Australian Nursing & Midwifery Accreditation Council

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Accreditation standards review

Written submission form

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Standards Review
4 September 2017

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

We are supportive of prescribing scheduled medications as part of midwifery scope of practice, however we do not support inclusion of educational content for prescribing of scheduled medicines in the Midwifery Accreditation Standards. The following points highlight our concerns regarding this:

- Prescribing is an advanced midwifery skill that is **not appropriate in an entry-to-practice** program.
- There is a **lack of clear detail about the level of content** that would be required, hence we have concerns about the very likely impact on **course requirements, length and cost**. Our organisation does not currently have any midwifery academics who are qualified to prescribe, therefore the organisation would face significant expense in order to support content delivery. In an already fiscal environment where multiple organisations, including our own, are undergoing substantial course rationalisation processes, this may represent a threat to existing midwifery pre-registration courses. Any **increase to course length may impact on enrolments and indeed midwifery graduates crucial to sustaining the workforce**.
- As a Rural Health School in Victoria we are connected with rural and regional maternity health services who are very supportive of our current midwifery pre-registration programs. There is **no evidence of industry feedback that supports or demands prescribing of scheduled medicines as a midwifery graduate skill**.
- **Very few Australian registered midwives are currently qualified to prescribe** (currently less than 2% of all current registrations as per MAS Consultation Paper 3). This presents considerable **challenges with regards to appropriate supervision of students** in relation to preparation to practice. We have concerns about future graduates being educationally prepared for a skill they rarely use in practice. Similarly, we are concerned that this could create a dichotomy in the workforce between midwives who can and cannot prescribe.
- Question 1 asks directly if the draft accreditation standards will prepare graduates to safely prescribe scheduled medicines within the scope of midwifery practice. Even if midwifery students receive sound educational content regarding prescribing of scheduled medicines, **they cannot as graduates do so until they are an 'eligible midwife'**. **This requires 3 years or 5000 hours of practice**. It is our view therefore, that the educational preparation to prescribe should be at a post graduate level.
- Relating to midwives practicing to the full scope of practice, we believe that there are other skills of significantly higher priority (e.g. suturing, cannulation) that should be included in the MAS if this is the goal.

- **Almost half of responses** to Consultation Paper 2 were **not in favour of including education for prescribing in midwifery pre-registration programs** and does not suggest overwhelming support or demand for its inclusion. We have **significant concerns about the multifaceted challenges of inclusion of this content in our curricula** that the current draft Standards do not address. The Standards must be feasible and able to be achieved.

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?

No

Rationale

- We are disappointed that the current draft Standards do not reflect evidence regarding CoCEs. ANMAC's **review process aims to utilise the 'best available evidence and relevant…benchmarks" to inform the standards**. This **contrasts with evidence** from the largest study conducted to date in Australia (Newton et al, Continuity of Care Experience Research: Summary for Participants, August 2020) reporting the **burden of CoCES on students, and the potential for harm and considerable impact on students'** personal lives. This is consistent with previous research, and feedback from our current students. There are **no known international benchmarks where students are expected to attend the majority of labour and births for CoCEs** (– e.g. New Zealand standards which do not outline a minimum requirement (*New Zealand Midwifery practice requirements standard 6.3. "Each student will have at least xx follow-through experiences, which may also lead to facilitation of birth"*) - and thus we request that the wording 'where possible' is added to this requirement.
- Consistent with our previous response to Consultation Paper 2, we believe that the draft accreditation **standards do not adequately cover the required knowledge and skills required in an outpatient antenatal setting**. Currently, there is significant variation in how students are accruing their 100 antenatal visit attendances, as this can currently be achieved in inpatient antenatal care or attendance at childbirth education sessions. Students are potentially graduating with very little exposure to an outpatient antenatal setting which puts them at risk of not being able to meet many of the standards for practice.
- We believe the **following information relating to simulation** from the previous 2014 Standards should **be included in the new Standards**:
  "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".
- We believe the current draft Standards' **focus on the primary birth attendant is incorrectly weighted**, **with no evidence to support the previous increase to 30 births**. Students regularly will attend a woman's birth purely for the purpose of being the primary birth attendant to meet requirements. This contributes to the **fragmented care approach that many women encounter in maternity care** and **does not align**

with midwifery philosophies or best practice. Likewise, **our regional and rural health services find it increasingly difficult to support students to achieve these 30 SVBs due to decreasing birth numbers and rising intervention rates**. This is a concern as **many services may simply cease offering intrapartum support for midwifery students** if they do not feel they can support the requirements.
As the Standards are a **minimum**, Universities can individually set higher numbers in their curricula as desired, and students would not be restricted from achieving higher numbers of SVBs.
Therefore, we propose Standard 3.12d be amended to reduce the number of births as the primary birth attendant to **20**, and increase the number of women where students provide 'direct and active care in labour' accordingly, from 10 to 20.

QUESTION 3

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

- We remain concerned about CoCE requirements in the draft Standards. There is a lack of acknowledgement in Consultation Paper 3 about clear evidence of the significant burden that recruiting and completing CoCEs places on students. The Standards need to be evidence based, therefore consideration and incorporation of evidence in relation to CoCE requirements is essential. We request that the wording 'where possible' be added to the requirement for students to attend the majority of CoCE labours/births.
- Review of requirement to act as primary birth attendant for 30 women experiencing spontaneous vaginal birth. As acknowledged in Consultation Paper 3 there are identified challenges in meeting this requirement, such as fewer women birthing spontaneously and promotion of fragmented care where students only attend a woman's labour and birth to facilitate the birth. It does not promote continuous intrapartum midwifery care and neglects the importance of midwifery care during the first stage of labour in supporting progress towards spontaneous vaginal birth. We would request reconsideration of this requirement in the draft Standards, perhaps with consideration of wording used in the New Zealand Midwife Education Standards:
    - *"Facilitation of a birth means that the midwifery student is involved in the woman's care throughout labour, taking a major part in all assessments and midwifery decision making, and that she has a 'hands on' role in assisting the birth of the baby and the placenta. Where a student has been unable to reach this number owing to lack of available women in labour, [this requirement] may be reduced … provided that the student actively participates in the care of at least another 20 women in labour and birth."*
- Include the simulation content included in our response to Q2 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?

QUESTION 5

Any additional feedback?

- The COVID-19 pandemic has demonstrated that it is important to have flexibility in Standards to allow adaptability in exceptional circumstances, rather than rigidity.
- As per above, we note that the New Zealand 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. It would be useful for the ANMAC Standards to incorporate similar guidance to allow flexibility in exceptional circumstances.