and manage postpartum hemorrhage and maternal shock;
18. recognize maternal and newborn complications and initiate emergency measures as required;
19. provide immediate assessment and care of the newborn, including assessment of respiratory and cardiac status and temperature maintenance;
20. support the newborn's transition immediately following the birth;
21. perform neonatal resuscitation according to provincial/territorial regulations and standards;
22. assist and support the early initiation of breastfeeding.

IV. CARE OF THE WOMAN DURING THE POSTPARTUM PERIOD, INCLUDING BREASTFEEDING

A. The entry level midwife should have the knowledge of:

1. maternal anatomy and physiology in the postpartum period, and the normal progress of the postpartum period;
2. anatomy of the breast, physiology of lactation and principles of effective breastfeeding, including the normal process and necessary conditions and factors for its success;
3. management of common discomforts of the postpartum period;
4. postpartum complications, including complications of breastfeeding, and their management;
5. emotional, psychological, social, cultural and sexual aspects of the postpartum period, breastfeeding and early parenting;
6. nutritional requirements of women during the postpartum period, including for lactation;
7. the health benefits of breastfeeding for mother and infant;
8. the influence of environmental, occupational, and biological factors on breastfeeding;

9. pharmacological agents and other substances and therapies used during the postpartum period and their effect on breastfeeding;
10. stimulation and suppression of lactation;
11. family planning, methods of contraception and their risks and benefits.

B. The entry level midwife should have the ability to:

1. assess the health and monitor the progress of the woman in the postpartum period;
2. assist the mother to establish and maintain breastfeeding, or her alternate chosen method of infant feeding;
3. identify special or abnormal maternal or infant situations that may influence breastfeeding, and develop an appropriate plan;
4. use appropriate therapies to support effective breastfeeding;
5. facilitate the introduction of the new family member;
6. recognize postpartum complications, including postpartum depression, and take appropriate action, including consulting or referring when indicated;
7. prescribe, order and administer appropriate pharmacologic agents as necessary in the postpartum period in accordance with provincial/territorial regulations and standards;
8. conduct a six week postpartum assessment of the woman, including vaginal and speculum examination where appropriate;
9. counsel clients in decision-making and use of contraceptive methods;
10. provide appropriate referrals for ongoing care;
11. facilitate the closure of the midwife-woman relationship.

V. CARE OF THE NEWBORN AND THE YOUNG INFANT

A. The entry level midwife should have the knowledge of:

1. anatomy and physiology of the newborn;
2. newborn assessment, including gestational age assessment;
3. growth and development of the healthy newborn;
4. the nutritional needs of the newborn including properties of breast milk and infant formula, and methods of infant feeding;
5. newborn screening and diagnostic testing;
6. abnormal conditions in the newborn;
7. prophylactic medications commonly administered to the newborn;
8. effects of prescriptive and non-prescriptive substances on the newborn, including those excreted through the breast milk;
9. environmental, biological and pharmacologic hazards to the newborn;
10. the physical and emotional needs of the newborn including appropriate safety considerations;
11. issues related to circumcision.

B. The entry level midwife should have the ability to:

1. perform a complete physical examination of the newborn;
2. provide ongoing newborn care and assessment of well-being and development;
3. recognize complications in the newborn and make appropriate referrals as necessary;
4. administer medications and immunizations to the newborn according to provincial/territorial regulations and standards;
5. perform a heel puncture to obtain blood samples;
6. provide information to parents regarding available public health and community resources, and make appropriate referrals for ongoing care.

VI. WELL WOMAN CARE, SEXUALITY AND GYNECOLOGY

A. The entry level midwife should have the knowledge of:

1. physiological and psychosocial components of human sexuality in general and during the childbearing cycle;
2. physiological and psychosocial aspects of human fertility;
3. normal reproductive health and signs and symptoms of pathology;
4. factors involved in women's responses to pregnancy, and resources for counseling and referral, including for women seeking termination.

B. The entry level midwife should have the ability to:

1. assess the woman's reproductive and sexual health;
2. provide well-woman care according to provincial/territorial regulations and standards;
3. inform and advise clients on issues of human sexuality, fertility and unplanned pregnancies, and make referral where appropriate;
4. support a woman seeking termination of pregnancy and make referrals when requested;
5. provide information on various methods of contraception.

VII. PROFESSIONAL, INTER-PROFESSIONAL, LEGAL AND OTHER ASPECTS OF THE PROFESSION

A. The entry level midwife should have the knowledge of:

1. current issues in midwifery at local, provincial, national and international levels;
2. the general structures and principles of the Canadian health care system;
3. legislation and public health policies and procedures relevant to midwifery nationally and in the province/territory in which she practises;
4. the history and philosophy of the midwifery profession in Canada;
5. the structure and function of professional and regulatory midwifery organizations in Canada;

6. community standards of care and the roles and responsibilities of other health care providers and their scopes of practice in the province/territory in which she practises;
7. the process of teambuilding and engaging in professional and inter-professional partnerships;
8. legal requirements of midwifery practice, including those respecting privacy and freedom of information, informed consent and informed choice, recording and reporting, and provincial/territorial data collection requirements;
9. the code of ethic, regulations and standards for midwifery in the province/territory in which she practises.

B. The entry level midwife should have the ability to:

1. work in a collegial manner with other caregivers in a variety of settings;
2. communicate and collaborate effectively and professionally with midwifery colleagues, students and other caregivers;
3. practise in accordance with provincial/territorial codes of ethics and other ethical frameworks and standards guiding midwifery practice.

VIII. PROFESSIONAL DEVELOPMENT

A. The entry level midwife should have knowledge of:

1. methods for assessing statistical evidence and critically appraising the research literature;
2. continuing education and quality assurance programs and requirements for the ongoing evaluation of midwifery practice;
3. midwifery practice management.

B. The entry level midwife should have the ability to:

1. engage in reflective practice;
2. share midwifery knowledge and participate in midwifery-related research;
3. recognize her personal and professional boundaries and limitations, practise appropriate self-care, and seek support when needed.

ADVANCED COMPETENCIES:

There are a number of advanced competencies that midwives in Canada may perform in certain jurisdictions and/or in certain circumstances, when provincial/territorial regulations and standards allow it. A few of the competencies that are considered "advanced" in one jurisdiction are considered "entry-level" in another. Currently there is no agreement on advanced competencies and this remains an area of difference between Canadian provinces and territories. There is, however, some initial discussion at a national level with regards to how advanced competencies may be recognized. It is expected that this discussion will continue and may result in a national statement regarding advanced competencies.

These advanced competencies include but are not limited to:

1. epidural monitoring;
2. application of scalp electrodes;
3. pharmacologic augmentation of labour;
4. induction of labour for post-dates pregnancy;
5. performing vacuum extraction;
6. first surgical assist at cesarean sections;
7. suturing of 3rd degree tears;
8. evacuation of the uterus;
9. fitting barrier methods of contraception;
10. prescribing contraceptives;
11. inserting umbilical vein catheters in the newborn;
12. providing well-baby care after six weeks postpartum and to healthy newborns in general;
13. providing well-woman care after six weeks postpartum and to healthy women in general.

APPENDIX C
PARTICIPANTS INVOLVED IN EXAM DEVELOPMENT

Participants Involved in Exam Development

NAS Project Coordinator

Wendy Martin

Exam Committee

Jane Kilthei, BC

Joanna Greenhalgh, Alberta

Janice Erickson, Manitoba

Robin Kilpatrick, Ontario

Maggy Moise, Quebec

Competencies Working Group

BC – 3

Alberta – 1

Manitoba – 1

Ontario – 3

Quebec – 3

NWT – 1

Item Writers (numbers per province)

BC – 1

Alberta – 1

Manitoba – 2

Ontario – 2

Quebec - 4

Pilot Participants (numbers per province)

BC – 4

Alberta – 1

Manitoba – 2

Ontario – 8

Quebec – 2

NWT – 1

Translation Team

Quebec - 2

Cut-score Setting Panelists (numbers per province)

BC – 1

Alberta – 1

Manitoba – 3

Ontario – 1

Quebec – 1

APPENDIX D
CURRENT EXAMINATION COMMITTEE MEMBERS

Canadian Midwifery Examination Committee Members
Current as of October 2008

Examination Manager

Sharon Mendes Barnett, Ph. D.

Committee Members

Jane Kilthei, British Columbia

Diane Rach , Alberta

Janice Erickson, Manitoba

Robin Kilpatrick, Ontario

Maggy Moise, Quebec

APPENDIX E
EXAM COMMITTEE TERMS OF REFERENCE

Exam Committee Terms of Reference

As of October 2007 CMRE Committee Terms of Reference is as follows:

Purpose: To oversee the CMRE.

Composition: 5-7 representatives of regulatory organisations that are members of the Canadian Midwifery Regulators Consortium.

- Each representative is to be from a regulatory body in one of the
- designated regions:
 - BC – 1 representative
 - Prairie – 2 representatives
 - Ontario – 1 representative
 - Quebec – 1 representative
 - Atlantic – 1 representative
 - Northern – 1 representative
- At least 50% should be current registered midwives in good standing
- and all committee members must have worked as registered
- midwives in Canada and have a commitment to keep up with the
- literature relevant to the Canadian competencies for Midwives and
- midwifery practice in Canada.
- Representatives not be directly involved in administering the CMRE in
- their province or territory
- Representatives are nominated by their province/territory and
- confirmed by the CMRC
- Representatives may not send a proxy to meetings
- There is no maximum length of term

Quorum: Three members

Language: Committee meetings, correspondence, and minutes will be in English

Confidentiality: All committee members must sign an affidavit of non-disclosure upon joining the committee.

Under no circumstances will anyone share any information related to exam content to anyone outside of the exam committee and exam staff.

Exam committee minutes may be shared with Board and relevant committee/staff members within regulatory organisations only and only after each person has signed an affidavit of non-disclosure, and only when exam content is not revealed therein.

Responsibilities:

- Reviewing, revising Blueprint, as necessary;
- Ensuring the exam tests the Canadian Competencies for Midwives (and that these latter are up-to-date)
- Approving all CMRE policies
- Approving CMRE general procedures
- Confirming exam dates and number of sites each sitting
- Reviewing exam statistics and feedback from each sitting of the CMRE and making relevant decisions
- Participating in validation processes for all new items, or appointing a relevant substitute for this work
- Participating in cut-score setting processes for all new items, or appointing an appropriate substitute for this work
- Regularly attending meetings

Meetings:

One in-person meeting per year before or after the annual CMRC meetings

Regular teleconference meetings (minimum three/year)

Frequent email communication