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NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

FILED
03/31/2026 11:24 AM
ARCHIVES DIVISION
SECRETARY OF STATE

CHAPTER 332
OREGON HEALTH AUTHORITY
HEALTH LICENSING OFFICE, BOARD OF DIRECT ENTRY MIDWIFERY

FILING CAPTION: Add legend drugs and devices competencies and examinations as a requirement for licensing and renewal.

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 04/30/2026 12:00 PM

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

CONTACT: Josh Page
503-934-0720
josh.page@oha.oregon.gov

1430 Tandem Ave. NE, Suite 180
Salem,OR 97301

Filed By:
Samantha Patnode
Rules Coordinator

HEARING(S)

Auxiliary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 04/29/2026
TIME: 10:00 AM - 12:00 PM
OFFICER: Samie Patnode

IN-PERSON HEARING DETAILS
ADDRESS: Health Licensing Office, 1430 Tandem Ave. NE, Suite 180, Salem, OR 97301

REMOTE HEARING DETAILS
MEETING URL: Click here to join the meeting
PHONE NUMBER: 1-669-254-5252
CONFERENCE ID: 1615539814
SPECIAL INSTRUCTIONS:
Passcode: 819789

NEED FOR THE RULE(S)

A Notice of Proposed Rulemaking for legend drugs and devices was filed and published in the March 2026 Oregon Bulletin. The Notice is being refiled and published in the April Oregon Bulletin to incorporate additional fiscal impact details and hearing information.

Licensed direct entry midwives (LDM) have the authority to purchase and administer authorized scheduled legend drugs and devices for use in pregnancy, birth, postpartum care, and newborn care if deemed integral to providing safe care to birthing persons and newborns.

These rules require direct entry midwifery applicants to pass an examination made up of a written and three skills

examinations related to legend drugs and devices. The three skills exams include administration of medication through injection, intravenous therapy, and suturing which demonstrate baseline competency in each skill area prior to licensure. These rules also require current LDMs to retake the legend drugs and devices skills assessment and written examination every three years in order renew their license.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE

The documents relied upon to develop the rules are as follows, the Board of Direct Entry Midwifery and Health Licensing Office Oregon Revised Statutes and Oregon Administrative Rules, Qualification Committee information including competencies, skills examination, written examination, candidate information bulletin which contains a reference list of resources to develop examination questions, Rules Advisory Committee information and financial and licensing documentation.

All documents are available at the Health Licensing Office, 1430 Tandem Ave Suite 180, Salem, OR 97301-1287. To obtain information or copies of information please contact Josh Page, Rules Coordinator, at 503-934-0720 or by email at josh.page@oha.oregon.com, during normal business hours Monday through Friday between 8 am to 4:30 pm.

STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE

All licensing requirements apply uniformly to every applicant. However, applying the same standard to everyone does not produce the same outcomes when applicants come from different educational, geographic, and economic starting points. Integrating legend drugs and device education into a candidate's initial training and supervised on the job experience—rather than concentrating it in a single one week (40 hour) course—can reduce barriers and improve equitable access to licensure.

Applicants from historically underserved racial and ethnic groups are more likely to face limited access to training programs, transportation challenges, and financial constraints. A single, intensive short course can be harder to attend for those balancing work, caregiving, or traveling long distances from rural areas.

Reducing barriers to licensure supports a more diverse midwifery workforce. Greater workforce diversity improves culturally concordant care and trust, which can lead to better outcomes for birthing people and newborns who have been disproportionately affected by maternal and infant health disparities in Oregon.

FISCAL AND ECONOMIC IMPACT:

There will likely be a fiscal impact on the public, applicants for a direct entry midwifery license, current LDMs in Oregon, and Oregon businesses, including small businesses such as birthing centers and LDMs who are sole proprietors. The Oregon Health Authority, Health Licensing Office, and Board of Direct Entry Midwifery will also be affected by the proposed rule changes. Additional agencies and organizations that may experience impacts include the Oregon Health Authority, Oregon Health Plan, Medicaid, urban and rural hospital systems, and other healthcare providers such as physicians, emergency medical technicians, and nurse practitioners.

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

IDENTIFY ANY STATE AGENCIES, UNITS OF LOCAL GOVERNMENT, AND MEMBERS OF THE PUBLIC LIKELY TO BE ECONOMICALLY AFFECTED BY THE RULE(S).

STATE AGENCIES

Health Licensing Office
The Health Licensing Office is a state agency that licenses and regulates direct entry midwives in Oregon. The Health Licensing Office will be responsible for drafting and maintaining the legend drugs and devices competencies, and the skills examination. The written examination must be uploaded to the Workday Database to allow the examination to be taken at alternative locations. The Health Licensing Office will develop written examination documentation such as a candidate information bulletin for the written examination that provides the details of the examinations and references from where the questions are sourced. The Health Licensing Office must update current license application forms and develop new forms related to proctor approval for administering the skills portion of the examination. Staff must review each application for a direct entry midwifery license and proctor approval forms
to ensure all requirements are met.

Oregon Health Plan
The requirement for LDMs to pass a written and skills examination on legend drugs and devices as a requirement for licensure, may create fiscal impacts for the Oregon Health Plan. Ensuring competency could influence utilization of covered services, alter patterns of home□birth care and emergency transfers, and require administrative updates to coverage policies, billing processes, and coordinated care organization guidance. These changes may affect actuarial assumptions and Medicaid cost projections, resulting in potential increases or decreases in overall program expenditures depending on how service utilization and clinical outcomes shift following implementation.

UNITS OF LOCAL GOVERNMENT
Units of local government will likely not be economically affected by the rule changes.

THIS SECTION ASSUMES APPLICANTS, LICENSED DIRECT ENTRY MIDWIVES, OTHER HEALTHCARE PROVIDERS ARE THE PUBLIC

Persons Training to Become Licensed Direct Entry Midwives
Individuals seeking licensure as an LDM are currently required to complete a 40□hour legend drugs and devices course. These courses are not consistently available, and the lack of regular scheduling often creates a significant barrier to timely licensure. The adoption of new rules that allow applicants to meet this requirement by passing a legend drugs and devices course examination is expected to increase flexibility, improve access, and support a more efficient path to licensure. The cost for the 40□hour legend drugs and devices course taught in Oregon is not readily available but similar courses across the United States range from $600–$1,500, depending on course administration (in□person or hybrid), clinical skills requirement (e.g., suturing, IV starts) and needed materials and equipment.

Requiring individuals training to become LDMs to complete core competency education in legend drugs and devices and to pass an examination that includes a written portion, and a three-part hands□on skills assessment is expected to create a direct fiscal impact on trainees. These requirements may increase out□of□pocket expenses related to instructional materials and supplies, examination and assessment fees and travel expenses to testing sites. Extended training and testing obligations may also delay entry into the workforce, resulting in temporary income loss. The overall economic impact will vary by trainee depending on program structure, geographic location, and the need for retesting or additional instruction.

Currently Licensed Direct Entry Midwives
Requiring LDMs to pass an examination that include a written portion, and a three-part hands□on skills assessment related to legend drugs and devices is expected to create a direct fiscal impact on licensees. LDMs may incur additional

expenses for examination fees, study materials, and any supplemental training needed to prepare for the examination. They may also experience indirect costs such as travel to testing sites, time away from practice, and potential loss of income during preparation or retesting. The overall economic impact will vary depending on the LDMs location, training needs, and the number of attempts required to successfully complete the examinations.

If a LDM cannot pass the required legend drugs and devices examination, they may face additional costs for retesting, supplemental training, and study materials. They may also experience lost income if they are unable to renew their license, which could reduce client volume and overall business revenue. Prolonged inability to meet the requirements could further jeopardize their ability to continue practicing, resulting in significant financial consequences.

Examination Fees

- Written examination fee including retake: $50.
- Skills examination fee: estimated to be $50 per hour to be paid for proctor(s) labor. Cost will depend on the time it takes each examination candidate to take each skill(s) examination and whether the practice area is set up in advance.
- The cost for equipment and supplies for the skills examination is listed below under (2)(c).

Potential Skills Examination Proctors

The three-part hands□on skills examinations require an approved proctor to oversee the examination process. Approved proctors include LDM and other licensed healthcare providers. Providers may benefit financially if proctoring duties are compensated, creating an additional revenue stream and expanding professional opportunities. However, they may also experience lost clinical income due to time away from patient care, uncompensated or under□compensated proctoring hours, travel expenses, and the use of clinical space or equipment for examination purposes. Small practices and sole proprietors may face added scheduling disruptions and temporary reductions in client volume. The overall economic impact will vary based on compensation arrangements, practice structure, geographic location, and the frequency with which providers are required to proctor examinations.

Other Healthcare Providers

Requiring LDMs to reaffirm their competencies with emergency drugs and devices every three years creates meaningful cost savings for hospitals and other healthcare providers by reducing the frequency and severity of obstetric emergencies. Reducing emergencies also may lower the need for expensive interventions such as emergency cesarean sections, NICU admissions, and ICU care. If an LDM has the ability and knowledge to assess complications and intervene earlier means better□managed transfers of care and communications with emergency staff, hospitals, physicians, and nurses. Altogether, reaffirming the competencies of LDMs help focus on preventative care and early indication to consult and transfer care.

Other Licensed Healthcare Providers Continued Competency

Nurses and physicians in Oregon both must reaffirm their competencies throughout their careers, but they do it through continuing education and periodic license renewal rather than repeated formal exams. Beginning in 2026 nurses must complete required continuing education, including mandated topics like pain management and cultural competency.

Physicians must complete continuing medical education every renewal cycle to maintain their licenses and stay current with evolving medical standards. In hospitals, both groups also undergo ongoing competency checks through credentialing, privileging, and performance evaluations, which ensures they maintain safe, up□to□date clinical skills for the entire duration of their practice.

Before 2026, Oregon nurses could keep their licenses active by showing they had recent clinical practice hours, rather

than only continuing education. The common standard was a nurse needed to show at least 960 hours of nursing practice within the previous five years to renew. Nurses who did not meet the practice-hour requirement could instead complete continuing education or other Board of Direct Entry Midwifery-approved competency activities. Starting in 2026, Oregon is removing the practice-hour option and moving entirely to continuing education as the way nurses demonstrate ongoing competence.

(2) Effect on Small Businesses:

LDMs who operate as small businesses, including sole proprietors and midwife-owned birthing centers, may experience direct fiscal impacts from the requirement to pass a written examination and three-part hands-on skills examinations related to legend drugs and devices. These impacts may include examination fees, costs for study materials or supplemental training, travel expenses, and lost revenue due to time away from client care. Businesses may also face temporary scheduling disruptions while licensees complete required testing. The degree of impact will vary based on practice size, geographic location, and the need for additional preparation or retesting.

If a proctor is a sole proprietor they may benefit financially if proctoring duties are compensated, creating an additional revenue stream and expanding professional opportunities. purposes. Small practices and sole proprietors will have less time for patient care and may face scheduling disruptions and temporary reductions in client volume. The overall economic impact will vary based on compensation arrangements, practice structure, geographic location, and the frequency of proctor examinations.

(a) Estimate the number and type of small businesses subject to the rule(s);

There are currently 100 active LDMs in Oregon.

There are currently 14 actively licensed birthing centers in Oregon.

The number of proctors is unknown due to the expanded list of healthcare providers that are allowed to proctor the skills examination.

(b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s);

Applicants and licensees will be required to maintain records of having passed the required legend drugs and devices examination for five years.

Proctors will be required to obtain specific forms prescribed by the Health Licensing Office to be used for documenting the skills examination information for each examinee taking a skills examination. Proctors must maintain the skills examination documentation for a minimum of five years following completion of the skills examination.

(c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

Proctors will be providing oversight and supervision of applicants and licensees taking the skills examinations. Proctors will be required to either find a location to perform the skills examinations or purchase computer software to hold examinations online. There may be costs associated with renting space or purchasing software. The costs also will vary based on the time it takes each person to complete each of the three skills examinations. Proctors are expected to

charge between $50 and $250 per examination for proctoring service.

The cost of equipment and supplies for each skills examination may be the responsibility of either the proctor or the examinee, depending on the terms of the agreed-upon arrangement. Costs can be decreased by buying in bulk, or if the examinee purchases their own supplies and equipment. Shipping costs are not included in the supplies and equipment listed below.

Administering Medications by Injection
$2.17 1 multi-dose medication vial with fluid (Practi-Vial 10ml by Wallcur, 30/$64.95)
$2.62 1 multi-dose medication vial with air (Practi-Vial 10 ml by Wallcur, 30/$78.60)
$2.95 1 single-dose medication vial with fluid (Demo Dose 2ml vial, filled)
$2.30 1 glass ampule with fluid (Demo Dose clear ampule, filled)
$0.50 21-ml syringe, 5/8" needle, 21-25 gauge
$0.80 15 or 10-ml syringe with 1.5" needle, 21-25 gauge
$0.80 1 filter needle
$0.59 1 3-ml syringe with 1.5" needle, 21-25 gauge
$0.30 6 alcohol preps (box of 100 / $4.95)
$1.25 52x2 or 4x4 sterile gauze pads (10/$1.79 for 2x2 or 10/$2.71 for 4x4)
$4 1 soft skinned fruit or a reusable injection simulator pad' ex: Practi-Injecta Pad injection simulator by Wallcur = $111:
$4 1 prepared 6"x6"x3" foam block; ($32 for an 8' x 4' x 3" medium density pad divided into 8 blocks)
Total cost for the Administering Medications by Injection skills examinations: $22.28

Administering IV Fluids; Medications
$9 1 bag IV solution (500 ml or smaller, LR or NS; can use 1000 ml if desired)
$7.20 1 IV administration/macro drip set, 0 gtts/mL or 15 gtts/mL
$4 1 peripheral IV catheter, 16, 18, or 20 gauge x 1.25" (varies on safety features, plain 50 for $51.88)
$0.75 1 Chux / underpad 24" x 23" (200 for $98.30)
$0.10 2 alcohol preps (box of 100 / $4.95)
$1 4 2x2 or 4x4 sterile gauze pads (10/$1.79 for 2x2 or 10/$2.71 for 4x4)
$0.78 1 tourniquet (single use) (300 for $30)
$1.40 2 transparent film dressing (Tagaderm, 6 cm x 7 cm, 10 for $6.69 or 100 for $55.99) or use sterile gauze with bandage tape
$2 1 roll bandage (surgical) tape (paper tape, box of 12 for $19)
$20 1 IV demonstration model (example: Medarchitect IV Practice Kit, $20)
$3 1 vial antibiotic powder (Practi-Powder yellow for training, $30 for $62.95)
$2 1 peripheral IV catheter, 18 or 20 gauge, 1.25" (varies on safety features, plain 50 for $51.88)
$2.90 1 IV extension set ("lock") (100 for $129.99)
$2.20 210 mL saline flush syringes (30 for $33.89)
$1 110 ml syringe with 20-gauge needle (100 for $47.95)
$0.20 1red top (for closing end of "lock") (20 for $17.28)
Total cost for the Administering IV Fluids; Medications skills examination
$57.53

Suturing
$13 1package suture – vicryl 3-0 with CT-1 needle or equivalent, 27" or longer
$0.50 1 packaged poly-lined towel/drape not fenestrated, 18" x 26" ($22 for 50) (or use a chux to simulate a sterile field)

$35 1 needle holder/needle driver cost varies based on brand and quality of instrument (reusable once sterilized)
$40 1 tissue forceps: cost varies based on brand and quality of instrument
(reusable once sterilized)
$5 1 hemostat – cost varies based on brand and quality of instrument (reusable once sterilized)
$5 1 surgical or stitch scissors - cost varies based on brand and quality of instrument (reusable once sterilized)
$4 1 prepared 6”x6”x3” foam block ($32 for an 8’ x 4’ x 3” medium density pad divided into 8 blocks)
Total cost for the Suturing skills examination $102.50

Items needed for all tests
$0.20 1 pair gloves (non-sterile, powder-free nitrile, box of 100 = $10)
$7 1 sharps container (use until full)
$0.05 1 method of trash removal, such as trash bag
$5 scissors
$ 12.25

Reference websites:
Wellcur: https://www.wallcur.com/
Mediarchitect: https://mediarchitect.net/
Tegaderm: https://www.3m.com/3M/en_LB/p/c/medical/bandages-dressings/b/tegaderm/

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

A Legend Drugs and Devices Qualification Committee (community engagement) was assembled and met throughout 2023 and 2024. Several committee members were owners of birthing centers and sole proprietors of a midwifery care business. A Rules Advisory Committee was convened which was made up of small business owners including birthing centers and sole proprietors. The Board of Direct Entry Midwifery approved the proposed rules for filing with the Secretary of States office and many of the Board of Direct Entry Midwifery members own small businesses.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:
332-015-0030, 332-015-0040, 332-015-0050, 332-015-0075, 332-015-0077, 332-020-0000, 332-020-0010, 332-020-0015, 332-026-0000, 332-026-0010, 332-026-0020, 332-026-0030, 332-040-0000

AMEND: 332-015-0030

RULE SUMMARY: Application requirements to become a licensed direct entry midwife in Oregon.

CHANGES TO RULE:

332-015-0030
Application Requirements Direct Entry Midwifery License ¶

(1) An individual applying for licensure to practice direct entry midwifery must:¶
(a) Meet the requirements of OAR 331 Division 30;¶
(b) Submit a completed application on a form prescribed by the Office, which must contain the information listed in OAR 331-030-0000 and be accompanied by the required application and license fees;¶
(c) Submit proof of being currently certified in cardiopulmonary resuscitation for infants and adults pursuant to ORS 687.420;¶
(d) Submit proof of being currently certified in neonatal resuscitation;¶

(e) Submit a written plan for emergency transport for birthing person or newborn pursuant to OAR 332-025-0020~~; and~~. ¶
(f) Submit proof of having current Certified Professional Midwife credential from NARM.¶
(g) Submit proof of having passed all four parts of the Legend Drugs and Devices examination, as described in OAR 332-015-0050(3)(a) and (b), within one year prior to the date of application on a form prescribed by the Office. The form must be submitted directly to the Office by the proctor who conducted and supervised the skills examination(s) and who has met all requirements listed in OAR 332-015-0075 and has been approved by the Office.¶
(2) In addition to the requirements listed in subsection (1) of this rule and pursuant to ORS 687.420, an applicant must show proof of having participated in:¶
(a) 25 deliveries as an assistant.¶
(b) 25 deliveries as the primary or the primary under supervision.¶
(c) 100 prenatal care visits, 25 newborn examinations, and 40 postnatal examinations.¶
(d) 10 deliveries where continuity of care was provided as an assistant or primary care provider. The continuity of care must include four prenatal visits, one newborn examination, and one postpartum exam for each of the 10 deliveries.¶
(3) Of the 50 births listed in subsection (2) of this rule, at least 25 deliveries must have taken place as a community birth and 10 births must have occurred within ~~the~~ two years before the date of application.¶
(4) For the purpose of this rule, experience as an assistant, primary or primary under supervision, must have been obtained in one of the following ways:¶
(a) As an Oregon licensed health care practitioner while the services provided were within the scope of the practitioner's license~~;~~.¶
(b) As a traditional midwife providing services in Oregon pursuant to ORS 687.415(2)(b)~~;~~.¶
(c) As an individual supervised by an LDM~~; o~~. Or¶
(d) Under other lawful means.¶
(5) If ~~the~~an applicant ~~received the~~was issued a license without first taking the 40 hours Initial Legend Drugs and Devices ~~c~~Continuing ~~e~~Education ~~prior to applying for licensure, it must have been obtained within two years before~~course, required prior to July 1, 2026, they must pass the Legend Drugs and Devices examination as listed in OAR 332-015-0050 at the ~~dat~~time of ~~application. If applicant receiv~~next renewal and attest ~~the continuing education within 12 months after applying for licensure, the applicant must attest to having received the continuing education at the time of next renewal on a form prescribed by the Office~~o having passed the examinations on a form prescribed by the Office.¶
(6) An applicant must maintain a record of documents required within this rule which may be subject to an audit or inspection by the Office. Documents may be stored electronically.¶
(7) The skills examination(s) listed under (1)(g) of this rule must be sent to the Office through mail, fax or email.¶
(~~6~~8) If the applicant has not received the Initial Legend Drugs and Devices continuing education listed under ~~OAR 332-020-0010(2) or (3)~~ at the time of application this information must be disclosed to each patient on the patient disclosure form required under OAR 332-025-0020.
Statutory/Other Authority: ORS 676.615, ORS 687.4~~15, ORS 687.4~~20, ORS 687.493, ORS 687.685
Statutes/Other Implemented: ~~ORS 687.415,~~ ORS 687.420, ORS 687.4~~85~~93

AMEND: 332-015-0040

RULE SUMMARY: Education requirements to become a licensed direct entry midwife in Oregon.

CHANGES TO RULE:

332-015-0040
Education ¶

~~A~~(1) An applicant's education must incorporate the general educational requirements listed in the NARM CPM candidate information bulletin, including:¶
(~~1~~a) Core competencies developed by MANA~~;~~.¶
(~~2~~b) NARM written test specifications~~;~~.¶
(~~3~~c) NARM skills assessment test specifications~~;~~.¶
(~~4~~d) NARM written examination primary reference list~~; and~~.¶
(~~5~~e) NARM skills assessment reference list.¶
(2) The Board has adopted the July 1, 2026, Legend Drugs and Devices Standard Competencies as the theory and practical instructional outline for the legend drugs and devices. ¶
(3) The July 1, 2026, Legend Drugs and Devices Standard Competencies can be obtained from the Office upon request.
Statutory/Other Authority: ORS ~~183,~~ 687.420, ORS 687.4~~80,~~93, ORS 676.615, ORS 687.485
Statutes/Other Implemented: ORS ~~183,~~ 687.420, ~~687.480,~~ORS 687.48593

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

OREGON BOARD OF DIRECT ENTRY MIDWIFERY

Legend Drugs and Devices Standard Competencies Information Packet

Implemented on July 1, 2026

HEALTH LICENSING OFFICE
1430 Tandem Ave. NE, Suite 180
Salem, OR 97301-2192
Phone: (503) 378-8667
Fax: (503) 585-9114
Email: hlo.info@odhsoha.oregon.gov
Website: www.oregon.gov/oha/ph/hlo

Overview of Competencies

1.00 PHARMACOLOGY

Definitions

1.1	Define a drug.
	• A medication or other substance which has a physiological effect when ingested or otherwise introduced to a body.
1.2	Explain how an Oregon Licensed Direct-entry Midwife can use Legend Drugs and Devices.
	• Legend drugs means any drugs which are required by state law or regulation of the pharmacy quality assurance commission to be dispensed on prescription only or are restricted to use by authorized practitioners only.

Action and Effects

1.3	Define the actions and effects of pharmacological agents.
	• A pharmacological action is a biochemical physiological mechanism by which the chemical produces a response in living organisms. The effect is the observable consequence of a drug action.
1.4	Explain the following competencies for each legend drug listed in 1.4.1 through 1.4.14.1, for maternal use, which are authorized for use by an Oregon licensed direct entry midwife. (The current information to explain each competency needs to be accessed through independent research by the student).
	• Pharmacological action • Onset of action • Peak effect • Therapeutic effects • Duration of action • Side effects (Mild to moderate Reactions) • Indications and contraindications • Adverse reactions (Severe) • Incompatibilities and drug interactions • Typical unit packaging • Dosage guidelines • Storage • Transporting • Disposal

1.4.1	Anti-hemorrhagics for use by intramuscular injection

			1.4.1.1	Oxytocin (Pitocin, Syntocin and generic)
			1.4.1.2	Methylergonovine (Methergine)
			1.4.1.3	Ergonovine (Ergotrate)
		1.4.2	Anti-hemorrhagics by intravenous infusion	
			1.4.2.1	Synthetic Oxytocin (Pitocin, Syntocin, and generic)
			1.4.2.2	Tranexamic Acid (TXA)
		1.4.3	Anti-hemorrhagics for oral administration	
			1.4.3.1	Methylergonovine (Methergine)
		1.4.4	Anti-hemorrhagic for buccal administration	
			1.4.4.1	Misoprostol (Cytotec)
		1.4.5	Anti-hemorrhagics for rectal administration	
			1.4.5.1	Misoprostol (Cytotec)
		1.4.6	Resuscitation intravenous fluid replacement	
			1.4.6.1	Lactated Ringer Solution
			1.4.6.2	0.9% Saline Solution
			1.4.6.3	D5LR (5% Dextrose in Lactated Ringers)
			1.4.6.4	D5W (5% Dextrose in water)
		1.4.7	Resuscitation with medical oxygen	
			1.4.7.1	Medical oxygen
		1.4.8	Intramuscular from subcutaneous injection	
			1.4.8.1	Epinephrine (Adrenalin)
		1.4.9	Local anesthetic	
			1.4.9.1	Lidocaine HCl (1% and 2%) (Xylocaine and generic)
			1.4.9.2	Procaine HCI (Novocain, Benzocaine, Cetacane and generic)
			1.4.9.3	Sterile water papules
		1.4.10	Rhesus sensitivity prophylaxis	

			1.4.10.1	Rho(d) Immune Globulin (RhoGAM, Gamulin Rh, Bay Rho-D and others)
		1.4.11	Tissue adhesive	
			1.4.11.1	Dermabond or generic
		1.4.12	Intravenous antibiotics for Group B Streptococcal prophylaxis	
			1.4.12.1	Penicillin
			1.4.12.2	Ampicillin
			1.4.12.3	Cefazolin
			1.4.12.4	Clindamycin
		1.4.13	Eye prophylaxis	
			1.4.13.1	Erythromycin Ophthalmic (0.5%) Ointment (Ilotycin, AK-Mycin and generics)
		1.4.14	Prophylaxis against Vitamin K Deficiency Bleeding (VKDB) for oral administration	
			1.4.14.1	Mephyton
		1.4.15	Prophylaxis against Vitamin K Deficiency Bleeding (VKDB) for intramuscular injection	
			1.4.15.1	Phytonadione (Vitamin K1) including AquaMephyton
		1.4.16	Resuscitation with medical oxygen	
			1.4.16.1	Medical oxygen
	1.5	Define an adverse reaction to a pharmacological agent.		
		• Any undesirable effect of a drug beyond its anticipated therapeutic effects occurring during clinical use.		
	1.6	Describe how an adverse reaction to a pharmacological agent is transferred to the baby.		
		• Drugs cross the placenta by diffusing at varying rates, depending on their physical and chemical properties. An adverse reaction can include direct transfer of a drug to the fetus causing harm, transfer of a substance at higher concentrations that are harmful to the fetus but safe for the parent, or an adverse reaction in the parent (such as anaphylaxis) leading to vasoconstriction to the uterus and harm to the fetus, often from hypoxia.		

	1.7	Describe how an adverse reaction to a pharmacological agent can affect the mother and the baby.
		• Birth defects and adverse reproductive outcome.
	Agonists and Antagonists	
	1.8	Define agonists.
		• A substance which initiates a physiological response when combined with a receptor.
	1.9	Define antagonists.
		• A substance that interferes with or inhibits the physiological action of another.
	1.10	Describe the key differences between agonists and antagonists and their counteractive mechanisms.
		• Agonists produce actions whereas antagonists inhibit the actions**.** Agonist drugs are drugs which are capable of activating receptors in the brain upon binding to the receptor resulting in the full effect of the opioids. Antagonist drugs bind to the receptors in the brain and block the binding of opioids to the receptors thereby inhibiting the effect of the opioid.
	1.11	Describe the binding and blocking effects of agonists.
		• An agonist binds to the receptor and produces an effect within the cell.
	1.12	Describe the binding and blocking effects of an antagonist.
		• An antagonist may bind to the same receptor, but does not produce a response, instead it blocks that receptor to a natural agonist.
	Tolerance	
	1.13	Define tolerance as it relates to pharmacologics.
		• The reduced reaction of subjects to a drug after its repeated use.
	1.14	Explain reduced reaction after repeated use.
		• Drug tolerance to a drug following its repeated use.
	1.15	Explain re-enhancement after dosage increases.
		• Increasing its dosage can re-enhance the effects of the drug.
	1.16	Explain accelerated tolerance and its reducing effects.

		• Increasing its dosage can re-enhance the effects of a drug however further reducing the effects of the drug.
	1.17	Explain the maternal physiological, and biochemical interactions to pharmacological agents.
		• Maternal – neurobehavior • Physiological - interactions such as protein binding as a result of hydrophobic or electrostatic interactions, adsorption of drugs onto solids, or chelation and complexation. • Biochemical - biotransformation
	Interactions	
	1.18	Explain adverse fetal effects resulting from pharmacological interactions.
		• Embryocidal • Fetotoxic • teratogenic
	Placebo Effects	
	1.19	Define Placebo Effect.
		• A beneficial effect produced by a placebo drug or treatment, which cannot be attributed to the properties of the placebo itself and must therefore be due to the patient's belief in that treatment.
	1.20	Explain how a placebo effect can be beneficial.
		• When improvement of symptoms is observed for pain or fatigue using a nonactive treatment.
	Compliance	
	1.21	Describe what it means to be in compliance with the administration of pharmaceuticals.
		• A state of being in accordance with prescribed rules and guidelines.
	Routes of Administration	
	1.22	Define the various routes of administration.
		• Intravenous (IV) - a solution containing the drug is administered directly into a vein, most often through an IV catheter in an infusion such as lactated ringers. • Intramuscular (IM) - administered using a needle directly into the muscle at a 90°. • Subcutaneous - administered using a needle to inject under the skin at a 45° angle. A.K.A.: Subdermal, hypodermal

		• Intradermal - administered using a needle within the layers of skin at a 15° angle. • Oral - administered into the mouth, usually swallowed. • Sublingual/buccal - administered orally but left to dissolve under the tongue(sublingual) or in the cheek(buccal). • Topical - applied topically to the skin, in the form of a cream or ointment. • Rectal - administered into the rectum, in the form of a tablet, suppository, or enema. • Vaginal - administered into the vaginal canal in the form of a tablet, capsule, cream, gel, or suppository. • Inhaled - administered by breathing into the lungs, through either the nose or mouth. • Ophthalmic - administered topically into the eyes, in the form of an ointment.
	Placental Transfer of Medications to the Fetus	
	1.23	Explain placental transfer.
		• Placental drug transfer by diffusion resembles transfer across a lipid bilayer. Transfer is favored by lipid solubility, a large concentration gradient of unbound drug, and maintenance of the drug in a nonionized state in the maternal circulation. Differences in maternal and fetal pH influence the maternal/fetal concentration ratio.
	1.24	Describe how pharmacological agents reach the fetus.
		• Primarily by crossing the placenta. However, drugs that do not cross the placenta may still harm the fetus by affecting the uterus or the placenta.
	Pharmaceutical Movement Through the Body	
	1.25	Explain how pharmaceuticals move through the body.
		• Absorption, distribution, and metabolism.
	1.26	Explain the different routes of absorption.
		• Sublingual, ingestion, inhalation and topical.
	1.27	Explain the primary objective of metabolism.
		• Facilitate a drug’s excretion by increasing its water solubility (hydrophilicity).
	1.28	Explain the route of excretion.
		• The most common route of excretion is the kidney.
	Tracking Legend Drugs and Devices in a home-based midwifery practice	

	1.29	Describe a system for tracking legend drugs and devices in a home-based midwifery practice.
		• The process in the form of a log or chart, to maintain a record of when a drug and device was received, used, and discarded.
	1.30	Explain requirements for tracking legend drugs and devices by an Oregon licensed direct entry midwife.
		Records must be maintained for five years and must be kept on the business premises and available for inspection upon request by the Health Licensing Office. <u>Purchasing</u> • Name of the drug • Amount received • Date of receipt • Drug expiration date <u>Administering</u> • Name of drug • To whom it was administered • Date it was administered to client • Amount of drug administered to client <u>Disposal</u> • Name of drug • Date of disposal • Place or means of disposal • Expired, deteriorated or unused legend drugs must be disposed of in a manner that protects the LDM, client and others who may come into contact with the material during disposal.
	1.31	Describe methods of tracking the expiration of legend drugs and devices.
		• The process in the form of a log or chart, to maintain a record of when a drug or device is expired.
	Dosage Guidelines	
	1.32	Explain what a dosage guideline is.
		• The recommended amount of drug to be administered or taken at any one time.
	1.33	Describe the appropriate labeling for legend drugs once removed from original packaging.

		• If a medication is removed from its original packaging it must be clearly labeled with name, dosage, lot number and expiration date. • If an injectable medication is put into a bag of fluids, the bag should be clearly labeled appropriately with the type and amount of medication in the bag.
	Drug References	
	1.34	Explain drug reference.
		• A package insert or drug reference text that provides information on the mechanism of action, uses, dosing, administration, side effects, drug interactions/incompatibilities and warnings for drugs, which would be consulted prior to administration or counseling a client about medications.

End of Section 1.00 PHARMACOLOGY

2.00 ADMINISTRATION OF MEDICATIONS THROUGH INJECTION

Universal Precautions	
2.1	Define universal precaution.
	• Set of strategies developed to prevent the transmission of blood borne pathogens.
2.2	Explain how to utilize universal precautions.
	• The use of disposable gloves and other protective barriers while examining all patients and while handling needles, scalpels, and other sharp instruments. Washing hands and other skin surfaces that are contaminated with blood or body fluids immediately after a procedure or examination.
Medication Administration Equipment	
2.3	List equipment needed for medication administration, based on route of administration.
	• Intravenous (IV) - gloves, drape/chux, antiseptic wipe, gauze, tourniquet, medical tape, needle with catheter, administration tubing/drip set, bag of fluids. Optional: Connector tubing/extension, clear dressing/Tegaderm, Saline flush, cotton ball, bandage. • Intramuscular (IM) - appropriately sized syringe with needle, gloves, alcohol wipe, cotton/gauze, bandage. • Subcutaneous - appropriately sized syringe with needle, gloves, alcohol wipe, cotton/gauze, bandage. • Intradermal - appropriately sized syringe with needle, gloves, alcohol wipe. • Inhaled - nasal cannula, oxygen mask, ambu bag, nasal spray, rescue inhaler. • Oral - cup, water. • Sublingual/buccal - gloves, no additional equipment necessary beyond drug to be administered. • Topical - gloves, no additional equipment necessary beyond drug to be administered. • Rectal - gloves, no additional equipment necessary beyond drug to be administered. • Vaginal - gloves, no additional equipment necessary beyond drug to be administered. • Ophthalmic - gloves, no additional equipment necessary beyond drug to be administered.
2.4	Explain the different needle sizes, length and bore needed for I.M., I.D, or SQ medication administration.

		Adult: • IM: 1 1/2" (1 1/2") needle with 20-25 gauge • SQ: 1/2" - 5/8" needle, 25-31 gauge • ID: 1/4" - 1/2" needle, 26 or 27 gauge Newborn • IM: 5/8" needle (1/2" - 1"), 22-25 gauge
	2.5	Explain when a filter needle must always be used when drawing up medication.
		• Must be used always when drawing from a glass ample.
	2.6	Explain what a filter needle is for use with glass ampules.
		• The filter creates a one-way flow when withdrawing or injecting fluid into or from the syringe. This allows any glass particles to be filtered out of the solution before using that solution in a patient or final product.
	2.7	Explain the different syringe sizes needed for medication administration.
		• Syringe selection should be based on the amount of medication to be delivered. The provider should select the smallest syringe possible, as this makes it possible to accurately control the amount of medication being administered, i.e., when giving epinephrine or Vitamin K (where the dose is less than 1cc), use a 1cc syringe to get the most accurate measurement. When giving Pitocin, methergine, or when the dosage is between 1ml and 3ml, us a 3cc syringe. When giving Lidocaine, use a larger syringe, i.e., 5cc to 10cc, depending on the needed dosage.
	2.8	Describe the different skin surface disinfectants used.
		Common types with varied uses include: Preferred • Isopropyl alcohol, which is effective on skin against all microbes. • Povidone iodine, which is effective against all microbes. Not preferred: • Chlorhexidine and other biguanides. Must be rinsed off after application, so usually not preferred as a disinfectant prior to injections, although has a longer protective effect against bacterial build-up. • Antibacterial dye, including gentian violet mercurochrome and acriflavine. Effectiveness is bacteria specific. Not preferred as a disinfectant prior to infection.
	2.9	Describe the different types of medication containers used and what medications within the LDM scope are packaged in which containers.

		Glass ampules • Hermetically sealed, single dose containers of sterile liquid medication, intended for parenteral administration, the ampules are constructed from glass, and shaped with a narrower portion or "neck." To access the medication, the provider breaks the glass by snapping the ampule at the neck. The resultant broken glass fragments create a small risk of injury to the provider. To reduce the risk, the ampule should be wrapped in gauze before breaking. Also, because there is a possibility that tiny glass fragments could fall into the medication, the liquid should be drawn up (but not administered) through a filter needle. Ampules may be clear or amber colored, with the latter used for medication that needs to be protected from light. • Formulary medications available in glass ampules: Vitamin K (AquaMephyton), Methergine, epinephrin, sterile water, oxytocin (Pitocin), tranexamicacid (TXA). Multidose containers • Containers that hold more than one dose of liquid medication, intended for parenteral administration. The vials may be constructed of either glass or plastic. The medication is accessed via a rubber stopper. Multi-dose vials are labeled as such by the manufacturer and typically contain an antimicrobial preservative to help prevent the growth of bacteria. • Formulary medications available in multidose containers: lidocaine HCL, epinephrin, oxytocin (Pitocin), sterile water. Single use vials • Containers hold one dose of liquid medication, intended for parenteral administration. The vials may be constructed of either glass or plastic. The medication is accessed via a rubber stopper. Single-dose or single-use vials are labeled as such by the manufacturer and typically lack an antimicrobial preservative. • Formulary medications available in single use vials: oxytocin (Pitocin), Vitamin K (AquaMephyton), epinephrin, Rh immune globulin (such as RhoGam), GBS prophylaxis antibiotics.
	Administration Sites	
	2.10	Differentiate the site for intramuscular injection.
		Adult • Sites for injection - vastus lateralis (outside of thigh), deltoid (upper arm), Ventrogluteal(hip), dorsogluteal (upper outer buttock). Newborn • Sites for injection - vastus lateralis (outside of thigh).
	2.11	Define the four parenteral routes of administering medication.
		• Intradermal (ID) - a shallow or superficial injection of a substance into the dermis, which is located between the epidermis and the hypodermis. This type

		of injection is used for administration of sterile water papules in labor for relief of back pain. It is administered in four sites over the sacrum. • Subcutaneous (SubQ or SC) - subcutaneous injections are administered into the adipose tissue layer just below the epidermis and dermis. Typical sites are outer aspects of arms, abdomen below the costal margin to the iliac crest and within an inch of the umbilicus and anterolateral aspects of the thighs and upper ventral glutes. Epinephrine is administered SubQ. • Intramuscular (IM) - an injection of medication deep into the muscle. Common sites are deltoid muscle, gluteal muscle, and the vests laterals muscle of the neonate. Medications for IM administration are Pitocin, Methergine for adults, and Vitamin K for newborns. • Intravenous (IV) - administration of medication through a port in a peripheral vein. Typically, the veins are in the arms, wrists, or hands.
	Point Checks	
	2.12	Describe the three-point check technique.
		• Expiration date. • Medication name. • Dosage.
	2.13	Describe when to perform the three point check techniques.
		• When drawing up medication. • Immediately before administering medication. • Repeat after administering medication.
	Administration	
	2.14	Describe when to use the Z -track method for parenteral administration of drugs.
		• When administering medication via intramuscular injection.
	2.15	List steps for administering drug I.M.
		• Refer to skills exam for correct administration.
	2.16	List steps for administering drug S.Q.
		• Refer to skills exam for correct administration.
	2.17	List steps for administering drug I.D.
		• Refer to skills exam for correct administration.
	Practical Applications	

	2.18	Demonstrate use of filter needle with glass ampule.
		• Refer to skills exam for correct administration.
	2.19	Demonstrate use of multi-dose vial.
		• Refer to skills exam for correct administration.
	2.20	Demonstrate I.M. Injection.
		• Refer to skills exam for correct administration.
	2.21	Demonstrate subcutaneous injection.
		• Refer to skills exam for correct administration.
	2.22	Demonstrate administration of sterile water papules.
		• Refer to skills exam for correct administration.
	2.23	Indicate the correct sites for injecting sterile water papules for back pain in labor.
		• On the lower back, locate the sacral dimples, which correspond to the dorsal sacral foramina, locating the superior iliac spines. These are the two anterior landmarks. Move lower, about 3-4 cm and 1-2 cm toward the sacral dimples, these are the two posterior landmarks. Connecting the four points should form a trapezoid, with the longest edge at top.

End of Section 2.00 ADMININSTRATION OF MEDICATIONS THROUGH INJECTION

3.00 TREATMENT OF SHOCK

Definitions

3.1	Define shock.
	• Condition caused by inadequate perfusion in the body.

Pathophysiology of Shock

3.2	Identify pathophysiology of shock.
	• Acute widespread reduction in effective tissue perfusion invokes an imbalance in oxygen levels, leading to anaerobic metabolism, lactic acidosis, cellular and organ dysfunction, metabolic abnormalities, and, if prolonged, irreversible damage and death.

Types of Shock

3.3	Explain the four types of shock.
	• Hypovolemic – occurs due to reduced cardiac preload, because insufficient blood is flowing into the ventricle, resulting in decreased stroke volume and cardiac output. Caused by loss of body fluids (usually defined as more than 15% of your body's blood / fluid supply). If due to blood loss, it is called hemorrhagic hypovolemic shock. If due to any other fluid loss, such as from dehydration or diarrhea, it is called non-hemorrhagic hypovolemic shock. • Distributive – occurs due to excessive blood vessel dilation leading to abnormal distribution of capillary blood flow resulting in inadequate supply of blood to the body's tissues and organs. Seen in cases of sepsis, anaphylaxis, and spinal cord injury (neurogenic shock). • Cardiogenic – occurs when the heart muscle fails to deliver blood for systemic circulation, i.e., pump failure. Causes include myocardial infarction (heart attack), heart failure, congenital cardiac defects, or decreased contractility from sepsis, ischemia, and inflammation. • Obstructive / Restrictive – occurs when arterial or venous flow is obstructed at any point in circulation. Causes include pulmonary embolism, tension pneumothorax, atrial valve stenosis, pericardiac tamponade, pressure from abnormal fluid accumulation in the pericardium, and cardiac injury, inflammation, or disease.

Phases of Shock

3.4	Explain the three phases of shock.
	• Compensated - low blood flow (perfusion) is first detected, a number of systems are activated in order to maintain/restore perfusion. The result of that activation is that the heart beats faster (tachycardia), breathing is faster (tachypnea) the blood vessels throughout the body become smaller in diameter (vasoconstriction), and the kidneys work to retain fluid in the circulatory system.

		• Uncompensated - the systems of the body are unable to improve perfusion any longer, and the patient's symptoms reflect that fact. Oxygen deprivation in the brain causes the patient to deteriorate. Heart rate, breathing rate are still above normal (although pulse becomes thready and respirations shallow) and blood pressure usually falls, although may be close to normal or below normal. • Irreversible - the length of time that poor perfusion has existed begins to take a permanent toll on the body's organs and tissues. The heart's functioning continues to spiral downward, and the kidneys usually shut down completely. Heart rate and respiratory rate are well above normal, until crashing to low rates incompatible with life. Even with treatment, patient often does not survive.
	Signs and Symptoms of Shock	
	3.5	Explain the signs and symptoms of shock.
		Compensated: • Increased pulse rate (100-120 bpm) • Increased respiratory rate (up to 25rr) • Blood pressure within normal limits, but with increasing diastolic • Anxiety • Pallor • Cool fingers and toes • Delayed capillary refill • Sweating / diaphoresis • Thirst • Nausea Uncompensated • Weak, fast, thready pulse rate greater than 120 bmp • Fast respiratory rate greater than 25 rr. • Dyspnea (difficulty breathing) • Falling blood pressure, systolic usually to 60 mm Hg or less • Dizziness • Lethargy • Confusion • Combativeness • Cold extremities • Swelling in the feet and ankles • Cyanosis (pale or blue tinged skin)

		• Hypercoagulation • Decreasing LOC (level of consciousness) <u>Irreversible</u> • Signs of cascading organ failure • Bradycardia • Serious cardiac dysrhythmias • Absent or difficulty palpating radial pulse • Frank hypotension • Pale, cold, clammy skin overall, including trunk • Cough producing white or pink frothy sputum • Very slow respiratory rate with gasping or very rapid, shallow breathing • Dilated pupils • Seizures • Coma • Cardiogenic shock can be accompanied by the signs and symptoms of a heart attack.
	Patient Assessment/Survey	
	3.6	Explain the purpose of a primary and secondary survey and list what to assess in the primary and secondary survey.
		The purpose of the primary survey is to establish baseline physiologic functions. <u>Primary Survey</u> • Airway • Breathing • Circulation (heartbeat) • Responsiveness / LOC The purpose of a secondary survey is to perform a more detailed & thorough examination to identify illnesses and injuries. <u>Secondary Survey</u> • Heart rate, pulse-rate, beat force, ease of locating • Blood pressure • Respirations – rate, depth, difficulty breathing, cough, sputum • Oxygen saturation • Skin color / Pallor • Skin cold / clammy or warm

		• Pupil size / dilation • Temperature • Capillary refill • History of events preceding shock • Nausea and/or vomiting • Thirst • Restlessness • Anxiety • Altered mental status
	Pulse Palpitation	
	3.7	Explain the locations of palpating a pulse.
		• Radial (thumb and wrist) • Carotid artery (side of the neck) • Brachial pulse (inner elbow) • Femoral (groin) • Apical (over the apex of the heart)
	3.8	Explain the relationship between pulse site and systolic blood pressure.
		• A palpable carotid pulse equals a systolic of at least 60 mm/hg. • A palpable brachial or femoral pulse equals a systolic of at least 70 mm/hg. • A palpable radial pulse equals a systolic of at least 80 mm/hg.
	Levels of Care in Treatment	
	3.9	List and define the three levels of care in the treatment of a patient in shock and their components.
		<u>Basic / Emergent</u> – able to perform without specialized equipment • Lie flat • Keep warm but not hot • Do not administer fluids by mouth • Use of the Trendelenburg position is no longer recommended for treatment of shock in most cases, including for postpartum hemorrhage <u>Intermediate</u> – requires some specialized equipment • Fluid replacement via I.V. or rectally • Administer oxygen

		Advanced / Rehabilitative – requires hospitalization, and advanced equipment/medications
	Special Positioning for Pregnant Person	
	3.10	Explain what the special positioning needs are for a pregnant woman in shock.
		• Lay on left side.
	3.11	Explain rational and physiology of positioning for a pregnant woman in shock.
		• To avoid compressing the inferior vena cava.
	I.V. Usage	
	3.12	Explain the reasons for using IV therapy for prevention or treatment of shock.
		• IV therapy restores volume the blood supply, allowing hemodynamics to stabilize and maintaining adequate perfusion throughout the body. Helps prevent progression to Uncompensated Shock. However, if sufficient blood volume is lost, IV therapy is not sufficient to prevent escalation of shock, as RBC replacement is needed to provide oxygen carrying capacity and prevent hypoxia/ischemia and resulting organ damage.

End of Section 3.00 TREATMENT OF SHOCK

4.00 INTRAVENOUS (IV) THERAPY

Equipment and Supplies

4.1	Explain the necessary equipment and supplies for administration of IV fluids.

- Gloves - universal precaution, wear gloves any time you may come into contact with body fluids.
- Chux/drape - placed under the arm to create a clean workspace, and to absorb any potential bleeding.
- Antiseptic wipe - cleanse the area prior to IV placement.
- Gauze - absorb any blood from the area or to use as a compress if needed.
- Tourniquet - placed around the arm, above the IV placement site in order to reduce the blood flow while placing the IV.
- Medical tape - used to secure the catheter and tubing at the IV placement site.
- Needle with catheter - needle is used to place the catheter into the vein, needle is then removed leaving behind the catheter.
- Sharps container - needle is placed directly into the sharps container after use.
- Administration tubing/drip set - attached to the catheter, this delivers the fluids from the bag.
- Bag of fluids - fluids being administered, often lactated ringers, sodium chloride, or sodium chloride with dextrose.
- IV pole/hanger - place to secure the bag of fluids to hang above the patient.
- Connector tubing/extension - often attached to the catheter and secured to the arm, this allows a more stable attachment to the drip set. May also have an additional port for administering medications or changing bags of fluids.
- Dressing/Tegaderm - a clear film that is placed over the IV site in order to secure it and keep it cleaner.
- Saline flush - used to flush IV lines/ports.
- Cotton ball - used when removing the IV to absorb any bleeding, apply gentle pressure to the site, and keep the site clean.
- Bandage - place over catheter site after removal.

4.2	Explain appropriate care of equipment and supplies used in IV fluids.

- Check for type, clarity, and expiration date prior to administering IV fluids. Check equipment, as plastic can degrade over time. Avoid getting packaging wet.
- Once IV solution has been opened (spiked) it should be used within 24 hours.
- Check color and clarity of IV fluids. Should be clear and free of particulates.
- IV fluids and supplies may degrade faster in high and low temperatures. If storing these items in a car, they may need to be replaced more often and

		checked regularly for color and clarity despite expiration date. • If IV is being used intermittently (such as with GBS prophylaxis), special care should be taken to avoid contamination at the catheter hub. With repeated disconnection and reconnection there is an increased risk of contamination. • If spike or catheter hub comes into contact with a non-sterile surface, it should be cleaned with an alcohol wipe or replaced with a new sterile set to prevent introducing bacteria into the bloodstream. A sterile replacement cap may also be used to limit the risk of contamination. Replace IV tubing with new sterile tubing every 24 hours.
	4.3	Explain the difference between the following solutions.
		• <u>Isotonic</u> – fluids have an osmotic pressure equal to that of normal body fluids. e.g., Lactated Ringers; .9% saline. • <u>Hypertonic</u> – fluids have an osmotic pressure greater than that of normal body fluids. e.g., D5LR (5% dextrose in Lactated Ringers. • <u>Hypotonic</u> – fluids have osmotic pressure less than that of normal body fluids. e.g., D5W (5% dextrose in water).
	Administration of Fluids	
	4.4	Explain and describe the IV administration of fluids to treat shock.
		● Preferred location of administration for shock is the antecubital area to ensure a quick infusion. ● When treating for shock, use the largest gauge catheter possible, 16 to 20 gauge preferred. For GBS prophylactic antibiotics administration, 18 to 22 gauge is acceptable. ● If unable to place an 18g due to vein size or difficulty finding an appropriate site, a smaller gauge may be used. More than one administration site can be used if needed. <u>Steps:</u> Gather and prepare supplies - gloves, drape/chux, antiseptic wipe, gauze, tourniquet, medical tape, needle with catheter, administration tubing/drip set, bag of fluids, sharps container. *Optional:* Connector tubing/extension, clear dressing/Tegaderm, Saline flush, cotton ball, bandage. ● Put on gloves and place chux under patients' arm. ● Check expiration dates, attach tubing to bag of fluids with spike, flush tubing to remove air, hang bag keeping catheter hub snapped into a clip to prevent contamination. ● Place tourniquet. ● Locate administration site and clean area with antiseptic wipe. Open catheter packaging and check the needle for burrs. Spin catheter on needle to loosen it. ● During needle placement, hold the skin taut with your non dominant hand to prevent the veins from rolling.

		● With the needle bevel pointing up, quickly insert the needle into the vein at a 25° angle. ● Watch for a flash indicating you are in a vein, then advance 1mm further. ● Advance the catheter. ● Tamponade the vein with your non-dominant hand while you remove the needle. ● Attach the IV tubing (or extension set if you are using it). ● Remove the tourniquet and start flow. Watch the drip chamber to ensure adequate flow. ● Secure catheter and tubing with micropore tape using a chevron pattern. ● Place clear dressing / tegaderm over site. ● Monitor IV for adequate flow, and pain or swelling at catheter site.
	4.5	Explain and describe rectal administration of fluids to treat or prevent shock.
		• Rectal administration of fluids is an alternative to oral or IV hydration. May be used to quickly administer fluids to the body in order to treat dehydration and/or treatment of shock. May also be used to increase hydration to allow the placement of an IV. ● If using a prepared enema, follow instructions provided with the product. Can be self-administered by a patient or a partner. <u>Instructions for rectal administration of IV fluids</u> ● Discuss procedure and obtain consent from the patient. Gather and prepare supplies - gloves, drape/chux, administration tubing/drip set, bag of fluids, sterile scissors (or clean with antiseptic wipe), sterile lube, and tape. ● Put on gloves and place chux under patient. ● Check expiration dates, attach tubing to bag of fluids with spike. ● Cut Catheter hub off with clean scissors (cut straight across, avoid cutting at an angle to prevent sharp edges) ● Flush tubing to remove air. ● Apply lube to tubing end that will be inserted into rectum. ● When patient is ready insert lubed end of tubing rectally, approx. 3-4 inches. ● Start flow, and tape tubing in place.
	4.6	Explain and describe the IV administration of fluids for GBS.
		Gather your supplies – IV tubing, extension set, tegaderm or tape, IV catheter, chux, tourniquet, gloves, antiseptic, fluids, antibiotics, syringes, needles, saline flush). • Apply the tourniquet and evaluate for suitable location, then release the

		tourniquet. • Put on gloves, check for allergies, and then draw up the antibiotics, using a triple check to ensure the correct antibiotic and dosage. • Inject the antibiotics into the bag of fluid and gently shake it. • Spike the bag and expel the air from the tubing, hanging the bag in a suitable location. • Attach a saline flush to the extension set and expel the air from the extension set. • Re-apply the tourniquet and thoroughly clean the target area. • Uncap your IV catheter, holding it at an angle appropriate for the target site, insert the needle and catheter, decreasing your angle as you proceed until you get flash in the chamber. • Proceed a millimeter further, before anchoring your needle and advancing only the IV catheter to the hub. • Apply pressure on the vessel above the insertion site, remove the needle and attach the end of the extension set. • Flush the saline through the extension set, remove the flush and attach the IV tubing. • Begin the flow of fluid at a rate that is appropriate for your drip set and fluid bag. • Once the fluid has finished infusing, discontinue the IV tubing, clean the end of the extension set, attach a saline flush, flush the extension set with saline, remove the flush and then lock to tubing. • Repeat these steps at the appropriate interval for the antibiotic being administered.
	IV Flow	
	4.7	Describe appropriate flow rate for IV administration for prevention and treatment of shock.
		• 15gtts/ml drip set
	4.8	List reasons why IV flow can be impeded.
		• Forgot to open clamp online • Bag empty • Kink in tubing • Tourniquet still on • Infiltration • Hit a valve in the vein with the catheter • Drip reservoir is too full

		• Catheter / needle punctured the vein wall • Bag is lower than the IV site
	4.9	Identify the signs and symptoms of IV failure (infiltration).
		• Lack of fluid flow • Swelling / fluid pooling at / around placement site • Pain at / around placement site • Cold at / around placement site • Bruise / hematoma formatting at / around placement site • Blanching at / around placement site • Fluid leaking from placement site
	Dangers and Risks	
	4.10	List risks associated with a poor technique when placing an IV
		● Failure to administer medication through intended route. ● Infiltration ● Hematoma ● Pulmonary embolism ● Air embolism ● Phlebitis • Extravascular medication administration.
	IV Check	
	4.11	List three aspects of IV fluid to check before administration.
		• Appropriate medication • Clarity • Expiration date
	Injection Protection	
	4.12	List actions to take to prevent infection when administering or changing an IV.
		• Hand hygiene • Sterile barriers, including op site. • Clean (no touch) technique • Limit catheter access
	4.13	Describe what to monitor while administering an IV and immediately after.

		• Fluid flowing freely. • Monitor lung sounds (for fluid build-up or pulmonary embolism) • Vital signs - Respiratory rate - Pulse - Blood pressure • Swelling, pain, redness, bruising, warmth, coolness, blanching at site or other signs of infiltration. • Client's level of consciousness (LOC) • Signs and symptoms of anaphylaxis (airway closure, etc.) • Improvement in client physical status • Client's emotional response • With long term IV use, watch for fluid overload (hypernatremia).
	Practical Applications	
	4.14	Demonstrate appropriate steps for administering in IV for prevention and treatment of shock.
		● Refer to skills exam for correct administration.
	4.15	Demonstrate how to change-out a bag of IV fluid.
		● Refer to skills exam for correct administration.
	4.16	On a live model, demonstrate the correct administration and discontinuation of at least four IVs in at least two separate sites and include a saline lock.
		● Refer to skills exam for correct administration.

End of Section 4.00 INTRAVENOUS (IV) THERAPY

5.00 SUTURING

Anatomy

5.1 Explain basic female pelvic floor and genital anatomy.

- Vulva - the externally visible outer genitalia, including labia minora, labia majora, clitoris, urethral opening, and perineum.
- Clitoris - organ containing a high concentration of nerve endings, located superior to the labia minora and urethral opening.
- Vagina - tube extending from the external vulva to the cervix.
- Vaginal floor (posterior vaginal wall) - posterior area of the vagina closest to the rectum.
- Vaginal ceiling (anterior vaginal wall) - anterior area of the vagina closest to the bladder.
- Vaginal fornices - area surrounding the cervix, where the vagina and cervix meet. Includes anterior and posterior fornix.
- Cervix - lower segment of the uterus that connects to the vagina.
- Vestibule - the area between the labia minora and the hymen, includes the urethra and introitus.
- Labia majora - outer labia, larger fold of skin surrounding the vaginal opening.
- Labia minora - inner labia, smaller fold of skin between the labia majora and vaginal opening.
- Mons pubis - the rounded area comprised of a fatty tissue layer, superior to the vulva, and anterior to the pubic bone and pubis symphysis.
- Pubic bone - prominent bone of the pelvis, located in the front of the body.
- Pubis symphysis - joint in the pubis symphysis comprised of cartilage.
- Introitus - entrance to the vagina.
- Hymen and hymenal ring/fragments - the hymen is a thin membrane just inside the vaginal opening. The hymen is usually intact at birth and will stretch/tear with various activities including intercourse. Parts of the hymen will remain visible around the vaginal opening creating a hymenal ring/fragments.
- Urethral opening - opening of the urethra where urine is excreted, located between the clitoris and vaginal opening.
- Perineum - external area located between the vagina and anus.
- Anus - external opening of the digestive tract, connected to the rectum.
- Anal sphincter - ring of fibrous retractable tissue that controls the opening and closing of the anus. May be used synonymously with anus but refers to the internal structure of the anus.
- Rectum - part of the digestive tract, connected to the anus.
- Mucosa - also known as mucous membrane. Internal tissues that line cavities

		including vagina, rectum, and mouth. • Coccyx - small bone protruding from the sacrum. May be injured during birth and/or used as a landmark. also known as the tailbone.
	Perineal Damage	
	5.2	List methods used in second stage that may prevent perineal damage.
		• Applying warm compress. • Slowing the rate at which the baby emerges. • Appropriate perineal massage. • Avoid vigorous perineal massage in second stage. • Birth head between contractions. • Avoid squatting and lithotomy positions. • Use of lubricants.
	5.3	Define degrees of perineal damage.
		• First degree - skin and tissue directly beneath the skin of the perineum. • Second degree - skin and muscle of the perineum and may extend deep into the vagina. • Third degree - perineal tear extends to the muscle around the anus. • Fourth degree - through the muscles around the anus and into the mucous membrane that lines the rectum.
	5.4	When performing a perineal exam to determine the need for sutures, what additional conditions or injuries should you evaluate for, that may interfere with suturing?
		• Hematoma • Vulvar varicosities • Extensive swelling • cystocele (are these things we would notice this early pp?) • rectocele • Prolapse • Cervical tear • Broken coccyx • Pubis symphysis separation • Visual observation • Palpate externally

		• Internal assessment • External rectal exam • Consider internal digital rectal exam
	5.5	Explain the steps to evaluate pelvic floor and genital area for damage following birth.
		• Visual observation • Palpate externally • Internal assessment • External rectal exam • Consider internal digital rectal exam
	5.6	Identify circumstances when perineal damage may not require repair.
		• Lacerations with approximation and hemostasis • Abrasions / skid marks
	5.7	List the types of perineal damage which requires transfer of care.
		• 3rd and 4th degree perineal tears.
	5.8	Explain the possible consequences of not repairing a perineal injury.
		• Urinary incontinence • Fecal incontinence • Pain with intercourse • Organ prolapse • Pelvic, perineal, vaginal pain • Infection • Hematoma
	Anesthetics	
	5.9	What are disadvantages of using local anesthetic for genital repair?
		• Causes swelling • prolongs postpartum paid • potential adverse reaction
	5.10	Explain pros and cons of local anesthetics; amide vs. ester based.
		Amides (Ex: Lidocaine) <u>Pros</u>

		• Quicker onset of action (immediate to 30 seconds). • Numbs more effectively. • Longer duration of numbness (about two hours). <u>Cons</u> • Shorter duration of numbness (average 20-30 minutes). • Can't use if allergic to Lidocaine or any Amide drugs. • High dose vitamin C will interfere with absorption. Esters (Ex: Novocaine) <u>Pros</u> • A good alternative if allergic to Amide drugs. <u>Cons</u> • Slower onset of action (2 to 5 minutes). • Doesn't numb as effectively. • Shorter duration of numbness (about an hour). • Can't use if allergic to Novocaine or any Ester drugs. • More common allergic reactions.
	5.11	Explain the pros and cons of epinephrine in local anesthetics with added epinephrin are not used for genital repairs.
		<u>Pros</u> • Constricts blood vessels and slows bleeding. • Prolongs duration of numbness. • Slows absorption allowing for a larger dose with less risk of toxicity. <u>Cons</u> • Prolongs the time it takes the body to disperse anesthetic from the perineal area, prolonging swelling while impairing circulation and oxygenation. • Can be used if necessary for a very bloody repair, but generally contraindicated for perineal repair. • Always contraindicated for a skin tag, labial, or periurethral tear or anywhere that has small blood vessels (if the small vessels are constricted (epinephrine is a vasoconstrictor) blood flow will slow, and the tissue may die from inadequate circulation. • Should never be used in combination with an oxytocic drug (combination can lead to severe hypertension).

		• Common side effects of epinephrine include rapid heart rate, palpitations, and chest pain, anxiety, headaches, etc. • Can intensify afterbirth pains.
	5.12	Explain use of approved local anesthetics, including route administrations.
		<u>Route Administration</u> • Into perineal, labial, vulval tissue via injection for the purpose of nerve block prior to repair of laceration. • Topical application prior to infiltration.
	Labial Lacerations	
	5.13	Explain equipment needed to effectively repair 1st and 2nd degree and labial lacerations.
		• Sterile drapes and gloves • Needle Driver (forceps) • Suture Scissors • Suture • Irrigation or cleansing solution • Tissue forceps • Light • Gauze • Anesthetic • 10-ml syringe with a 22-gauge needle
	Suturing	
	5.14	Explain the differences between synthetic and organic sutures.
		<u>Synthetic (Ex: Vicryl)</u> • Minimal acute inflammatory tissue reaction, longer staying power (keeps wound edges together longer and minimizes the risk of wound dehiscence (separation of the edges). Disadvantages: fragments might remain in tissue long after healing is complete, causing local irritation and necessitating removal, and braided strands can harbor bacteria which can lead to infection. <u>Organic (Ex: Chromic gut)</u> • Designed to be broken down by production of enzymes that act on any foreign material and attempt to break it down, therefore it produces more of an inflammatory response. Tensile strength greatly reduced by 10-14 days and

		usually completely broken down by 6-8 weeks. If infection is present, suture breaks down more quickly, which is an advantage. Has more 'package memory' which mean it holds kinks or bends instead of laying flat.
	5.15	Explain the differences in needle size and the most appropriate use of each.
		• 2-0 gut or synthetic for anal, rectal, or lateral vaginal injuries. • 3-0 gut or synthetic for most genital repairs. • 4-0 synthetic for fine labial, clitoral or periurethral repairs. • The lower the number, the larger the strand of suture is and the greater the tensile strength. Chromic gut strands are larger than synthetic suture strands in general. • CT-1 taper point half-circle needle for most repairs including vagina and perineum (this is the largest needle we would use). • CT-2 taper point half-circle needle for skin, shallow sutures near skin or shallow vaginal tears (this is the medium sized needle). • SH taper point half-circle needle for labial tears, skin tags (this is the smallest needle we would use).
	5.16	Explain the differences in the cutting edge and most appropriate use of each.
		• <u>Taper</u> – sharp tip and smooth edges, which are ideal for subcutaneous tissue as they are difficult to pass through the skin. (This needle recommended for genital repair). • <u>Cutting</u> – sharp tip and edges making it ideal for penetrating skin and placing skin sutures. (This needle is not recommended for genital repair). • <u>Taper Cutting</u> – curved needles with ½ circle can be used for everything. (This needle is not recommended for genital repair).
	5.17	Demonstrate the correct use of a needle holder to make an instrument tie.
		• Refer to skills examination for correct administration.
	5.18	Explain the pros and cons of instrument ties.
		<u>Pros</u> • Safer (less risk of needle poke). • Easier to reach things in a tight space with instruments. • Provider preference. <u>Cons</u> • Harder to learn.
	5.19	Explain pros and cons of hand ties.

		<u>Pros</u> • Provider preference. <u>Cons</u> • Risk of needle stick.
	5.20	List steps for first degree repair.
		• Refer to skills exam for correct administration.
	5.21	List steps for Second degree repair.
		• Refer to skills exam for correct administration.
	5.22	List steps for labial repair.
		• Refer to skills exam for correct administration.
	5.23	Explain how to maintain aseptic technique while suturing.
		• Hand washing • Gloving • Sterile equipment
	5.24	Explain the benefits of a running mattress stitch for closure of perineal skin.
		• Less scarring • Fewer undissolved stitches • Less pain
	Practical Applications	
	5.25	Demonstrate dual instrument suturing techniques and other practitioner safety techniques.
		• Refer to skills exam for correct administration.
	5.26	Demonstrate instrument and hand tie suturing techniques and other practitioner safety techniques.
		• Refer to skills exam for correct administration.
	5.27	Demonstrate four basic stitches.
		• Interrupted – refer to skills examination for correct administration. • Basting - refer to skills examination for correct administration.

		• Lock blanket - refer to skills examination for correct administration. • Running mattress - refer to skills examination for correct administration.

End of Section 5.00 SUTURING

AMEND: 332-015-0050

RULE SUMMARY: Examinations and retake examination requirements.

CHANGES TO RULE:

332-015-0050
~~NARM Midwifery Examination~~ Examinations for Licensure and Retake Examination Requirements
~~The qualifying examination is the NARM examination. An applicant is responsible for payment of all fees for NARM applications, examinations, and any other fees paid directly to NARM~~(1) Pursuant to ORS 687.420 the Board may establish standard qualifications for licensure including but not limited to requiring passage of a Board approved examination. ¶
(2) The Board has determined that an applicant for a license or renewal of a license must pass the Legend Drugs and Devices examination to purchase and administer authorized scheduled legend drugs and devices used in pregnancy, birth, postpartum care, newborn care, and resuscitation. ¶
(3) The Legend Drugs and Devices examination consists of the following four parts:¶
(a) The written examination which consists of multiple-choice questions related to pharmacology, administration of medications through injection, intravenous therapy, treatment of shock and suturing.¶
(b) The skills examinations consist of three parts that assess the applicant's skills on how to safely administer authorized scheduled legend drugs. The three skills examinations are:¶
(A) Administration of medication through injection.¶
(B) Administration of intravenous fluids.¶
(C) Suturing. ¶
(4) The skills examinations listed in subsection (3)(b) of this rule must be supervised and conducted by a proctor who has met all requirements listed in OAR 332-015-0075 and has been approved by the Office.¶
(5) The skills examinations listed in subsection (3)(b) of this rule may be conducted and supervised by different proctors. Each proctor must meet all requirements listed in OAR 332-015-0075 and be approved by the Office prior to conducting a skills examination. ¶
(6) The skills examinations listed in subsection (3)(b) of this rule are valid for three years and must be kept current.¶
(7) An applicant is responsible for payment of all examination fees including but not limited to fees paid directly to an approved proctor.¶
(8) An applicant who does not pass the written examination listed in subsection (3)(a) of this rule may retake the written examination the next business day. ¶
(9) An applicant who does not pass a skills examination listed in subsection (3)(b) of this rule may retake that portion of the skills examination the next business day up to three times. ¶
(10) An applicant who has failed any portion of the skills examination listed in subsection (3)(b) of this rule three times must wait six months before retaking that skills examination for the fourth time.
Statutory/Other Authority: ORS 676.615, ORS 687.48~~0, 687.48~~5, ORS 687.420, ORS 687.493, ORS 687.425
Statutes/Other Implemented: ORS ~~676.615, 687.480,~~87.420, ORS 687.493, ORS 687.48~~2~~5

ADOPT: 332-015-0075

RULE SUMMARY: Requirements to become a proctor for the legend drugs and devices skills examinations.

CHANGES TO RULE:

332-015-0075
Legend Drugs and Devices Skills Examination: Proctor Application and Requirements
(1) To be an approved proctor for a skills examination portion of the examination listed in OAR 332-015-0050 an individual must:¶
(a) Submit a completed application on a form prescribed by the Office, which must contain the information listed in OAR 331-030-0000.¶
(b) Submit proof of holding a qualifying credential or authorization listed in subsection (2), (3) or (4) of this rule that is active with no current disciplinary action imposed by the Board or other regulatory body. ¶
(2) To be approved to proctor the administration of medication through injection skills examination the applicant must be one of the following:¶
(a) Oregon Licensed Direct Entry Midwife.¶
(b) NARM Certified Professional Midwife.¶
(c) Oregon Registered Nurse.¶
(d) Oregon Certified Nurse Midwife.¶
(e) Oregon Licensed Paramedic.¶
(f) Oregon Licensed Advanced Emergency Medical Technician.¶
(g) Oregon Licensed Medical Doctor. ¶
(h) Oregon Licensed Doctor of Osteopathic Medicine. Or¶
(i) Oregon Licensed Doctor of Naturopathy.¶
(3) To be approved to proctor the intravenous therapy skills examination the applicant must be one of the following:¶
(a) Oregon Licensed Direct Entry Midwife.¶
(b) NARM Certified Professional Midwife.¶
(c) Oregon Registered Nurse.¶
(d) Oregon Certified Nurse Midwife.¶
(e) Oregon Licensed Paramedic.¶
(f) Oregon Licensed Advanced Emergency Medical Technician.¶
(g) Oregon Licensed Medical Doctor.¶
(h) Oregon Licensed Doctor of Osteopathic Medicine. Or¶
(i) Oregon Licensed Doctor of Naturopathy.¶
(4) To be approved to proctor the suturing skills examination the applicant must be one of the following:¶
(a) Oregon Licensed Direct Entry Midwife.¶
(b) NARM Certified Professional Midwife.¶
(c) Oregon Certified Nurse Midwife.¶
(d) Oregon Licensed Medical Doctor.¶
(e) Oregon Licensed Doctor of Osteopathic Medicine. Or¶
(f) Oregon Licensed Doctor of Naturopathy.¶
(5) Prior to proctoring a skills examination listed in subsection (2), (3) or (4) of this rule, written approval must be received by the Office. Written approval may be obtained by the Office electronically.¶
(6) A person applying to be an approved proctor who does not meet the requisite requirements listed in subsection (2), (3) or (4) of this rule may submit satisfactory documentation to the office that demonstrates the applicant has substantially equivalent education and training in legend drugs and devices to those individuals listed in the requisite subsection (2), (3), or (4) of this rule, this may include training received outside of Oregon.¶
(7) A skills examination listed in subsection (2), (3) or (4) of this rule must be performed under direct supervision of an approved proctor. Supervision may be in person or virtual in real time.¶
(8) An approved proctor must:¶
(a) Supervise only one examinee, at a time.¶
(b) Exercise management, guidance, and control over the portion of the examination being administered and exercise professional judgment during the examination.¶
(c) Exercise professional judgment.¶
(d) Follow the skills examination(s) guidelines prescribed by the Office, verifying only the steps performed by the examinee.¶
(e) Document the skills performed under OAR 332-015-0050(3)(b) by the examinee, on a form prescribed by the Office.¶

(f) Maintain the skills examination documentation for a minimum of five (5) years following completion of the skills examination.¶
(g) Documentation listed under subsection (8)(f) of this rule may be stored electronically.¶
(h) Respond to all requests for information from the Office related to the skills examination(s).¶
(9) An approved proctor is responsible for all matters relative to the examinee during the skills examination.¶
(10) An approved proctor may also provide legend drugs and devices education listed under OAR 332-015-0040.¶
(11) An approved proctor must submit proof to the Office each time an applicant or licensee has passed a skills examination listed in OAR 332-015-0050. The proof must be submitted on a form prescribed by the Office.
Statutory/Other Authority: ORS 676.615, ORS 687.485, ORS 687.420, ORS 687.425, ORS 687.493
Statutes/Other Implemented: ORS 687.420, ORS 687.425, ORS 687.493

ADOPT: 332-015-0077

RULE SUMMARY: Qualification and Requirements to take the legend drugs and devices written examination.

CHANGES TO RULE:

332-015-0077
Qualification and Requirements for Legend Drugs and Devices Written Examination
(1) Before an individual can take the written portion of the examination listed in OAR 332-015-0050 the individual must submit a form prescribed by the Office, which must contain the information listed in OAR 331-030-0000, and be accompanied by payment of all required fees.¶
(2) An individual must receive approval from the Office to take the written portion of the examination listed in OAR 332-015-0050. All documentation must be received and verified prior to taking the written portion of the examination.
Statutory/Other Authority: ORS 676.615, ORS 687.485, ORS 687.420, ORS 687.425, ORS 687.493
Statutes/Other Implemented: ORS 687.420, ORS 687.425, ORS 687.493

AMEND: 332-020-0000

RULE SUMMARY: License and renewal requirements for a licensed direct entry midwife.

CHANGES TO RULE:

332-020-0000
License Issuance and Renewal ¶

(1) LICENSING: An LDM is subject to the provisions of OAR Chapter 331, Division 30 regarding the issuance and renewal of a license, and provisions regarding authorization to practice, identification, and requirements for issuance of a duplicate license.¶
(2) LICENSE RENEWAL: To avoid delinquency penalties, license renewal must be made prior to the license entering inactive status. To renew, an LDM must:¶
(a) Submit a renewal application form~~;~~.¶
(b) Submit payment of renewal fee~~;~~.¶
(c) Attest to having obtained required continuing education under OAR 332-020-0010, on a form prescribed by the Office~~;~~.¶
(d) Attest to being currently certified in cardiopulmonary resuscitation for infants and adults pursuant to ORS 687.425~~;~~.¶
(e) Attest to being currently certified in neonatal resuscitation~~; and~~.¶
(f) Attest to having participated in peer review pursuant to 332-025-0015.¶
(g) Attest to having passed the Legend Drugs and Devices examination as listed in OAR 332-015-0050 within the last three years.¶
(3) INACTIVE LICENSE RENEWAL: A license may be inactive for up to three years. When renewing after entering inactive status the LDM must:¶
(a) Submit a renewal application form~~;~~.¶
(b) Submit payment of renewal and delinquency fees~~;~~.¶
(c) Attest to having obtained required continuing education under OAR 332-020-0010, on a form prescribed by the Office, whether license is current or inactive~~;~~.¶
(d) Attest to being currently certified in cardiopulmonary resuscitation for infants and adults pursuant to ORS 687.425~~;~~.¶
(e) Attest to being currently certified in neonatal resuscitation~~; and~~.¶
(f) Attest to having participated in peer review pursuant to 332-025-0015.¶
(g) Attest to having passed the Legend Drugs and Devices examination as listed in OAR 332-015-0050 within the last three years.¶
(4) EXPIRED LICENSE: A license that has been inactive for more than three years is expired and the licensee must reapply and meet the requirements listed in OAR 332-015-0030.¶
(5) An LDM must maintain documentation and records required for renewal of a license for at least five years. This information may be stored electronically and may be subject to an audit or inspection by the Office.
Statutory/Other Authority: ORS 676.~~568~~615, ORS 6~~76.572~~87.485, ORS 6~~76.576~~87.420, ORS 687.425, ORS 687.493
Statutes/Other Implemented: ORS 6~~76.572~~87.420, ORS 687.425, ORS 687.493

AMEND: 332-020-0010

RULE SUMMARY: Continuing education requirements for a licensed direct entry midwife.

CHANGES TO RULE:

332-020-0010
Continuing Education ¶

(1) Standard Continuing Education Renewal Requirements: To maintain licensure, an LDM must complete at least ~~35~~18 continuing education hours every ~~two~~ years ~~from~~ the date of initial licensure~~, and every two years thereafter~~. Continuing education under this rule must be related to the services listed in ORS 687.405, cultural competency, patient charting, ethics, communication, or professional development.¶
(2) In addition to the requirements listed in section (1) of this rule ~~fiv~~, one of the ~~35~~18 hours listed in subsection (1) of this rule must be related to legend drugs and devices ~~pursuant to OAR Chapter 332, Division 26, which must include at least one (1) of the following:¶~~
~~(a) P~~and ~~p~~harmacology, covering drugs listed in ORS 687.493, OAR 332-026-0010 and OAR 332-026-0020.¶
(~~b~~3) ~~Administration of medications through injection.¶~~
~~(c) Advanced treatment of shock.¶~~
~~(d) Intravenous therapy.¶~~
~~(e) Suturing.¶~~
~~(3) Initial Legend Drugs and Devices Continuing Education: An LDM must complete 40 hours of instruction in an approved curriculum prior to purchasing or administering legend drugs and devices listed in OAR Chapter 332, Division 26 of these rules or by the date of first renewal following initial licensing as an LDM. The initial continuing education is comprised of theory, hands-on practice, and skills testing for competency which must include:¶~~
~~(a) 10 hours in pharmacology, covering drugs listed in ORS 687.493, OAR Chapter 332, Division 26 including;¶~~
~~(b) Four hours of administration of m~~In accordance with ORS 687.425, an LDM who attended fewer than five births during the previous renewal year must complete an additional 10 hours of continuing ed~~i~~u~~cation~~s ~~through injection;¶~~
~~(c) Four hours in advanced treatment of shock;¶~~
~~(d) 12 hours in intravenous therapy; and¶~~
~~(e) 10 hours in suturing.¶~~
~~(4) In addition to the requirements listed in subsection (1) of this rule and in accordance with ORS 687.425, an LDM who has attended fewer than five births in the previous renewal year must obtain an additional 10 hours of continuing education~~ during the next renewal cycle.¶
(a) The additional 10 hours must be separate from all other continuing education requirements.¶
(b) The additional ~~10~~ hours ~~of continuing education must be obtained during the next license renewal cycle. The additional 10 hours of continuing education must be related to~~must cover subjects listed in subsection (1) of this rule.¶
(c) An example pertaining to the timing of when the additional 10 hours of continuing education must be obtained is: An LDM who held a license from April 20~~18~~24 to April 20~~19~~25 who attended fewer than five births during that time period must obtain an additional 10 continuing education hours between April 20~~19~~25 and April 202~~0~~6.¶
(~~5~~4) Continuing education may be obtained through online courses, attendance at lectures, sessions, courses, workshops, symposiums seminars or other presentations offered by:¶
(a) Institutions or programs accredited by a federally recognized accrediting body~~;~~.¶
(b) Institutions or programs approved by the Oregon Higher Education Coordinating Commission~~;~~.¶
(c) An organization offering continuing medical education opportunities, including legend drugs and devices training, including but not limited to, Accreditation Council for Continuing Medical Education, MEAC accredited or pre-accredited schools and the Oregon Midwifery Council~~; o~~. Or¶
(d) Any Board-approved professional organization, or association, hospital, or health care clinic offering continuing education related to the subject matter listed in subsection (1) ~~or (7)~~ of this rule.¶
(~~6~~5) Continuing education relating to the subject matter listed in subsection (1) of this rule may also be obtained through research, authorship or teaching, provided that no more than half the required hours be in research, authorship or teaching.¶
(~~7~~6) Up to ~~10~~(5) hours of continuing education relating to subject matter listed in subsection (1) of this rule may be completed through self-study that may include clinical service learning. Documentation substantiating the completion of continuing education through self-study must be ~~submitted on forms provided by the Office.~~maintained by the licensee. ¶
(~~8~~7) Notwithstanding any other continuing education requirements and of the ~~35~~18 continuing education hours listed under subsection (1) of this rule, in order to be eligible to renew a license, an authorization holder must

obtain one hour of continuing education in cultural competency (CCCE) every other time the authorization is subject to renewal. The requirement of this paragraph is effective on and after July 1, 2021. The CCCE must be either:¶
(a) Approved by the Oregon Health Authority~~; o~~. Or¶
(b) Meet the skills requirements established by the Oregon Health Authority by rule~~; o~~. Or¶
(c) One of the educational institutions or organizations listed in subsection (4) of this rule which are in compliance with one of the requirements listed in subsection (~~8~~7) of this rule.¶
(~~9~~8) The Board encourages completion of required CCCE from the approved list promulgated by the Oregon Health Authority, available on the Board's website. The Board shall also accept CCCE that is not obtained from the Oregon Health Authority's approved list, to the extent the Board determines the CCCE meets the skills requirements established by the Oregon Health authority in rules that are effective at the time the CCCE is obtained.¶
(~~10) Section (8) does~~9) Requirements listed in subsection (8) of this rule do not apply to the authorization holders who are:¶
(a) Retired and not practicing the profession in any state~~;~~.¶
(b) Not practicing the profession in this state~~; o~~. Or¶
(c) Residing in this state~~,~~ but not practicing in the profession in any state.¶
(1~~1~~0) Obtaining and maintaining proof of participation in continuing education is the responsibility of the licensee. The licensee must ensure that adequate proof of attainment of required continuing education is available for audit or investigation or when otherwise requested by the Office. Adequate proof of participation is listed under OAR 332-020-0015~~(3)~~.¶
(1~~2~~1) Hours of continuing education that are obtained in excess of the minimum requirements listed in this rule will not be carried forward.¶
(1~~3~~2) Documentation of participation in continuing education requirements must be maintained for five years following renewal and must be available to the Office upon request.¶
(14~~3~~) For the purpose of this rule, continuing education must include periods of continuous instruction and education. One hour of continuing education is one hour of actual class time, not to include breaks, rest periods, travel, registration or meals.~~¶~~
~~(15) A copy of Board-approved curriculum objectives January 2021 Legend Drugs and Devices Program is available at the Health Licensing Office or on the Office website. Payment of administrative fees may be required. Refer to OAR 331-010-0030 for applicable public record request fees.¶~~
~~(16) Requirements listed under OAR 332-020-0000 cannot be used towards the continuing education requirements listed in this rule.~~
Statutory/Other Authority: ORS 687.425, ORS 676.615, ORS 6~~76.850~~87.485, ORS 687.420, ORS 687.493
Statutes/Other Implemented: ORS 687.425, ORS 6~~76.850~~87.420, ORS 687.493

AMEND: 332-020-0015

RULE SUMMARY: Continuing education audit and required documentation if a license holder is audited.

CHANGES TO RULE:

332-020-0015
Continuing Education: Audit and Required Documentation
(1) The Office will audit a select percentage of licensees determined by the Board to verify compliance with continuing education requirements.¶
(2) An LDM notified of selection for audit of continuing education attestation must be submitted to the Office, within 30 calendar days from the date of notification, satisfactory evidence of participation in required continuing education in accordance with OAR 332-020-0010.¶
(3) If selected for audit, an LDM must provide documentation of the required continuing education. Documentation must include:¶
(a) Certificate of completion, official transcript, statement or affidavit from the sponsor attesting to attendance or other documentation approved by the Office;.¶
(b) Name of sponsoring institution, association, or organization;.¶
(c) Title of presentation and description of content;.¶
(d) Name of instructor or presenter;.¶
(e) Date of attendance and duration in hours; a. And¶
(f) Course agenda.¶
(4) If documentation of continuing education is incomplete, the licensee has 30 calendar days from the date of the notice sent to the licensee to submit further documentation to substantiate having completed the required continuing education.¶
(5) An LDM notified of having been selected for an audit must show proof of having:¶
(a) Participated in peer review pursuant to OAR 332-025-0015;.¶
(b) The required certification in cardiopulmonary resuscitation for infants and adults; and.¶
(c) The required certification in neonatal resuscitation. And¶
(d) Having passed the Legend Drugs and Devices examination as listed in OAR 332-015-0050 every three years.¶
(6) Documentation listed in subsection (5) of this rule must be kept and maintained for five years following renewal and must be available to the Office upon request.
Statutory/Other Authority: ORS 676.568, ORS 676.615, ORS 687.425
Statutes/Other Implemented: ORS 687.425

AMEND: 332-026-0000

RULE SUMMARY: Requirements for purchasing, administering and storing legend drugs and devices.

CHANGES TO RULE:

332-026-0000
Access to and Administration of Legend Drugs and Devices ¶

(1) ~~An LDM is prohibited from purchasing or administering legend drugs and devices, until the continuing education listed in OAR 332-020-0010 has been completed and attestation submitted to the Office upon renewal.¶~~
~~(2) Pursuant to ORS 687.493, an LDM who completes the continuing education listed in OAR 332-020-0010 is authorized to purchase and administer legend drugs and devices listed in OAR 332-026-0010, 332-026-0020, and 332-026-0030.¶~~
~~(3)~~ An LDM must comply with all local, state and federal laws and regulations regarding the administration, distribution, storage, transportation and disposal of legend drugs and devices listed in OAR 332-026-0010, 332-026-0020, 332-026-0030.¶
(4~~2~~) Approved legend drugs must be inventoried and securely stored when the product is not in use, including samples or any remaining portion of a drug.¶
(5~~3~~) Records regarding approved legend drugs and devices must be maintained for five years. Records must be kept on the business premises and available for inspection upon request by the Office. Upon request by the Board or Office, an LDM must provide a copy of records. Records must include, but are not limited, to the following:¶
(a) Name of drug, amount received, date of receipt, and drug expiration date~~;~~.¶
(b) Name of drug and to whom it was administered; date and amount of drug administered to client~~;~~.¶
(c) Name of drug, date and place or means of disposal.¶
(6~~4~~) Expired, deteriorated or unused legend drugs must be disposed of in a manner that protects the LDM, client and others who may come into contact with the material during disposal.¶
~~(7) An LDM is required to obtain education and training before administering or purchasing any legend drug or device.¶~~
~~(8) An LDM is not required to administer and purchase any legend drugs or devices.~~
Statutory/Other Authority: ORS 676.615, ORS 687.~~7~~4493, ORS 687.485, ORS 687.480
Statutes/Other Implemented: ORS 687.~~7~~4493, ORS 687.480

AMEND: 332-026-0010

RULE SUMMARY: List of approved legend drugs for maternal use.

CHANGES TO RULE:

332-026-0010
Approved Legend Drugs For Maternal Use ¶

An LDM may administer the following legend drugs as approved by the Board for maternal use:¶
(1) Anti-Hemorrhagics for use by intramuscular injection i~~ncludes~~s limited to:¶
(a) Synthetic Oxytocin (Pitocin, Syntocin and generic);¶
(b) Methylergonovine (Methergine); ~~or~~¶
(c) Ergonovine (Ergotrate); ¶
(2) Anti-Hemorrhagics by intravenous infusion is limited to:¶
(a) Synthetic Oxytocin (Pitocin, Syntocin, and generic); ~~or~~¶
(b) Tranexamic acid.¶
(3) Anti-Hemorrhagics for oral administration is limited to:¶
(a) Methylergonovine (Methergine);¶
(b) Misoprostol (Cytotec).¶
(4) Anti-Hemorrhagics for rectal administration is limited to Misoprostol (Cytotec).¶
(5) Resuscitation is limited to medical oxygen and intravenous fluid replacement.¶
(6) Intravenous fluid replacement i~~ncludes~~s limited to:¶
(a) Lactated Ringers Solution;¶
(b) 0.9% Saline Solution;¶
(c) D5LR (5% Dextrose in Lactated Ringers); or¶
(d) D5W (5% Dextrose in water).¶
(7) Anaphylactic treatment by subcutaneous injection is limited to Epinephrine.¶
(8) Local anesthetic includes:¶
(a) Lidocaine HCl (1% and 2%) (Xylocaine and generic);¶
(b) Topical anesthetic;¶
(c) Procaine HCl (Novocain, benzocaine, cetacane and generic); ~~and~~¶
(d) Sterile water papules.¶
(9) Rhesus Sensitivity Prophylaxis is limited to Rho(d) Immune Globulin (RhoGAM, Gamulin Rh, Bay Rho-D and others).¶
(10) Tissue adhesive (Dermabond or generic).¶
(11) Intravenous antibiotics for Group B Streptococcal prophylaxis is limited to the following and is only to be used solely for the purpose of Group B Streptococcal prophylaxis:¶
(a) Penicillin;¶
(b) Ampicillin;¶
(c) Cefazolin; ~~or~~¶
(d) Clindamycin.
Statutory/Other Authority: ORS 676.615, ORS 687.493, ORS 687.480, ORS 687.485
Statutes/Other Implemented: ORS 687.493, ORS 687.480

AMEND: 332-026-0020

RULE SUMMARY: List of approved legend drugs and devices for neonatal use.

CHANGES TO RULE:

332-026-0020
Approved Legend Drugs For Neonatal Use ¶

An LDM may administer the following legend drugs as approved by the Board for neonatal use:¶
(1) Eye Prophylaxis for disease of the newborn is limited to Erythromycin Ophthalmic (0.5%) Ointment (Ilotycin, AK-Mycin and generics).¶
(2) Prophylaxis for hemorrhagic disease of the newborn for oral use is limited to Mephyton.¶
(3) Prophylaxis for hemorrhagic disease of the newborn for intramuscular injection includes:¶
(a) AquaMephyton; ~~and~~¶
(b) Konakion.¶
(4) Resuscitation is limited to medical oxygen.
Statutory/Other Authority: ORS 676.615, ORS 687.493, ORS 687.485, ORS 687.480
Statutes/Other Implemented: ORS 687.493, ORS 687.480

AMEND: 332-026-0030

RULE SUMMARY: List of approved devices.

CHANGES TO RULE:

332-026-0030
Approved Devices ¶

An LDM may use the following Board approved devices:¶
(1) Devices for injection of medications including:¶
(a) Needles.¶
(b) Syringes.¶
(2) Devices for administration of intravenous fluids including:¶
(a) Drip sets.¶
(b) Catheters.¶
(3) Devices for maternal and neonatal resuscitation including:¶
(a) Suction devices;¶
(b) Oxygen-delivery devices.¶
(c) Bag-Valve-Mask-Sets.¶
(d) Airway adjunct.¶
(4) Devices for rupturing the amniotic sac.¶
(5) Devices for repairing the perineal area including:¶
(a) Sutures;¶
(b) Instruments for completing a repair.¶
(c) Local anesthetic administration devices.
Statutory/Other Authority: ORS 676.615, ORS 687.493, ORS 687.485, ORS 687.480
Statutes/Other Implemented: ORS 687.493, ORS 687.480

AMEND: 332-040-0000

RULE SUMMARY: Fees collected for services rendered.

CHANGES TO RULE:

332-040-0000
Fees ¶

(1) An applicant and licensee are subject to the provisions of OAR 331-010-0010 and 331-010-0020 regarding payment of fees, penalties and charges.¶
(2) Fees established by the Office pursuant to ORS 676.576 are as follows:¶
(a) Application:¶
(A) License: $150.¶
(B) License by reciprocity: $750.¶
(b) ~~E~~Written examination - ~~Oregon laws & rul~~Legend Drugs and Devices: $50.¶
(c) Original issuance of license: $800 for one year.¶
~~(d) Renewal - License: $800 for one year.¶~~
~~(e) Reactivation of license: $150.¶~~
~~(f~~¶
(d) License renewal: $800 for one year.¶
(e) Other administrative fees:¶
(A) Delinquency fee: $50 for each year the license is inactive for up to three years.¶
(B) Replacement of license, including name change: $25.¶
(C) Duplicate license document: $25~~ per copy, with a maximum of three.~~ ¶
(D) Affidavit of licensure ~~for reciprocity~~credential: $50.¶
(E) An additional $25 administrative processing fee will be assessed if a non-sufficient funds or non-negotiable instrument is received for payment of fees, penalties and charges. Refer to OAR 331-010-0010.¶
~~(3) As of April 1, 2020, an applicant applying for an original license totaling $800 may be granted a $350 license fee discount for a total cost for the license $450 until July 1, 2024. An application fee of $150 must be paid in order to grant the $350 license fee discount. The license fee discount is available to individuals who meet all application requirements for direct entry midwifery licensure under OAR 332-015-0030 and reside in Oregon. ¶~~
~~(4) As of April 1, 2020, an applicant applying to renew a license totaling $800 may be granted a $200 discount for a total cost for the license $600 until July 1, 2024. The license fee discount is available to individuals who meet all renewal requirements for direct entry midwifery licensure under OAR 332-020-0000 and reside in Oregon.~~
Statutory/Other Authority: ORS 676.576, ORS 676.615, ORS 676.625, ORS 676.568, ORS 687.420, ORS 687.425
Statutes/Other Implemented: ORS 676.576, ORS 676.615,~~ ORS 676.625, ORS 676.568,~~ ORS 687.420, ORS 687.425