Australian Nursing & Midwifery Accreditation Council

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Accreditation standards review

Written submission form

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Standards Review
12 August 2020

I am a professor of Midwifery engaged in research, education and clinical care, and am pleased to have the opportunity to respond to the third stage of the consultation in the 'Review of Midwife Accreditation Standards' Consultation Paper 3.

QUESTION 1

The educational preparation for prescribing outlined in the draft accreditation standards will prepare graduates to safely prescribe scheduled medicines within the scope of midwifery practice. Please indicate your agreement/disagreement with this statement using the following options. Yes/ No Unsure/other. Where possible please provide a rationale to support your response.

No.

Rationale

I have responded 'no' to this question because I do not support the inclusion of prescribing as part of the education in entry-to-practice midwifery programs.

While the consultation paper describes 55% of responses were in favour of including education for prescribing in entry-to-practice midwifery programs, this is taking all responses as equal, and giving no additional weight to responses of those representing organisations (such as the Royal Women's, or the ANMF etc) or groups.

While the respondents 'in favour' of the inclusion of prescribing in the education for entry-to-practice midwifery programs reason that this supports **for the full scope of midwifery practice, I consider other aspects much more relevant – such as the skills of suturing and cannulation – these are skills that are needed in time critical circumstances, and can save lives as well as improve care.** It was also stated that including prescribing would improve women's quality of care and make better use of the midwifery workforce. I don't agree with either of these reasons either - the vast majority of midwifery care provided across the country is in hospitals, and the workforce is already well used, with a substantial amount of data suggesting women are satisfied with their care. In many organisations midwives can already undertake limited 'prescribing' based on standard orders, and having graduate midwives educated to prescribe will not greatly enhance our service, and does not value-add for most places.

I would prefer enhanced consolidation of basic skills, not this advanced skill. There are many more salient skills to ensure a quality midwifery workforce. The students have so many skills to learn and consolidate, so my view is that prescribing should be considered an advanced skill that can be undertaken as a postgraduate qualification.

There is a lack of evidence to robust evidence to support this change to the Standards, and given this and the above points, I do not support the inclusion of prescribing in the education for midwifery entry-to-practice.

QUESTION 2
***Do the draft accreditation standards cover the required knowledge, skills and attitudes to ensure that the graduate meets the NMBA Midwife standards for practice*?**

Response: No

Rationale:

There are a number of outcomes from the second round of consultation which I do not agree with. The reasons I do not consider the outcomes were based adequately on the feedback are:

- **Firstly**, as described above, is that all responses to the consultation were considered as equal, and no additional weight was given to responses of those representing major organisations such as or groups. Equal weight was given to individual responses. This is unacceptable in my view. If this decision-making strategy had been transparent previously I would have advised all the midwives employed at the Women's and elsewhere to submit individual responses. Instead I assumed their voices and views would have been heard as part of organisational submissions – but it seems this was not the case.
- **Secondly**, the evidence presented was not adequately taken into account – and I assume this is for the same reason – that the majority of 'respondents' did not cite it. *This is not a reason for disregarding evidence.*

1. The first area of concern is that **the current draft of the Standards does not reflect the best evidence regarding requirement for students to attend the majority of births for Continuity of Care Experiences (COCEs).**

The ANMAC review process is to use the 'best available evidence and relevant national and international benchmarks' to develop the standards. But this process has not been applied here. The largest study conducted to date in Australia (Newton et al, Continuity of Care Experience Research: Summary for Participants, August 2020), reported that although the value of COCEs was recognised and appreciated by students, there was a substantial burden on individuals with particular concern identified regarding the requirement to attend a majority of births when this requirement is often beyond a student's control. The study also raised major concerns about impact on the personal lives of students and concerns about personal safety.

In the draft standards the rationale for the decision that this standard will be remaining unchanged, and that the students must attend the "majority of labour and births" for their COCEs is that the majority of 'respondents' were in favour of this – and again I am extremely disappointed at this interpretation of *one response=one person* and that all responses count equally, and that somehow attending the majority of the births translates into the *embodiment of woman-centred care*. **Yet the other side of the argument was not taken into account, despite being based in evidence.** The respondents supported attendance "where possible", and cited difficulties experienced by students including not being notified the woman was in labour, having to travel long distances to be with the woman, compulsory attendance at lectures/tutorials and unable to be released from a rostered practice commitment. **Why is this not important? What happens when safety is compromised? Why are the study findings about the major concerns about the impact on the personal lives of students and concerns about personal safety not relevant compared with an arbitrary decision to count each response as equal?**

The draft standards **should be amended to state that the student attends the majority of labour and births 'where possible'** with a footnote included that defines the circumstances in which a student could not attend (e.g. woman not calling the student or choosing not to have her/him present, hospital refusing permission, attendance at compulsory university teaching or learning activity, attending paid employment, caring duties or precipitate birth).

2. Other concerns related to labour and birth care and ***the required knowledge, skills and attitudes to ensure that the graduate meets the NMBA Midwife standards for practice***

a) There was a section on simulation in the 2014 that has been removed in the current draft, but which relates directly to Question 2 posed here in consultation 3. The paragraph on simulated scenarios for learning relates directly to ensuring our midwifery graduates do complete their course with as many skills as possible towards being able to practice to their full scope of practice, but it has been removed, and I am not sure why. I would prefer it was back in the Standard. The paragraph is:

> *"Simulation as an educational method can provide learning conditions to develop competency in less common clinical practice areas such as maternity and neonatal emergencies, vaginal breech births, perineal infiltration and episiotomies. It may also be used to develop foundational skills including, but not limited to, venepuncture, cannulation, catheterisation, perineal repair and interpretation of fetal heart patterns".*

b) I think there is an over-focus on the student being the primary birth attendant in a very complex context. There is often interventions in labour which mean a student may have done all the labour care for a woman, but the birth is instrumental, therefore does not count as a 'primary birth attendant' birth. It is increasingly difficult for students to achieve 30 spontaneous vaginal births in many settings, and especially in regional Victoria where health services are taking less students for placement due to their reduced numbers of women having spontaneous vaginal births. Yet at the same time there are midwifery workforce shortages, and a high level of commitment to ensuring students become midwives.

Given the lack of evidence that was behind the increase to 30 births, I would like to see a more flexible approach to the way births are counted, and to see an increased value placed on the provision of direct labour care. For example, a reduction as needed on the current requirement of students being the primary birth attendant, with a reciprocal increase in the number of women where students provide direct and active care in labour.

Therefore, I ask that Standard 3.12d be amended:

- increase the number of women where students provide direct and active care in labour from 10 to 20
- reduce the number of births required where the student is the primary birth attendant from 30 to 20 when there is a reason 30 births as the primary birth attendant is not

possible, and where there is demonstrated involvement in direct and active care in labour in 20 women.

QUESTION 3
Please provide any other feedback about the content of the draft standards.

As detailed above, I believe that the draft Standards should be amended to:

1. Add a caveat to the requirement for students to attend the majority of COCE labour and births by adding the words "where possible".
2. Increase the number of women where students provide direct and active care in labour from 10 to 20 and reduce the number of births to allow flexibility where justified such that the student is the primary birth attendant is from 30 to 20
3. Add the wording around simulation back into the Standards as per our response to question 2 above.

QUESTION 4
Are there further issues that should be addressed in the revision of the Midwife Accreditation Standards that have not been discussed so far in the consultation process?

1. Add a caveat to the requirement for students to attend the majority of COCE labour and births by adding the words "where possible".
2. Increase the number of women where students provide direct and active care in labour from 10 to 20 and reduce the number of births to allow flexibility where justified such that the student is the primary birth attendant is from 30 to 20
3. Add the wording around simulation back into the Standards as per our response to question 2 above.
4. I note that the New Zealand Midwifery Accreditation Standards include reference to using discipline lead discretion when a student is close to, but not meeting, a Standards requirement at completion of the course. Our preference would be for the ANMAC Standards to incorporate similar guidance to allow flexibility in exceptional circumstances in relation to achieving the attendance and the majority of births for COCEs, and achieving 30 spontaneous vaginal births.

QUESTION 5
Any additional feedback?

1. Add a caveat to the requirement for students to attend the majority of COCE labour and births by adding the words "where possible".
2. Increase the number of women where students provide direct and active care in labour from 10 to 20 and reduce the number of births to allow flexibility where justified such that the student is the primary birth attendant is from 30 to 20
3. Add the wording around simulation back into the Standards as per our response to question 2 above.