Australian Nursing & Midwifery Accreditation Council

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Accreditation standards review

Written submission form

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Standards Review
24 July 2020

Thank you for the opportunity to respond to the Stage 3 review of the Midwife Accreditation Standards (2014).

I am a registered midwife and nurse in NSW and am currently a clinical academic holding a joint appointment between a Local Health District and a University as the Professor of Nursing and Midwifery Research. I believe my 40 years of experience as a clinician, academic, researcher and supervisor of undergraduate and postgraduate students in the field of midwifery provides me with well-informed insights into the contemporary educational preparation of future midwives and how the Standards impact on women's experience of childbirth and most importantly the quality and safety of maternity care.

I have read the consultation paper in detail and have the following comments to make in particular in relation to Standard 3 as requested.

Background

As one of the architects of the evidence-based model of care known as 'Continuity of Care', with research published in 1995 under my previous surname of Rowley (Rowley MJ, Hensley MJ, Brinsmead MW & Wlodarczyk JH. 1995, 'Continuity of care by a midwife team versus routine care during pregnancy and birth: a randomised trial.', *Med J Aust.*, vol. 163, no. 6, pp. 289-293), I am gratified to read that the Standards continue to endorse the opportunity for students of midwifery to participate in this model of care as part of their preparation for midwifery practice experience.

This model of care has been well established, through a systematic review of many robust randomised controlled trials, to provide significant benefits for women during pregnancy, childbirth and beyond (Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews 2016, Issue 4. Art. No.: CD004667. DOI: 10.1002/14651858.CD004667.pub5). It is essential therefore that students are enabled to experience this model of care during their educational preparation. Continuity of midwifery care is the gold standard of midwifery practice recognised world-wide as providing the most effective and satisfying contemporary model of maternity care for childbearing women. As the underpinning philosophy of maternity care is woman-centredness and partnership between women, their families and their midwife, it is the foundational model for the preparation of a safe, competent, midwifery professional workforce.

It must be acknowledged that not all maternity service providers in Australia offer models of Continuity of care based on the evidence of best practice. The lack of maternity service provision of Continuity of care models to which students can be attached during their CoCE therefore may raise challenges for some education providers, but not others. This issue requires some comment within the Standards in order to clarify how the requirement to complete the CoCE can be met without placing unjustified burden on the student. I offer these comments because the response to Question 1 in the review seeks further comment as to whether some programs will require extra time in order to address the requirements for the educational preparation for prescribing.

My understanding is that many programs simply add the CoCE requirements to the student's already full clinical practice program without considering how they will manage to complete all that is required. If the student is attending a rotation in a clinical setting for several weeks, as well as attending to coursework requirements including lectures or tutorials and assignment requirements, adding the CoCE at the same time adds significant unjustified burden. Undergraduate students in particular are most often self-funded so are employed outside of their program of education and may well also have family responsibilities that require time to complete. The on-call component of the CoCE must therefore be well considered when designing the midwifery practice experience. I have the following contributions to make:

1. The Standards should include some guide as to where in the program, and how, the CoCE is best provided.
2. My recommendation is that the CoCE occur in the second year of the three-year undergraduate program, as the model for <u>all</u> midwifery practice experience in second year. This would provide opportunity for the student to experience the model as intended and enable an experience of the full scope of midwifery practice.
3. The CoCE should occur within an industry provided CoCE model, where such models are provided.
4. Where no CoCE models are provided the student will be partnered with a pregnant woman and will follow her wherever she attends for care, receiving clinical supervision for the student educational experience from whichever clinician is providing the woman's care at each occasion.
5. For postgraduate students in an employed model of midwifery preparation for practice program, 3 months of their program should occur within a CoCE model of care if one exists in their employing health service, with the previous 3 months spent in Antenatal clinic
6. If no such model is available in their employing health service then the postgraduate student will be supported by the employing health service to carry a caseload of 10 women due to birth in a 3 month period in order to complete the 10 CoCE requirement, and is not required to work on a rostered shift model during this time.
7. Requiring the 10 CoCE to be completed in this way will provide time to simultaneously complete the educational preparation for prescribing.
8. Further research into how best to enable the CoCE requirement to be met should be undertaken.

<u>QUESTION 1</u> 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
<u>Rationale</u>: Completing the educational preparation for prescribing during the preparation for practice program enables the graduate to work to the full scope of practice of the midwife and improves the safety and accessibility of relevant medications for women. Meeting this requirement may also require a change to the way some programs are constructed to ensure adequate time for this component to be included. I have provided some thoughts on how this might be done in the preceding comments.

<u>QUESTION 2</u> Do the draft accreditation standards cover the required knowledge, skills and attitudes to ensure that the graduate meets the NMBA Midwife standards for practice?
Yes
<u>Rationale</u>: The continued inclusion of the CoCE requirement for attending the entire childbearing experience of 10 women is an essential component of the program that has been retained in the revised standards. I commend the review panel and the review process on considering the evidence and the opinions of the profession and education bodies in retaining the CoCE as a hallmark of the educational preparation of midwives in Australia. Research is currently underway to further articulate the pedagogical intent of the CoCE and how it can best be assessed for each student. This will inform ongoing evaluation and any potential future review and refinement of the Standards.

<u>QUESTION 3</u> Please provide any other feedback about the content of the draft standards. Will the following aspect of the Prescribing framework be altered so that the midwife will be able to prescribe once the program has been successfully completed and the student has graduated? "…practised as a midwife for the equivalent of three years' full-time clinical practice (5,000 hours) in the past six years"

Additional Issues The following questions seek to provide an opportunity for the identification of issues not covered so far in the consultation process or other issues you wish to raise.

<u>QUESTION 4</u> 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? No further comment

<u>QUESTION 5</u> Any additional feedback? The continued focus on the type and number of clinical experiences that the student is required to complete in the clinical setting can become problematic in different clinical settings. For example, students in many private hospital settings may be less exposed to straightforward normal birth without intervention or anaesthetic. Opportunities to be the primary birth attendant for the required number of women may also become problematic when the woman's primary care provider is an obstetrician. Could the Standards advise that these clinical requirements can also be demonstrated by the student and assessed in a simulated environment in the clinical laboratory setting in situations where meeting the required number of experiences is not possible. Or should there be a recommendation that only a certain proportion of the MPE is undertaken in a private hospital setting and students whose primary location is the private hospital also need to undertake MPE in the public hospital setting?