Australian Nursing & Midwifery Accreditation Council

Review of Midwife Accreditation Standards

Survey Analysis

Owner: Accreditation

Audience: For stakeholders

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Background

The Australian Nursing and Midwifery Accreditation Council (ANMAC) is the independent accrediting authority for nursing and midwifery programs of study with responsibility for maintaining and facilitating the development of accreditation standards leading to registration as a nurse and/or a midwife. To ensure standards remain current, contemporary and effective, ANMAC follows a five-year cyclical review. The current registered midwife accreditation standards were approved in 2014 and are now due to be revised.

Stage 1 of the consultation undertaken by ANMAC to gather feedback from stakeholders to ensure the standards meet future midwifery workforce challenges consisted of a survey, conducted online over a two-week period in February 2019. Stakeholders were asked the following question:

> *"In your experience what are the five key issues to consider in educating the future midwifery workforce. Please list your issues in order of priority and give a short rationale*
>
> *(100 words or less) for each of your choices".*

One hundred and twenty-six stakeholders provided issues. The data were analysed using NVivo. First, the issues were grouped according to the priority respondents assigned the issue. Second, the issues and rationales were coded into categories (nodes) using NVivo. Appendix A lists the categories together with the number of times the issue was identified. The issues referenced the greatest number of times (20 or above) are outlined below.

Clinical Placement (91)

Time

Time was a consistent theme in relation to workplace learning. More time learning in the workplace was linked to the perception of competence and increased confidence. Time was also linked to work readiness ('graduates with too little experience'). More time (and therefore more exposure and more experience) was linked to the following - the achievement of basic skills, reducing the theory practice gap, improved clinical decision making, greater understanding of workplace organisation and different models of care (working and supporting women in medicalised models, MGP).

Time was also linked to quality learning. Some respondents identified that time spent focussing on achieving the current minimum practice requirements impacted negatively on the quality of the relationships that students are able to build with women. This perceived reduced quality of relationships was also linked to the undermining of the concept of woman-centred care.

Quality

The need for quality in clinical placements and the connection to improved learning was a consistent theme in this category. What constituted 'quality' was not always identified however the following factors appeared to be linked to a perception of quality:

- nationally agreed standards that service sites must demonstrate to be able to provide placements (adequate supervision, appropriate staff/student ratios, supernumerary placements)
- improved communication between program providers and clinical facilities
- differing models of support for learning (teaching/supervision)
    - mentorship
    - preceptorship
    - teachers with clinical teaching qualifications and a willingness to facilitate learning
- exposure to differing models of care from wellness to complexity

The varied and inconsistent nature of clinical sites and the impact on the quality of learning that could be experienced/accomplished was perceived as a barrier to quality. This concept was also linked to the burden of achieving the minimum practice requirements (little exposure to continuity models of care, declining birth numbers, increasing intervention rates) experienced by students in some areas of Australia.

Content (69)

This category of issues related to the topics that respondents considered should be included in midwifery pre-registration programs. The topics included:

- leadership skills
- management of change
- adult learning principles
- critical thinking and problem solving
- advocacy
- caring for women experiencing complexity

There was overlap between the content and clinical- basic skills categories. Responses coded to Content identified a range of skills considered crucial to a well-prepared midwife including:

- CTG monitoring
- Ability to cannulate and perineal suturing
- Caring for women birthing in water
- Immunisation
- Preventing/caring for women with birth injuries
- Postnatal care
- Prescribing and ordering and interpretation of diagnostic tests

There was also overlap between Content, Employment and Clinical Placements with references to the need to understand the reality of the workplace (differing models of care, nature of shift work, public versus private maternity care systems). Experience in models of homebirth was also included in the topics.

Employment issues (63)

There were a varied number of issues identified in this category. Many related to newly graduated midwives (future employment opportunities, availability of transition to practice programs, support for newly graduated midwives in the workplace) while others were related to the midwifery workforce as a whole (professional development opportunities, costs of furthering education, staff/patient ratios [related to the midwives' ability to support student learning], retention of the midwifery workforce, increased clinical and administration demands, the availability of Professional Indemnity Insurance).

Employment/workplace issues specific to the future education of midwives included the need for improving the practice environment to prevent the reality shock newly graduated midwives face in providing care in a largely medicalised system of maternity care. Realty shock was also linked to retention of midwives and the need to facilitate resilience in the midwifery workforce. Factors thought to be important for educating the midwives of the future include the provision of a safe environment, a quality learning experience, models of care (continuity) that are congruent with best practice, optimal support for students by well-prepared midwifery teachers/supervisors, adequate staff/patient ratios.

Continuity (43)

> *"Needs to be more focused on continuity of care experiences……Preparing students to take up evidenced based care should be the goal of a midwifery degree."*
>
> *"Importance of continuity of care. The best maternity outcomes occur when a woman has continuity of care and continuity of carer."*

The importance of ensuring graduates were competent in providing care in continuity of midwifery care models was a consistent theme in this category and respondents highlighted the well -researched benefits of the model for women and babies.

Just as consistently, the challenges of privileging the model in midwifery workplace practice were highlighted.

> *"The CoC experience minimum requirements has been so watered down – it's hardly worth the effort and students fight to get out of doing even the minimum requirements - and this is because the value (has) been downgraded significantly in education requirements."*
>
> *"The significant impact that needing to follow women through COCE has on students and their abilities to maintain a balanced life during their studies".*

Respondents highlighted a number of challenges including:

- Access (slow roll out of the model, few models for education and employment)
- Lack of support for midwives working in the model
- Midwifery educators with limited experience in the model

Continuity of care experiences were considered by some to be burdensome for students and not reflective of the real world of practice (increasing complexity, increasing intervention, medical models of care). Difficulties experienced in undertaking university study, clinical placements and continuity of care experiences simultaneously and managing the competing priorities of each were highlighted.

Woman-centred care (28)

Respondents wrote about the importance of woman-centred relationships in midwifery and its centrality as a philosophical underpinning of care. Woman-centred care was linked with self-efficacy, autonomy, and informed choice for women. As a concept, woman-centred care should be embedded in, as well as role modelled throughout, midwifery pre-registration education programs.

At the same time one respondent highlighted what they perceived as a disconnection between the development of woman-centred relationships and the apparent focus on the completion of tasks reflected in the minimum practice requirements.

> *"While we teach woman-centredness and holistic ways of being with women, we give numbers of tasks to be achieved within a time frame which focuses student on task completion not the woman."*

Evidence Based/Research (26)

The twin themes of evidence and research were reflected in the responses in this code. Respondents highlighted the need for the midwife of the future to have the skills to critically analyse research evidence,

to base their practice and information to women on the best available evidence, and to contribute to the generation and translation of evidence into practice.

It was argued that educating the midwife of the future starts by focusing on evidenced based midwifery led models of care. There was acknowledgement that students do not always experience a practice environment that reflects the best evidence however, one respondent said,

> *"We must continue to educate for what we know is evidence based best practice - even if many students are not seeing it in the workplace - education should not be compromised just because services do."*

Respondents felt that students should be critical consumers of research evidence and midwifery educators should be engaged in generating research. To do this more emphasis on research skills in the midwifery curriculum was considered essential. One respondent stated,

> *"……if you want to educate a midwifery workforce who is ready and able to do what is required to sustain midwifery ……..then all midwives need to know how to evaluate care practices and conduct research that will inform and change practice. ……If we are serious about changing the future of midwifery in Australia for women, then we need to get serious about research……."*

Birth and interventions (25)

The consistent theme in this category was the midwives' responsibility to promote physiological birth, to challenge unnecessary intervention rates, to be savvy and political in supporting women in a climate of increasing medicalisation of birth. At the same time some respondents highlighted the importance of skilled midwifery care for women and babes experiencing complexity. One respondent considered that students were well prepared to care for well women but needed more knowledge and experience in caring for women and babies with complex needs.

Clinical - basic skills (25)

As identified there were overlaps in coding between the Clinical – basic skills, Content and Clinical Placements categories. The majority of factors identified in Clinical – basic skills related to the need to increase the level of clinical skills of graduates, both holistic and specific.

Holistic skills included communication, collaboration and referral, the ability to detect variations from the norm, time management, documentation, escalation of care, and problem solving in emergency situations. Specific skills needed by the well-prepared midwife included perineal suturing, vaginal examinations, understanding the mechanisms of labour and pharmacology and medication administration.

Respondents highlighted instances where graduates were not well prepared for practice and some linked this lack to the time students spent in workplace learning. One respondent considered that there should be an emphasis in practice on mastery of skills not merely completing a one-off competency assessment.

Support (22)

The support referred to in this category was wide ranging. Respondents wrote of the need to have strategies to support - workplace learning, to reduce stress and burnout, to mitigate the educational burden on students, to care for women 'outside the norm' and/or experiencing abuse, to provide compassionate care for women and their babies.

> *"To mitigate burnout and workforce attrition, midwives need the knowledge and skills to support their own and their colleagues' emotional wellbeing."*

Respondents identified the need for support for specific categories of students including rural and remote students and Aboriginal and Torres Strait Islander students.

Support strategies included mentoring, debriefing after traumatic events, access to formal support services, fostering resilience, adequate supervision and assessment of workplace learning experiences.

Scope of practice (21)

> *"A midwife in Australia is authorised to provide maternity care on their own responsibility to women with non-complicated pregnancy, labour and birth and during the postnatal period up to six weeks after their baby is born"* (ACM, 2016).

The need to ensure that midwives were educated to work, on graduation, to the full scope of midwifery practice (as defined above) was a consistent theme in this category. To enable the graduate to give the care implicit in this definition a range of knowledge and skills were emphasised including pre-conception care, specific content on women's health, cannulation, perineal suturing, prescribing, ordering and interpreting diagnostic tests. Additionally, understanding professional accountability for care, understanding and adhering to professional standards, legislative requirements, consultation guidelines and policies were seen as crucial.

The capability to engage in Independent practice on graduation was mentioned several times as the goal of pre-registration midwifery programs.

Some respondents wrote of a "lack of clarity regarding the scope of practice" and "scope of practice issues" however no explanation as to the specific issues was given.

One respondent stated,

> *"The midwifery scope of practice involves significant responsibility. It is impossible to prepare a midwife for this role in 12 months regardless of experience in another profession. Abolish the 12-month course for RNs."*

Additional themes were identified by combining categories. These themes were considered pertinent to the revision of the standards.

Culture and diversity

Respondents argued that the student cohort in midwifery should reflect the diversity of our culture and highlighted the need to consider how to better support students and birthing women from diverse backgrounds.

First, it was thought important to facilitate access to midwifery programs for indigenous women from remote communities. Second, developing educational approaches specifically targeted to meet the needs of Aboriginal students was deemed necessary. Better understanding of the needs of indigenous women birthing in the maternity care system was also highlighted.

The same issues were raised for students and women from culturally and linguistically diverse backgrounds.

Rural and Remote

Respondents considered that students in rural and remote areas were disadvantaged with less access to practice placements, less diversity in the available placements as well as the need to travel further and incur accommodation costs if required to travel to a metropolitan area for specialist practice experiences.

Cost

Cost was identified as an issue influencing both students and access to specialist education.

Firstly, the cost of education for students. Costs associated with attending appointments with women in continuity of care experiences (petrol, car registration and maintenance, phone), as well as the difficulties in engaging in part-time work due to being on-call. Suggestions to reduce the financial burden included

bursaries, stipends, scholarships and more flexibility in sequencing of clinical practice. Reducing the numbers of minimum practice experiences required for registration was also advocated.

One respondent identified that providing access to specialist education (FSEP, PIPER) for rural universities was increasingly costly.

Governance

Responses coded to several nodes (Midwifery lead, Midwifery v Nursing, Cost) highlighted issues related to the governance of midwifery within the tertiary system.

> *"The profession of midwifery must be able to shape the content and processes of midwifery curricula (not another profession) therefore programs in midwifery must be able to demonstrate not only a midwifery lead in name but midwifery leadership in practice."*

There is a need for strong leadership in midwifery education. Respondents highlighted the need for the leadership of programs to be in the hands of a midwife as well as the need to protect workplace learning opportunities in an environment of cost containment.

Duration and type of pre-registration programs

There were contrasting opinions regarding the type and duration of programs best suited to support the midwife of the future. In keeping with the strong emphasis on the need for more clinical experience in previous categories (Content, Clinical Placement, Clinical – Basic skills) respondents advocated for a four-year degree. In relation to program type some respondents advocated ceasing the 12-month minimum requirement for a Graduate Diploma arguing more time was needed to acquire the knowledge, skills, attitudes expected of a registered midwife.

Appendix A

MAS Survey

Nodes

Name	Files	References
Aboriginal and Torres Strait Islander Health-Students	1	7
Accountability	1	1
Availability	1	1
Birth and Interventions	1	25
BN Vs GD Vs Masters Vs Dual Degree	1	10
CALD Women	1	3
Clinical - Basic Skills	1	25
Clinical Placement	1	91
Communication	1	15
Competence	1	1
Complexity	1	14
Conduct and Ethics	1	3
Content	1	69
Continuity	1	43
Costs	1	13
Diversity	1	6
Educators	1	20
Employment Issues	1	63
Equity	1	3
Evidence Based	1	26
Four Year Degree	1	7
Funding	1	1
Hours	1	1
ICM Standards	1	2
Informatics	1	1

Informed Consent	1	10
Inter-Intraprofessional	1	16
Lactation-Breastfeeding	1	7
Legislation	1	3
Medicines - Medication Management	1	9
Mental Health	1	2
Midwifery Lead	1	4
Midwifery Vs Nursing	1	10
Models of Care	1	12
Pathways	1	6
Philosophy	1	3
Politics	1	6
Prescribing	1	2
Relationships	1	2
Resilience	1	10
Risk Management	1	6
Rural and Remote	1	14
Safety and Quality	1	6
Scope of Practice	1	21
Simulation	1	1
Standards for Practice	1	1
Stillbirth	1	1
Student Numbers	1	4
Support	1	22
Women Centred	1	28

Aboriginal and Torres Strait Islander Health-Students

<Files\\MASSurvey1> - § 7 references coded [1.06% Coverage]

Reference 1 - 0.15% Coverage

Developing educational principles to support Aboriginal students where the western ways of teaching and assessment can be adapted to meet the needs of Aboriginal world views

Reference 2 - 0.15% Coverage

identifying and supporting Aboriginal students

Reference 3 - 0.15% Coverage

Access for Indigenous midwives - models for educational access are limited and need to be expanded to support our Indigenous communities to support midwives to be trained for their communities

Reference 4 - 0.15% Coverage

Cultural Saftey - Aboriginal and Torres Strait Islander people

Reference 5 - 0.15% Coverage

To embrace more cultural safety around indigenous health

Reference 6 - 0.15% Coverage

Indigenous women and how their care needs differ from non indigenous women

Reference 7 - 0.15% Coverage

Not enough practical and clinical time in community with ATSI people

Accountability

<Files\\MASSurvey1> - § 1 reference coded [0.15% Coverage]

Reference 1 - 0.15% Coverage

Accountability - midwives need to understand that they are resposible and accountable for the care of women. Midwives also need to be accountable for working to their full scope of practice and ongoing education.

Availability

<Files\\MASSurvey1> - § 1 reference coded [0.15% Coverage]

Reference 1 - 0.15% Coverage

availability of courses

Birth and Interventions

<Files\\MASSurvey1> - § 25 references coded [3.73% Coverage]

Reference 1 - 0.15% Coverage

Normal birth

Reference 2 - 0.15% Coverage

Cultural studies in the sense of macro picture of women, wellness, patriarchy, gender issues, public health impact of midwifery - how greater risk profile and induction/csection rates, birth trauma have big impact on population, not just individual family.

Reference 3 - 0.15% Coverage

Increasing complexity of the role and deviating away fron 'normal' midwifery

Reference 4 - 0.15% Coverage

Curriculum to encompass the needs of ALL women. At present very focused on low risk well women and Continuity of Care. Does not prepare the student for the needs of the comlex woman and the important role the midwife has in that woman's journey

Reference 5 - 0.15% Coverage

Safely identifying variation from Normal and acting on this- hardest skills to learn and these need to be learned at the beginning of the career. Don't just relay on a chart or a machine to tell you your woman is sick or baby dying in front of you

Reference 6 - 0.15% Coverage

Birthing in water

Reference 7 - 0.15% Coverage

Equal emphasis on normal and abnormal birth

Reference 8 - 0.15% Coverage

Protecting normal birth and reducing unnecesary intervention

Reference 9 - 0.09% Coverage

Recognising 'normal' in a high intervention environment.

Reference 10 - 0.15% Coverage

Promoting normal birth in a highly technological society

Reference 11 - 0.15% Coverage

BMIDS- there education encourages "natural" process of birth. However care of a postop caesarean section ist so important. We have had 3, yes 3 pressure area sores in maternity because washes and pressure care is a "Nursing duty"

Reference 12 - 0.15% Coverage

protecting the perneum and reducing birth trauma to the woman

Reference 13 - 0.15% Coverage

Complex care - a lot of students come out of uni well prepared for normal birth but lack confidence and knowledge to provide care to women and babies with complex needs

Reference 14 - 0.15% Coverage

Medicalisation of births, increased inductions, caesareans and interventions. These are of concern.

Reference 15 - 0.15% Coverage

Promoting normal birth for all women despite risk factors

Reference 16 - 0.15% Coverage

increasing intervention rates particlularly the caesarean section rate

Reference 17 - 0.15% Coverage

Clear focus on women centered natural physiological birth. Birthing has shifted from a natural and healthy process- women are now expecting pain free births and need support and education to make a shift to natural and healthy

Reference 18 - 0.15% Coverage

Midwives must be in a position to stand up and challenge the high rates of intervention- epidurals and unnecessary cesarean births- the midwife of the future nees to be savvy and political and be prepared to be part of the change

Reference 19 - 0.15% Coverage

Increase the number of freestanding birth centres to enable women to birth in a home-like environment. This keeps birth normal and reduces medical intervention

Reference 20 - 0.15% Coverage

Push for vaginal deliveries

Reference 21 - 0.15% Coverage

Increasing difficulty for students to acquire the number of births with a decreasing birth rate and increasing intervention rates

Reference 22 - 0.15% Coverage

Stop forcing women to give birth on their backs

Reference 23 - 0.15% Coverage

Some consumers desires to have a less medicalised pregnancy and birth

Reference 24 - 0.15% Coverage

Not enough vaginal births

Reference 25 - 0.15% Coverage

New Health Challenges in maternity care - birth is no longer always 'normal' yet women can still have vaginal births with quality midwifery care

BN vs GD vs Masters vs Dual Degree

<Files\\MASSurvey1> - § 9 references coded [1.22% Coverage]

Reference 1 - 0.15% Coverage

Type of midwifery qualification

Reference 2 - 0.15% Coverage

Should we be evaluating the difference between Grad Dip and B Mid courses?

Reference 3 - 0.15% Coverage

Bachelor of Midwifery courses - access is being reduced as universities are opting for dual degrees over direct entry. reducing the hours of access and exposure to midwifery content and clinical placements. No clear focus on either profession, both are short changed

Reference 4 - 0.15% Coverage

Ensure that health services and hospitals provide a learning environment for the students regardless of qualification (Bachelor of Grad Dip). Currently there is a bias for grad dip students.

Reference 5 - 0.15% Coverage

high quality undergrad education with a post grad option for a minority of nurses

Reference 6 - 0.15% Coverage

Too much focus on nurses being midwives currently. Nurses and midwives are combining two three year degrees into four years. They seem to be missing a lot of information in this condensing. They have less depth and seem to have less questioning minds. I spoke to an academic who had taught in both systems and she felt that the four year degree was very shallow. I am very concerned about this. We need to have graduates who have a good understanding of the profession and a depth of knowledge. Also they need to have current experience as graduates, not diluted by recent nursing placements.

Reference 7 - 0.15% Coverage

Take nursing out of midwifery. They are two seperate professions but yet nurses only need to do a graduate certificate to become a midwife. They need to do a full three years midwifery training

Reference 8 - 0.01% Coverage

Get rid of the 12 month course for RNs

Reference 9 - 0.15% Coverage

Direct entry midwifery training

Reference 1 - 4.03% Coverage

It is important to continue to offer both Bachelor of Midwifery and Post-Graduate pathways to become a Midwife. This provides the opportunity to ensure the future workforce needs are met across all locations of Australia.

CALD Women

<Files\\MASSurvey1> - § 3 references coded [0.45% Coverage]

Reference 1 - 0.15% Coverage

Education in CALD appropriate care, advice and communication not only for indigenous women but all CALD women

Reference 2 - 0.15% Coverage

Cultural studies in the sense of macro picture of women, wellness, patriarchy, gender issues, public health impact of midwifery - how greater risk profile and induction/csection rates, birth trauma have big impact on population, not just individual family.

Reference 3 - 0.15% Coverage

Culturally appropriate care. Respect for each woman and her social network, their background and beliefs, including how that relates to maternity care. Availability of linguistically diverse information in order for each woman to make an informed decision about her care.

Clinical - basic skills

<Files\\MASSurvey1> - § 25 references coded [3.79% Coverage]

Reference 1 - 0.15% Coverage

Basics - there appears to be alot of pressure on the students that they are missing vital basic skills such as palpation and S-F measuring, basic pharmacology and common medication use.

Reference 2 - 0.15% Coverage

Clinical skills competence in assessement, intervention and repair of the interventions midwives undertake- Midwves need to be able to do the skills well that they need to be ready for the Australian work environment but also able to transfer this learning to overseas sites such as the UK, Canana, Africa

Reference 3 - 0.15% Coverage

preparedness for the job: time management, clinical skills, paperwork, dealing with difficult people

Reference 4 - 0.15% Coverage

documentation

Reference 5 - 0.15% Coverage

escalation of care

Reference 6 - 0.15% Coverage

fetal surveilance

Reference 7 - 0.15% Coverage

Lack of clinical skills. Unable to perform a VE after qualifying. Emphasis needs to be on mastering skills not completing a one off competency. Competencies should be progressively completed.

Reference 8 - 0.15% Coverage

Future needs (skills/knowledge/attitudes) of 'the' midwive in the context of future societal changes

Reference 9 - 0.15% Coverage

Limitations in skill base for graduates: related to insufficient practical placement hours

Reference 10 - 0.15% Coverage

Lack of general nursing experience/ knowledge prior to being registered as a midwife: related to the course being limited to midwifery only

Reference 11 - 0.15% Coverage

BMIDS- there education encourages "natural" process of birth. However care of a postop caesarean section ist so important. We have had 3, yes 3 pressure area sores in maternity because washes and pressure care is a "Nursing duty"

Reference 12 - 0.15% Coverage

Not being truly work ready on completion of the course

Reference 13 - 0.15% Coverage

Must have general nursing as well. When midwives are trained only as midwives in Australia they lack depth and general nursing skills such as post-operative care, deteriorating patients and many medications

Reference 14 - 0.15% Coverage

Ensure the basic fundamentals are well and truly covered. Students are coming out now not even knowing the exact mechanisms of labour and birth, details about placentas, good pregnancy care and how to be independant.

Reference 15 - 0.15% Coverage

Communication collaboration and referral skills

Reference 16 - 0.15% Coverage

Midwifery acute skills pertinent to direct entry midwives

Reference 17 - 0.15% Coverage

foundational knowledge

Reference 18 - 0.15% Coverage

Students need to be prepared to care for women across the continuum. The current training system asks for students to have a number of abdominal palpations and a number of booking in appointments and a number of complex cares, but still students graduate with not enough ability to pick up variations from normal it seems.

Reference 19 - 0.15% Coverage

Add perineal suturing to curriculum. Beneficial for clients and midwives. Again support hospital system as well as community midwifery

Reference 20 - 0.15% Coverage

high level of clinical skills. Need to be able to manage the care of woman safely by providing care for low risk women and women who are high risk or become high risk

Reference 21 - 0.15% Coverage

Knowing key procedures and guidelines and commonly used drugs really really well. I did not know this well enough and have found nearly memorising common policies essential in my first year out.

Reference 22 - 0.15% Coverage

Ensuring graduates have sound Clinical skills

Reference 23 - 0.15% Coverage

Graduating midwives should be skilled and accredited in cannulation and suturing. These are basic and essential skills for all midwives and all institutions should be facilitating these.

Reference 24 - 0.15% Coverage

Nursing basics - eg ability to do a cannula

Reference 25 - 0.15% Coverage

Clinical skill and experience - knowing when and how to act in an emergency

Clinical Placement

<Files\\MASSurvey1> - § 90 references coded [13.54% Coverage]

Reference 1 - 0.15% Coverage

Better preparedness for clinical environment- professionalism, working in team environments and under pressure

Reference 2 - 0.15% Coverage

Needing a clinical facilitator to spend time with students one on one

Reference 3 - 0.15% Coverage

Have preceptors and enough senior support on the floor

Reference 4 - 0.15% Coverage

Appropriate, quality midwifery practice experience

Reference 5 - 0.15% Coverage

safe and supported workplaces

Reference 6 - 0.15% Coverage

Access to clinical placements, especially for regional and rural students being able to access tertiary settings. A lot of the hospitals have very firm relationships with metro unis and do not accept placement requests from smaller, regional unis so our students are at a distinct disadvantage

Reference 7 - 0.15% Coverage

Practical/hands on at placements supported by CMEs

Reference 8 - 0.15% Coverage

Need to ensure sufficient overall clinical practice hours in an environment where universities are seeking to reduce costs. Risk of midwifery being aligned to nursing hours.

Reference 9 - 0.15% Coverage

Need to ensure adequate clinical supervision and assessment in an emotionally and culturally secure manner.

Reference 10 - 0.15% Coverage

The impact of placement on income, working around placement/classes is extremely difficult. Students on placement should receive some payment - apprentices do.

Reference 11 - 0.15% Coverage

undergraduate nursing students have little to no exposure to maternal health, undergraduate exposure of maternal health may improve postgraduates considering midwifery qualifications, and will have a clear view of the midwifery profession

Reference 12 - 0.15% Coverage

Medical System - not every public hospital has midwifery continuity of care, and not every public hospital supports midwifery continuity of care or even midwifery care. Understanding the reality of the medical system will help students from the trauma and shock they experience in clinical placement when both they and the registered midwife is unable to stand up against the medical team

Reference 13 - 0.15% Coverage

Mentorship - student midwives would benefit grately from continuity at the same hospital and be linked to a registered midwife buddy, another midwife that is knowledgable and skilled and willing to mentor a student and provide debriefing and answer questions, someone the student trusts.

Reference 14 - 0.15% Coverage

Clinical placements - the number of students that are in their final year that have not even reached half way of signing off their births is a huge concern. As a student, ten years ago, my first placement was on Birth Suite. I had four births by the end of that 2 week placement. I had signed off all my births mid third year.

Reference 15 - 0.15% Coverage

Skill competency - clinical practice hours

Reference 16 - 0.15% Coverage

24/7 nature of work. Must do clinical placements 24/7 to be work ready

Reference 17 - 0.15% Coverage

To prepare midwifery students to work in continuity of midwifery care models, midwifery courses must include practicum placements in sites that practice this model of care rather than having to attain this experience through Continuity of Care Experiences, which are burdensome and do not reflect real-world practice

Reference 18 - 0.15% Coverage

mentoring learners in cclincial setting

Reference 19 - 0.15% Coverage

More clinical time to master the basic skills of midwifery

Reference 20 - 0.15% Coverage

include rural and remote clinical placements for all future midwives

Reference 21 - 0.15% Coverage

Development of resources that will support educators to do their job in a tightly understaffed environment

Reference 22 - 0.15% Coverage

Continuity of Care numbers: PG students doing 10 in 12 months places unnecessary pressure on them. It also puts their safety and well being at risk due to the additional hours they do to meet the requirements. In NSW they are employed 32hrs/week. The student is often forced to either attend a shift after a limited break or working then attending CoC resulting in excessive hours that would not be allowed if it was paid time. Suggest PG program reduce to 5 CoC.

Reference 23 - 0.15% Coverage

More clinical hours for Bmid program: Clinical placements are fragmented with long gaps in placements.

Reference 24 - 0.15% Coverage

Clinical skills competence in assessement, intervention and repair of the interventions midwives undertake- Midwves need to be able to do the skills well that they need to be ready for the Australian work environment but also able to transfer this learning to overseas sites such as the UK, Canana, Africa

Reference 25 - 0.15% Coverage

Access to placement opportunities

Reference 26 - 0.15% Coverage

lack of clinical facilitators on the floor: increased workloads for core staff, inadequate education / debriefing of students, lack of clinical opportunities

Reference 27 - 0.15% Coverage

disjointed rotations through their clinical placement - difficult to put things into perspective: harder for the clinical picture of the client's journey as well as putting theory into practice

Reference 28 - 0.15% Coverage

Staff:Patient ratios so that students being mentored are not trreated as auxiliary staff

Reference 29 - 0.15% Coverage

Opportunities to follow through clients of independent midwives

Reference 30 - 0.15% Coverage

Placements. There is often inconsistencies in placements from day to day. It may be more advantageous to do longer placements in a particular specialty in the same hospital

Reference 31 - 0.15% Coverage

Clinical Readiness

Reference 32 - 0.15% Coverage

Placement and experience in continuity models above standard continuity expropriation (MGP placements)

Reference 33 - 0.15% Coverage

Preceptorship in placement

Reference 34 - 0.15% Coverage

increased time in clinical domain during training

Reference 35 - 0.15% Coverage

Clinical Placement with a junior workforce. Junior midwives are teaching student midwives due to the lack of senior midwives. This is concerning due to the issues with skills and knowledge that experience brings.

Reference 36 - 0.15% Coverage

Clinical experience. Newly qualified midwives are daunted by having to look after a number of women. They are unprepared for time management. In Victoria only 4 women so how do other states manage?

Reference 37 - 0.15% Coverage

Lack of exposure to antenatal care. Whilst continuity of care is recognised as the gold standard, graduates are not adequately prepared to provide this care to women. 80 hours in a clinic is a drop in the ocean. Follow through appointments do not meet this need as atending with a woman does not mean education from the midwife

Reference 38 - 0.15% Coverage

Increased number of placements available (quiality)- universities could take more students, however, in general placements are limited.

Reference 39 - 0.15% Coverage

QUALITY clinical placements- the need has been discussed for both nursing and midwifery in many forums.

Reference 40 - 0.06% Coverage

Midwives on clinical need to embrace students, be positive, supportive, great role models etc.

Reference 41 - 0.15% Coverage

Placing a higher value on the clinical/practical component of midwifery education. Setting the bar high to make high quality, questioning, well rounded, work-ready midwives of the future.

Reference 42 - 0.15% Coverage

Clinical placements - consolidation of skills during learning and after graduation. high emphasis on graduate year by employers, not accessible to all graduates. Implementation of the AMSAT tool would assess this

Reference 43 - 0.15% Coverage

Limitations in knowledge base for graduates: related to insufficient practical placement hours

Reference 44 - 0.15% Coverage

Mentorship - one-to-one consistent mentorship between practitioner and student, as modeled in the UK, would improve clinical learning outcomes.

Reference 45 - 0.15% Coverage

the challenge for students to commit to a rotational roster: In recent contrast I have students not interested in shift work post graduate

Reference 46 - 0.15% Coverage

more clinical to faciltate critical decision making

Reference 47 - 0.15% Coverage

Increase in workplace clinical and administation demands

Reference 48 - 0.15% Coverage

Workplace expectations of access to staff outside of work hours and unpaid work

Reference 49 - 0.15% Coverage

Lack of clinical placement

Reference 50 - 0.15% Coverage

Education not aligned with the clinical requirements

Reference 51 - 0.15% Coverage

Clinical Skills - More on the job training required (which in turn helps busy hospitals) and helps students reduce their theory/practice gap.

Reference 52 - 0.15% Coverage

not enough clinical exposure

Reference 53 - 0.15% Coverage

Clinical expertise - practical skills and experience

Reference 54 - 0.15% Coverage

Ensure that health services and hospitals provide a learning environment for the students regardless of qualification (Bachelor of Grad Dip). Currently there is a bias for grad dip students.

Reference 55 - 0.15% Coverage

Enhanced connection/linkage between universities and health services to ensure students have consistency with their academic and practical learnings. Students needs the health and education systems to collaborate.

Reference 56 - 0.15% Coverage

Ensuring that quality clinical placements are provided to all student midwives, that do not purely focus on 'numbers' of experiences but on the quality of the clinical experience. Clinical opportunitities are not uniform across the country and may need to be reviewed at a state level.

Reference 57 - 0.15% Coverage

Meet workforce needs in terms of numbers - this has implications in terms of provision of quality clinical experiences balanced with achievable clinical requirements (this needs examining at a state by state level as there are inconsistencies between states in terms of clinical opportunities)

Reference 58 - 0.15% Coverage

access to clinical places - industry are very add hoc in determining how many students they will support each year, and some with thousnads of births per year support minimal numbers of students. This needs to change given the looming shortage of midwives.

Reference 59 - 0.15% Coverage

onerus clinical requirements for students to complete ie numbers of specified clinical experiences. This is particularly unfair given that nurses have no such requirements.

Reference 60 - 0.15% Coverage

Improving the practice environment – optimal support for students by well prepared midwifery practice midwives. There are a number of other elements that come into this, a safe environment, quality learning experiences, models of care (continuity) that are congruent with best practice are some of the elements

Reference 61 - 0.15% Coverage

maintain high levels of clinical experience and continuity case load

Reference 62 - 0.15% Coverage

good well informed clinical leadership

Reference 63 - 0.15% Coverage

No where near enough practical hours currently. Graduates come out with too little practical experience. They are often not confident in looking after a woman in labour or even in organising their postnatal workload. More practical hours might also give them more ability to care for women antenatally and have more knowledge of what to do when a woman comes in with a pregnancy complication.

Reference 64 - 0.15% Coverage

Have a mentoring system, grad year as in new zealand suporting grads with working in the community or hospital

Reference 65 - 0.15% Coverage

longer placements and better options for placements esp around rural, breastfeeding and continuity of care. Barely touching on 1000 hours practical over 3 years is not enough.

Reference 66 - 0.15% Coverage

Clinical time

Reference 67 - 0.15% Coverage

Clinical support

Reference 68 - 0.15% Coverage

Clinical time with all health care providers

Reference 69 - 0.15% Coverage

Clinical placement that allows safe learning

Reference 70 - 0.15% Coverage

Placement hours

Reference 71 - 0.15% Coverage

high level of clinical skills. Need to be able to manage the care of woman safely by providing care for low risk women and women who are high risk or become high risk

Reference 72 - 0.15% Coverage

Hands on experience. The more the better, the earlier the better to prepare for the real world and apply everything that's learned.

Reference 73 - 0.15% Coverage

Need to mandate a minimum number of hours to be attended in hospitals as some students are spending large periods of time with private practice midwives and are not gaining sound skills in some areas such as medication administration

Reference 74 - 0.15% Coverage

demand for midwifery student placement is greater than supply. As birthing services are more centralised and less birthing is offered in rural areas, less available placement opportunities exist for students.

Reference 75 - 0.15% Coverage

Stop the culture of bullying students. At times this feels endemic. It would be better to educate rather than intimidate or belittle

Reference 76 - 0.15% Coverage

Collaborate with all institutions to provide substantial rural placements. Too many of our graduating midwives are confined to the tertiary system and have no experience outside of this.

Reference 77 - 0.15% Coverage

Enable students to attend homebirths, facilitate insurance for same. Same reason as above

Reference 78 - 0.15% Coverage

Clinical Placement Sites/Rational. There needs to be nationally agreed standards developed that service sites must demonstrate to be able to take on student midwives for training. Currently, the quality of clinical placement is not consistent and in my experience, student midwives are exploited especially students undertaking a graduate program of training. They are used to back fill staff shortages and inadequate supervision and training is occuring. Service providers will tell universities they are supervising students, but the reality is thaty are not. Hospital service providers need to be held accountable for this. Further, it is imperative, that students get a 'BALANCED" exposure to both Public and Private models of care. What i mean by this is, it is not appropriate to send a student to a private obstetric hospital for all of her training. This simply does not expose the student to a wide range of models oand they have NO exposure to a midwifery continuity of care model. Students who only complete their midwifery training in a private obstetric unit, = obstetric nurse training- not midwifery training. If private hospitals want obstetric nurses, then please develop a seporate form of training for this. Thanks

Reference 79 - 0.15% Coverage

complexity and number of clinical experience requirements. Students are mostly mature age and have family responsibilities and part time work. They find it stressful to study, attend allocated placement shifts and be "with-woman" when undertaking their CCE. Most have part time work to juggle to feed themselves and family.

Reference 80 - 0.15% Coverage

competitivness of placement positions and variations in programs making it difficult for students, universities and placement venues.

Reference 81 - 0.15% Coverage

availability of quality clinical placements

Reference 82 - 0.15% Coverage

Hours of clinical practice are important and a minimum should be set. This should be commensurate with EU and New Zealand standards

Reference 83 - 0.15% Coverage

Increasing difficulty for students to acquire the number of births with a decreasing birth rate and increasing intervention rates

Reference 84 - 0.15% Coverage

Educating student Midwives in line with evidence but having placement within a medicalised system

Reference 85 - 0.15% Coverage

Not enough variety eg practical midwifery group practice

Reference 86 - 0.15% Coverage

Not enough midwifery mentorship

Reference 87 - 0.15% Coverage

New evidence suggests that there are different models of care that suit birthing women - this needs to be translated to education with placements in all the models

Reference 88 - 0.15% Coverage

Sufficient clinical placements

Reference 89 - 0.15% Coverage

appropriate clinical placements

Reference 90 - 0.15% Coverage

reduce 'clinical experience numbers' - the courses are rigorous and it is disempowering that we force students into recording experiences in the way that we do

Reference 1 - 3.29% Coverage

It is essential that student Midwives feel safe and supported during clinical placement, establishing a structured mentored program for student midwives would provide this support.

Complexity

<Files\\MASSurvey1> - § 12 references coded [1.82% Coverage]

Reference 1 - 0.15% Coverage

Complex care due to the large number of women now experiencing health conditions with pregnancy

Reference 2 - 0.15% Coverage

the need for the curriculum to educate on the co mornidities that are now accompanying women into pregnancy, birth and motherhood

Reference 3 - 0.15% Coverage

complex knowledge and undertsanding of immunisation education

Reference 4 - 0.15% Coverage

Increase in complex patients

Reference 5 - 0.15% Coverage

understanding comorbidites and treatment

Reference 6 - 0.15% Coverage

Increase in focus required on high risk pregnancies

Reference 7 - 0.15% Coverage

Complex care - a lot of students come out of uni well prepared for normal birth but lack confidence and knowledge to provide care to women and babies with complex needs

Reference 8 - 0.15% Coverage

Knowledge & Understanding - midwives need to have a greater understanding of physiology, the theory behind what they do. As the population becomes more complex, midwives need to understand how this impacts on pregnancy etc.

Reference 9 - 0.15% Coverage

Recognition of the increasingly complex health needs of women and the need for graduates to have the ability to provide safe care to all women across all models of care

Reference 10 - 0.15% Coverage

complexity and number of clinical experience requirements. Students are mostly mature age and have family responsibilities and part time work. They find it stressful to study, attend allocated placement shifts and be "with-woman" when undertaking their CCE. Most have part time work to juggle to feed themselves and family.

Reference 11 - 0.15% Coverage

Preparation of midwifery graduates to better manage complex care issues and a greater understanding of women's health issues.

Reference 12 - 0.15% Coverage

Students are older / have families / challenging lives - education needs to be more flexible to accomadate this

Reference 1 - 1.46% Coverage

Understanding contemporary midwifery care in the context of Australian practice.

Reference 2 - 5.09% Coverage

Midwives are expecting to practice holistic care and provide midwifery continuity of care for women without risk. The reality of modern maternity is women with complex needs, high activity in the hospital system and limited opportunities to practice in continuity of care models.

Communication

<Files\\MASSurvey1> - § 15 references coded [2.27% Coverage]

Reference 1 - 0.15% Coverage

Effective communication at all levels and with all people without the ability to get messages accross and her messages clearly the midwife is less effective and potentially dangerous. A range or escalation skills is also essential

Reference 2 - 0.15% Coverage

Suitability. We intake many student Midwives who have little or no communication skills, no interest in the wider picture of midwifery every year. How can you just leave it up to an ATAR score to get into such a program as Midwifery. We need passionate midwives with a personality to meet the needs of the job. I would like to see universities interview students and maybe consider lowering the ATAR score.

Reference 3 - 0.15% Coverage

Advocacy(both for student and women)

Reference 4 - 0.15% Coverage

Commuication skills and experience relating and connecting with women during the perinatal period

Reference 5 - 0.15% Coverage

Communication collaboration and referral skills

Reference 6 - 0.15% Coverage

Collaboration and consultation and referral issues

Reference 7 - 0.15% Coverage

Advocating for woman - to work in partnership with women to provide education to make informed decisions

Reference 8 - 0.15% Coverage

Communication skills

Reference 9 - 0.15% Coverage

communication ,and team work

Reference 10 - 0.15% Coverage

Better communication with labouring women when there are issues, and what would be the best way forward to avoid traumatic births (eg bring adaptable and flexible and working off birth plans with good consultation with mother)

Reference 11 - 0.15% Coverage

How to manage the institutionalisation of birth. For example the demands of the hospital and medical framework in supporting women through natural birth. This is more than advocacy it requires strong knowledge and communication.

Reference 12 - 0.15% Coverage

Midwives must be in a position to stand up and challenge the high rates of intervention- epidurals and unnecessary cesarean births- the midwife of the future nees to be savvy and political and be prepared to be part of the change

Reference 13 - 0.15% Coverage

Patient welfare- not dismissing cries for help

Reference 14 - 0.15% Coverage

Communication between staff

Reference 15 - 0.15% Coverage

Empathy and bedside manner

Competence

<Files\\MASSurvey1> - § 1 reference coded [0.15% Coverage]

Reference 1 - 0.15% Coverage

Clinical Competence - once graduated as a midwife can work anywhere, need to ensure all have suitable level of clinical skills in all areas.

Conduct and Ethics

<Files\\MASSurvey1> - § 3 references coded [0.45% Coverage]

Reference 1 - 0.15% Coverage

Professionalism - form many relationships through midwifery and with social media very prevalent, midwives need to understand what is suitable professional behaviour.

Reference 2 - 0.15% Coverage

Don't downplay difficult births. Don't downplay difficulties during birth. Make sure birth notes are truthful and don't omit errors.

Reference 3 - 0.15% Coverage

Protecting dignity

Content

<Files\\MASSurvey1> - § 67 references coded [10.15% Coverage]

Reference 1 - 0.15% Coverage

CTG interpretation should be incuded in education.

Reference 2 - 0.15% Coverage

Graded assertiveness skills should be taught at University so midwives feel comfortable with advocacy for women

Reference 3 - 0.15% Coverage

Midwives need education on how to sensitively raise and discuss various pregnancy risks and poor pregnancy outcomes with ALL pregnant women to empower her with knowledge to help keep her and her baby safe. (see stillbirth senate inqury report recommendation 11)

Reference 4 - 0.15% Coverage

Requirements around antenatal care provision could be expanded to include how midwives need to continue to work with women even if she is not low risk (women are onlder and sicker than they have ever been but still benefit from midwifery care)

Reference 5 - 0.15% Coverage

Include management of maternal reports of altered fetal activity (reduction in strength, frequency and/or pattern) in content about CTG interpretation (this will ensure that the midwife is not only looking as a CTG trace to assess fetal wellbeing but also listening to the woman)

Reference 6 - 0.15% Coverage

I wish I'd been able to cannulate and suture and be competent at venepuncture by graduation - I'm trying to catch up now, especially as a direct entry grad.

Reference 7 - 0.15% Coverage

Cultural studies in the sense of macro picture of women, wellness, patriarchy, gender issues, public health impact of midwifery - how greater risk profile and induction/csection rates, birth trauma have big impact on population, not just individual family.

Reference 8 - 0.15% Coverage

few midwives see women prior to 20 weeks gestation and afetr 5 days post partum hence more learning focussing on this period.

Reference 9 - 0.15% Coverage

Standard 4: Expand curriculum that details what comprehensive assessment is to plan appropriate care.

Reference 10 - 0.15% Coverage

Reality - nursing and midwifery students need to understand the reality of working in Austrlian Maternity Services. From the shift work, the difference between private and public systems, to the difference between midwifery continuity of care models, homebirth models and public team maternity care.

Reference 11 - 0.15% Coverage

Medical System - not every public hospital has midwifery continuity of care, and not every public hospital supports midwifery continuity of care or even midwifery care. Understanding the reality of the medical system will help students from the trauma and shock they experience in clinical placement when both they and the registered midwife is unable to stand up against the medical team

Reference 12 - 0.15% Coverage

To ensure practice reflects best available evidence, midwives need the knowledge and skills associated with Implementation Science and Change Leadership to be able to move research findings into clinical care.

Reference 13 - 0.15% Coverage

adult learning principles

Reference 14 - 0.15% Coverage

understanding of the physiology

Reference 15 - 0.15% Coverage

Solid teaching & knowledge of the anatomy & phsiology to inform their practice

Reference 16 - 0.15% Coverage

More clinical time to master the basic skills of midwifery

Reference 17 - 0.15% Coverage

Graduate midwives with skills required for care across the continuum and midwifery led care to include IV cannulation, perineal suturing, water birth, prescribing and ordering diagnostics

Reference 18 - 0.15% Coverage

Graded assertiveness skills - it is extremely hard to advocate for women in such medically driven models and graduates need to be confident and competent in speaking up for women and during critical care periods

Reference 19 - 0.15% Coverage

Bachelor of Midwifery and Post-Graduate programs need to be more tailored to the needs of each group.Some subjects in PG program are already covered in the General Nursing Degree. Such as research: principles remain the same. Cultural Awareness: PG program only needs to focus on maternity issues as they have covered the major concepts previously.

Reference 20 - 0.15% Coverage

Curriculum to encompass the needs of ALL women. At present very focused on low risk well women and Continuity of Care. Does not prepare the student for the needs of the comlex woman and the important role the midwife has in that woman's journey

Reference 21 - 0.15% Coverage

Education and mentoring of women, families, community and the professions- eduation needs to be incorporated into every interaction with women, colleagues and other professionals

Reference 22 - 0.15% Coverage

Providing content that relates practically

Reference 23 - 0.15% Coverage

Much more practical education - hands-on experience turns out to be more beneficial than theoretical learning, Students need to understand early how hospitals work

Reference 24 - 0.15% Coverage

Fit for practice. I know student who are in their 3rd year who have never given an IM injection or can't take a blood sample. Surely these basic skills must be included in a sign off in year 1/ first part of year 2.

Reference 25 - 0.15% Coverage

Clinical Readiness

Reference 26 - 0.15% Coverage

Advocacy(both for student and women)

Reference 27 - 0.15% Coverage

Teaching and valuing empathy

Reference 28 - 0.15% Coverage

Assist Rural & Remote Hospital Centres in Midwufery Care

Reference 29 - 0.15% Coverage

cover full spectrum antenatal, intra, post and newborn care

Reference 30 - 0.15% Coverage

4. Do we need a module on midwifery leadership – will it lead to increased professionalism

Reference 31 - 0.15% Coverage

eadership and managing change. In order to change the crucial issues in the practice environment we need graduates who understand how to influence and drive change. Not all future influences on practice are known at this stage so dealing with change and leading debate are essential skills. Improving the practice environment – optimal support for students by well prepared midwifery practice

Reference 32 - 0.15% Coverage

Teaching what 'being with a woman means'. Too often I see midwives monitoring CTG's from the nurses station and not providing ongoing support to women. I feel we have lost some of the personal touches of midwifery in a high risk, high pressure environment. Good midwifery care is ensuring women feel supported regardless of there birth. The importance of supporting a woman through a 'normal low risk' birth all the way through to a Cat 1 caeser.

Reference 33 - 0.15% Coverage

Critical thinking - seems to be lacking when they come out of uni

Reference 34 - 0.15% Coverage

CTG 's

Reference 35 - 0.15% Coverage

critical thinking skills development. Graduate midwives ask a lot of questions quite rightly. they need to be taught how to think critically. Whole picture problem solving

Reference 36 - 0.15% Coverage

Advocacy

Reference 37 - 0.15% Coverage

Promotion and support of physiology

Reference 38 - 0.15% Coverage

Placing a higher value on the clinical/practical component of midwifery education. Setting the bar high to make high quality, questioning, well rounded, work-ready midwives of the future.

Reference 39 - 0.15% Coverage

complex knowledge and undertsanding of immunisation education

Reference 40 - 0.15% Coverage

Education not aligned with the clinical requirements

Reference 41 - 0.15% Coverage

Ensure SCN is a key component of any midwifery degree

Reference 42 - 0.15% Coverage

applying anatomy and physiology to thier everday practice

Reference 43 - 0.15% Coverage

Leadership skills. To be an independant practitioner you must have autonomy and know how to manage that

Reference 44 - 0.15% Coverage

Educating for home births.

Reference 45 - 0.15% Coverage

Providing the trainees with learning environments that are supportive but not smothering

Reference 46 - 0.15% Coverage

In an increasingly complex health care system, midwifery graduates need more education on leadership and governance.

Reference 47 - 0.15% Coverage

Critical thinkers inclusive of research focus and how this informs practice and how they as midwives can contribute to the body of evidence

Reference 48 - 0.15% Coverage

Local to Global and global to local perspective and understanding of women's health

Reference 49 - 0.15% Coverage

Practice readiness - problem solving ability, priority of workload and how, when and who to seek help from when needed.

Reference 50 - 0.15% Coverage

Leadership and managing change. In order to change the crucial issues in the practice environment we need graduates who understand how to influence and drive change. Not all future influences on practice are known at this stage so dealing with change and leading debate are essential skills.

Reference 51 - 0.15% Coverage

Lectures that are relevant to training

Reference 52 - 0.15% Coverage

consistent curriculum content

Reference 53 - 0.15% Coverage

need to understand that birth is more than just a physiological event- that it is spiritual, cultural, emotional, mental and that in order to provide safe care these need to be acknowledged and respected

Reference 54 - 0.15% Coverage

The physical injuries that significant numbers of women are suffering during child birth and better understanding of how these come about during labour

Reference 55 - 0.15% Coverage

The statistics around birth injuries and understanding that they do happen and why/when/how to avoid

Reference 56 - 0.15% Coverage

Less personal opinion from midwives. They need to follow hospital protocol when giving advice. Too many mixed opinions at this stage which is confusing to a mother. No breastfeeding bias, no settling method bias etc. What the hospital adopts as what they want to advise, all midwives should stick to

Reference 57 - 0.15% Coverage

How to manage the institutionalisation of birth. For example the demands of the hospital and medical framework in supporting women through natural birth. This is more than advocacy it requires strong knowledge and communication.

Reference 58 - 0.15% Coverage

National Curriculum/Rational. Currently there is inconsistency not only in the maternity services that women can access but also there is inconsistency in what students are being taught and are having exposure to across Australia. This does not support the future of midwifey or the Governments promises to give women access to Midwives and Midwifery Models of care. Please support the future of midwifery, by getting serious about this and develop a National Midwifery Training Curriculum. Then and ony then can you actually say with confidence that we are training a quality furtue midwifery workforce. Thanks

Reference 59 - 0.15% Coverage

educated to contemporary practice

Reference 60 - 0.15% Coverage

Preparation of midwifery graduates to better manage complex care issues and a greater understanding of women's health issues.

Reference 61 - 0.15% Coverage

Increased proficiency in caring for late preterm and/or sick neonates.

Reference 62 - 0.15% Coverage

Greater emphasis on the postnatal period, particularly the health of the mother

Reference 63 - 0.15% Coverage

Teach parents small things like how to bathe the baby

Reference 64 - 0.15% Coverage

To educate strong midwives not hand maidens

Reference 65 - 0.15% Coverage

To embrace kindness

Reference 66 - 0.15% Coverage

International experience whereidwofery is the only care

Reference 67 - 0.15% Coverage

Understanding and using data to inform change.

Reference 1 - 4.76% Coverage

Understanding contemporary midwifery care in the context of Australian practice.

- Including how to conduct comprehensive assessment, plan care, prioritization, and management of the demands of the complex health care system and current maternity care provision

Reference 2 - 5.60% Coverage

Demonstrates professionalism, reflective practice and is accountable for individual professional development

- Is responsible for ongoing professional development in order to maintain knowledge of evidenced based care; maintain and develop clinical skills of midwifery care; and practice critical reflection
- Contributes to a workplace culture that is safe and supports learning, shared knowledge and mentors learners

Continuity

<Files\\MASSurvey1> - § 42 references coded [6.25% Coverage]

Reference 1 - 0.15% Coverage

Continuity of care (COC) and pathways to beginning practice –while evidence supports that COC is best practice there are limited placement opportunities and current minimal requirements limit students' ability to optimise learning in this environment

Reference 2 - 0.15% Coverage

continuity of carer and continuity of care

Reference 3 - 0.15% Coverage

Continuity of care

Reference 4 - 0.15% Coverage

supporting students into continuity of care models once qualified

Reference 5 - 0.15% Coverage

Exposure to continuity of care models in order to prepare new midwives to transition into these models on graduation.

Reference 6 - 0.15% Coverage

Medical System - not every public hospital has midwifery continuity of care, and not every public hospital supports midwifery continuity of care or even midwifery care. Understanding the reality of the medical system will help students from the trauma and shock they experience in clinical placement when both they and the registered midwife is unable to stand up against the medical team

Reference 7 - 0.15% Coverage

Value of contunity of carer - working alongside multidisciplinary team

Reference 8 - 0.15% Coverage

To prepare midwifery students to work in continuity of midwifery care models, midwifery courses must include practicum placements in sites that practice this model of care rather than having to attain this experience through Continuity of Care Experiences, which are burdensome and do not reflect real-world practice

Reference 9 - 0.15% Coverage

Continuity of Care numbers: PG students doing 10 in 12 months places unnecessary pressure on them. It also puts their safety and well being at risk due to the additional hours they do to meet the requirements. In NSW they are employed 32hrs/week. The student is often forced to either attend a shift after a limited break or working then attending CoC resulting in excessive hours that would not be allowed if it was paid time. Suggest PG program reduce to 5 CoC.

Reference 10 - 0.15% Coverage

CoC follow through numbers versus acquisition of midwifery knowledge

Reference 11 - 0.15% Coverage

C of C with women that students interact with, rather than focus on number of births witnessed etc

Reference 12 - 0.15% Coverage

Opportunities to follow through clients of independent midwives

Reference 13 - 0.15% Coverage

Placement and experience in continuity models above standard continuity expropriation (MGP placements)

Reference 14 - 0.15% Coverage

Experiencing continuity of Care

Reference 15 - 0.15% Coverage

While a COC is great and graduates want to be involved - it is currently too onerous

Reference 16 - 0.15% Coverage

Continuity of midwifery care available to all women and a continuity program that accepts and supports newly graduated midwives. This way they can be supported to practice the philosophy they've been taught.

Reference 17 - 0.15% Coverage

Continuity of Care - evidence based as gold standards of care, minimal models for access for learning, minimal models for future employment, reduced numbers of CoC experiences in training

Reference 18 - 0.15% Coverage

Continue the midwifery continuity of care component of the program - minimum 15 - as it is all about woman centered care

Reference 19 - 0.15% Coverage

Understanding and working within continuity models of midwifery care that utilise a wellness based approach to maternity care

Reference 20 - 0.15% Coverage

Continuity of carer

Reference 21 - 0.15% Coverage

Educating for best practice (continuity of carer) is difficult due to slow roll out of these models and limited student placements

Reference 22 - 0.15% Coverage

Improving the practice environment – optimal support for students by well prepared midwifery practice midwives. There are a number of other elements that come into this, a safe environment, quality learning experiences, models of care (continuity) that are congruent with best practice are some of the elements

Reference 23 - 0.15% Coverage

Midwifery students require greater access to continuity of care models for clinical practice

Reference 24 - 0.15% Coverage

maintain high levels of clinical experience and continuity case load

Reference 25 - 0.15% Coverage

continuity of care - midwifery lead models must increase

Reference 26 - 0.15% Coverage

Needs to be more focus on continuity of care experiences. Placement should not take priority over COC women, as they lose the understanding of care through pregnancy. Graduates seem to come out with a fear of caring for women across the continuum. This should not be so. This is what midwives do. They obviously need a lot more time in antenatal care to graduate if they are not able to care for women in pregnancy. Preparing students to take up evidence based care should be the goal of a midwifery degree.

Reference 27 - 0.15% Coverage

Continuity of carer

Reference 28 - 0.15% Coverage

Promoting Midwifery led continuity of care models

Reference 29 - 0.15% Coverage

Sustainability of midwiferyled continuity of care through transitions of graduate midwives

Reference 30 - 0.15% Coverage

Encouraging political action to promote Midwifery led continuity of care in an increasing obstetric risk based model of care

Reference 31 - 0.15% Coverage

The significant impact that needing to follow women through COCE has on students and their abilities to maintain a balanced life during their studies

Reference 32 - 0.15% Coverage

The accreditation standards - there is a focus on birth (30 births required) as opposed to the continuum of care and the relationship with the woman

Reference 33 - 0.15% Coverage

Lack of systemic support for midwives practicing in a continuity of carer model

Reference 34 - 0.04% Coverage

Increase continuity of care experiences for student midwives (given that that is the model that has the best evidence so graduates should be able to take up this role immediately

Reference 35 - 0.15% Coverage

Increase the continuity of care models available to women. This is the safest model of birthing care for low risk women

Reference 36 - 0.15% Coverage

Midwifery Models of Care/Rational: Currently, the roll out of midwifey models of care is in its infancy across the country. Not all public hospital services have embraced midwifery models of care and they do not exist in the private obstetric hospital systems. This means, there are very few midwives and service providers experienced midwifery models of care and the reality is - students do not gain quality experience in these models. The COC experiences that students engage in, plays lip service to the prinicple and philosopy of midwifery continuity of care. It is curretnly just another thing to tick off and not a quality learning exercise. Another underpinning reason for this is: 97% of our women are accessing medical obstetric models and the system and focus of care irrespective, is management of minimal risks and disease and illness prevention and management. The COC experience minimum requirements has bee so watered down - its hardly worth the effort and student fight to get out of doing even the minimum requirements - and this is because the value of the value of been downgraded significantly in educations requirements.

Reference 37 - 0.15% Coverage

Midwives prepared to support & promote physiological birth in a continuity model at registration

Reference 38 - 0.15% Coverage

Midwifery educators to provide education themselves been in COC position

Reference 39 - 0.15% Coverage

availability of continuity of midiwfery care models for both clinical practice and as new graduates

Reference 40 - 0.15% Coverage

evidence overwhelmingly indicates superiority of continuity of care for women therefore we must prepare graduates to work in this capacity. We need to increase continuity of care experience for students so they are confident in this model on graduation

Reference 41 - 0.15% Coverage

Placements in Continuity of care

Reference 42 - 0.15% Coverage

Importance of continuity of care. The best maternity outcomes occur when a woman has continuity of care and continuity of carer.

Reference 1 - 7.70% Coverage

Understand the principles of continuity of care and collaboration with other members of the multidisciplinary team Compassionate care and establishing a relationship of trust is essential for midwives to provide continuity of care to women, optimizing the best clinical outcome for mothers and babies

- Collaboration with other midwives, medical staff and allied health enables communication and safe clinical outcomes

Costs

<Files\\MASSurvey1> - § 13 references coded [1.97% Coverage]

Reference 1 - 0.15% Coverage

The costs associated with specialist education services (e.g. FSEP and PIPER) are significant to the overall budget for the midwifery programs but are almost ot the point of becoming prohibitive. This means that the students will receive the required instruction from their lecturers, instead of experts in the field, which can lead to a loss of the knowledge translation for the student

Reference 2 - 0.15% Coverage

Need to ensure sufficient overall clinical practice hours in an environment where universities are seeking to reduce costs. Risk of midwifery being aligned to nursing hours.

Reference 3 - 0.15% Coverage

The impact of placement on income, working around placement/classes is extremely difficult. Students on placement should receive some payment - apprentices do.

Reference 4 - 0.15% Coverage

Paid postgraduate models

Reference 5 - 0.15% Coverage

difficulties in getting a permanent job after: costs incurred in getting degree, disillusionment for grads, ?long term implications on workforce

Reference 6 - 0.15% Coverage

scholarships to asssit candidates to conduct midwifery training

Reference 7 - 0.15% Coverage

support for a graduate midwife program and resouces / funds to support this

Reference 8 - 0.15% Coverage

cost, when you work remote, there is a considerable cost to travelling for education. Work place no longer pays for this and the around 700 does not cover much.

Reference 9 - 0.15% Coverage

distance, again many of us have to travel for education, this entails increased costs and we have to use our personal leave to do this.

Reference 10 - 0.15% Coverage

complexity and number of clinical experience requirements. Students are mostly mature age and have family responsibilities and part time work. They find it stressful to study, attend allocated placement shifts and be "with-woman" when undertaking their CCE. Most have part time work to juggle to feed themselves and family.

Reference 11 - 0.15% Coverage

The financial burden of attending all their clinical placement shifts and CCE women, paying for parking at university and the hospitals while attempting to work (and study).

Reference 12 - 0.15% Coverage

Students are older / have families / challenging lives - education needs to be more flexible to accomadate this

Reference 13 - 0.15% Coverage

Bursary is required to support students who spend time juggling the midwifery course and paying houseld bills - they drop out through exhausation and lack of flexibility

Diversity

<Files\\MASSurvey1> - § 6 references coded [0.91% Coverage]

Reference 1 - 0.15% Coverage

Diversity - midwives need to be inclusive of our diverse culture , gener prefences, religious beliefs both within the workforce and the women and families being cared for

Reference 2 - 0.15% Coverage

Diversity - voluntary and involuntary migration mean midwives are facing more issues such as linguistic barriers, PTSD, FGM, etc. A subject specific to this is necessary.

Reference 3 - 0.15% Coverage

subjects 'global ' issues and not highlighting the challenges of the rural family in accesing healthcare in Australia especially for metro students

Reference 4 - 0.15% Coverage

Midwifery care needs to be culturally appropriate and aim to bridge the gap in outcomes for women and babies in groups that have been identified as being at risk.

Reference 5 - 0.15% Coverage

need to understand that birth is more than just a physiological event- that it is spiritual, cultural, emotional, mental and that in order to provide safe care these need to be acknowledged and respected

Reference 6 - 0.15% Coverage

Moving forward - embrace the future of maternity care, technology and diversity among patient populations needs.

Educators

<Files\\MASSurvey1> - § 20 references coded [3.03% Coverage]

Reference 1 - 0.15% Coverage

educators with appropriate higher level degree

Reference 2 - 0.15% Coverage

Practical skills taught by midwifery clinicians in the workplace, not by university lecturers who have not practiced for many years if at all

Reference 3 - 0.15% Coverage

Availability of staff to educate. Currently all midwifery staff within in regional facilites are taught via midwifery educator or hospital educator clinically, these edcuators are expected to teach a large numebr of staff, as well as new grads and BMids, i think thier is not enough of them in regional NSW most birthing facilities, level 3 or below do not have an educator, and level 4 and above have only 1 educator to take this task on

Reference 4 - 0.15% Coverage

Access to quality educational courses for CMEs to ensure they have access to the best resources possible to teach

Reference 5 - 0.15% Coverage

Development of resources that will support educators to do their job in a tightly understaffed environment

Reference 6 - 0.15% Coverage

Quality frameworks for CMEs to provide guidance and examples of orientation programs or TPP programs to assist them without them having to reinvent the wheels

Reference 7 - 0.15% Coverage

lack of clinical facilitators on the floor: increased workloads for core staff, inadequate education / debriefing of students, lack of clinical opportunities

Reference 8 - 0.15% Coverage

not enough senior clinicians to taech students

Reference 9 - 0.15% Coverage

Bullying from educators

Reference 10 - 0.15% Coverage

Education given by people that have not actually worked on the floor for a long time.

Reference 11 - 0.15% Coverage

lack of clinical support for student midwives - some venues keep adding to the job list of midwivery clinical teachers (probably all clinical teachers) so that they have very limited time when they are available for the students.

Reference 12 - 0.15% Coverage

Strong mentor-based graduate programs are required in all midwifery units

Reference 13 - 0.15% Coverage

excellent teaching and role modelling

Reference 14 - 0.15% Coverage

Mentoring - many current midwives do not know how to work with students. They need to be comfortable & competent in mentoring future midwives.

Reference 15 - 0.15% Coverage

good clinical supervision and support that dovetails with what students are learning at university. it requires that clinical partners and university work closely and that clinical partners see their role and responsibility in educating the midwives of the future

Reference 16 - 0.15% Coverage

Midwifery leadership

Reference 17 - 0.15% Coverage

Lack of consistency in supervision of midwifery students across Australia

Reference 18 - 0.15% Coverage

Universities- Midwivery needs to be acknowledged as seporate from Nursing in both regulation and educationla instutions. Currently, in universities, midwifery is subsumed into the school of nursing and the net effect of this is that it is treated as a boutique program and therefore given minimal resourcing. This needs to change. In the national curriculum, there needs to be greater claritity stipulated around a standard that not only states the teacher to student ratio numbers but also, mechanisms that enable the educators maintain clinical currency by working alongside students in placement settings. Further, midwifery education, needs to be a school in its own right and have a mandated research arm. Thanks

Reference 19 - 0.15% Coverage

Midwifery educators to provide education themselves been in COC position

Reference 20 - 0.15% Coverage

Have more clinical workshops built into the course weekly taught by practising midwives - those who are actually in practice

Employment Issues

<Files\\MASSurvey1> - § 63 references coded [9.54% Coverage]

Reference 1 - 0.15% Coverage

Ignorance of the broader health system

Reference 2 - 0.15% Coverage

More support from managers to help achieve qualifications and skills

Reference 3 - 0.15% Coverage

Set education programs and education days

Reference 4 - 0.15% Coverage

Have preceptors and enough senior support on the floor

Reference 5 - 0.15% Coverage

professionalism and communication mulidisciplinary team

Reference 6 - 0.15% Coverage

midwife retention

Reference 7 - 0.15% Coverage

safe and supported workplaces

Reference 8 - 0.15% Coverage

Inconsistent funding for midwifery student employment. Midwifery is the only postgraduate program without mandatory paid student placements. The hospitals can elect to place students in an employment model but the funding is not always adequate to entice the agencies to do so, or the funding does not account for students needing significant supervision for their placements (as this is still a pre-registration program) or the need for students to seek experiences outside of their 'home' clinical agency. Most commonly, this is to seek higher acuity placements, SCN, or birth experiences. For these reasons, many students are supernumerary. They have to juggle financial constraints alongside their studies, putting them at a disadvantage

Reference 9 - 0.15% Coverage

ensuring a 'glass ceiling' doesn't exist - ie: include aspects of nursing, child & family health, NICU in curriculum

Reference 10 - 0.15% Coverage

Mentoring within health facilities for new Graduates adds support

Reference 11 - 0.15% Coverage

I wish I'd been able to cannulate and suture and be competent at venepuncture by graduation - I'm trying to catch up now, especially as a direct entry grad.

Reference 12 - 0.15% Coverage

Medical System - not every public hospital has midwifery continuity of care, and not every public hospital supports midwifery continuity of care or even midwifery care. Understanding the reality of the medical system will help students from the trauma and

shock they experience in clinical placement when both they and the registered midwife is unable to stand up against the medical team

Reference 13 - 0.15% Coverage

Availability of staff to educate. Currently all midwifery staff within in regional facilites are taught via midwifery educator or hospital educator clinically, these edcuators are expected to teach a large numebr of staff, as well as new grads and BMids, i think thier is not enough of them in regional NSW most birthing facilities, level 3 or below do not have an educator, and level 4 and above have only 1 educator to take this task on

Reference 14 - 0.15% Coverage

Recently we had the oppurtunity to do an audit on the hours of education that is expected of the trained midwife, they not only ahve to incorporate mandatory training that is requested by thier facility, they also need to complete hours of education in regards to mdiwifery, such as K2 FONT, ONT, PROMPT (if it is in thier facilty), Breastfeeding the list goes on and on, this training exceeds 40hrs, without in-services, mandatory training and any extra training that is required

Reference 15 - 0.15% Coverage

I think a dedicated educational page, that allows staff in specilised field access to eduacation, many midiwves espically in regional and remote ares travel extensively to train and attend education and assistance

Reference 16 - 0.15% Coverage

consistancy in language is a very important need throughout NSW, depedning on where you are and where you work the language that is used within midwifery is inconsistant and places added burden on midiwves when they are moving from facility to facility

Reference 17 - 0.15% Coverage

Safety issues for staff and clients, how to protect them all from harm, mindfulness awareness for staff, true management of staff fatigue to support client safety

Reference 18 - 0.15% Coverage

increased workload in clinical areas restricting midwives from attending planned education

Reference 19 - 0.15% Coverage

difficulties in getting a permanent job after: costs incurred in getting degree, disillusionment for grads, ?long term implications on workforce

Reference 20 - 0.15% Coverage

lack of clinical facilitators on the floor: increased workloads for core staff, inadequate education / debriefing of students, lack of clinical opportunities

Reference 21 - 0.15% Coverage

Staff:Patient ratios so that students being mentored are not trreated as auxiliary staff

Reference 22 - 0.15% Coverage

Reality check: most students get a terrible shock after learning the ideals of midwifery at Uni, and then are confronted by the reality of maternity care. They are also expected to be flag-bearers for change - this is not fair, given experienced midwives' patent inability to alter the toxic reality of maternity care in Australia.

Reference 23 - 0.15% Coverage

Ratios - mother and baby separate

Reference 24 - 0.15% Coverage

3. Are we preparing our B Mid students to work in our public health system?

Reference 25 - 0.15% Coverage

5. Can we do anything about PII? And PPMs

Reference 26 - 0.15% Coverage

retention of newly qualified midwives into the workplace

Reference 27 - 0.15% Coverage

opportunities for ongoing professional development once qualified and mandator allocation of time to complete annual competencies

Reference 28 - 0.15% Coverage

Providing a safe environment for women to be able to safely birth at their choice of place (including home).

Reference 29 - 0.15% Coverage

Working towards making a safer, kinder, midwifery valuing workplace/institution.

Reference 30 - 0.15% Coverage

Suitable placements of graduates into appropriate positions: due to lack of experience

Reference 31 - 0.15% Coverage

Lack of flexibility around utilising nursing staff in hospitals: related to midwives and general nursing

Reference 32 - 0.15% Coverage

Retention- unrealistic expectations of midwifery and low resillience

Reference 33 - 0.15% Coverage

Increase in workplace clinical and administation demands

Reference 34 - 0.15% Coverage

Workplace expectations of access to staff outside of work hours and unpaid work

Reference 35 - 0.15% Coverage

not enough leave, as education is now done in our own time

Reference 36 - 0.15% Coverage

Ratios - Midwives are caring for more complex women and complex babies but the ratios are the same. It's dangerous (6 women and 6 babies at night for one midwife plus the extra load you pick up when a colleague takes a break)

Reference 37 - 0.15% Coverage

increase in grad workforce taeching students

Reference 38 - 0.15% Coverage

Transitioning Students straight into midwifery continuity of carer models rather than the standard rotation through wards known as the transition to professional practice

Reference 39 - 0.15% Coverage

Not enough time

Reference 40 - 0.15% Coverage

Need more study days

Reference 41 - 0.15% Coverage

Too much conflict between hospitals different standards followed in difficult work places.

Reference 42 - 0.15% Coverage

Bullying from educators

Reference 43 - 0.15% Coverage

Providing accessible and acceptable postgrad opportunities within hospitals and other places that promote a professional workforce that is sustainable

Reference 44 - 0.15% Coverage

Some units are not offering new grad positions to BMid graduates

Reference 45 - 0.15% Coverage

Limited new grad positions across the country - might be better off making BMid a 4 yr degree so they do not need new grad postilions

Reference 46 - 0.15% Coverage

Improving the practice environment – optimal support for students by well prepared midwifery practice midwives. There are a number of other elements that come into this, a safe environment, quality learning experiences, models of care (continuity) that are congruent with best practice are some of the elements

Reference 47 - 0.15% Coverage

good well informed clinical leadership

Reference 48 - 0.15% Coverage

Poor respect for student midwives by Organisations

Reference 49 - 0.15% Coverage

No guarantee that a student would be placed at an organisation for a graduate position they were completing their training

Reference 50 - 0.15% Coverage

slow process in Queensland for graduating midwives to be reemployed in Metro North Queensland waiting 6 months to commence graduate year. Then new midwives need re skilling

Reference 51 - 0.15% Coverage

No hiring of BMIG as a contract (PAID) as a student midwife to help support recruitment in the public sector in QLD (Metro North)

Reference 52 - 0.15% Coverage

Universities see as a business and so does public health student midwives a given a position to train then it can be withdrawn the following year as there is no committed numbers of student midwives in an organisation. All universities are competing for positions. It seems if the university is close to a hospital it takes students but what about students that work in the facility but chose a different university to study??? they are told to bad we only take one or two specific universities completely biased

Reference 53 - 0.15% Coverage

Have a mentoring system, grad year as in new zealand suporting grads with working in the community or hospital

Reference 54 - 0.15% Coverage

Support a grad program in the community. More grad positions for grad midwives. Open options of care for clients

Reference 55 - 0.15% Coverage

Staffing levels in hospitals, adequate numbers are required for safe care

Reference 56 - 0.15% Coverage

Better support for a transitional year with mentoring available and support through education funding

Reference 57 - 0.15% Coverage

Availability of graduate midwife programs and adequate supervision during new grad program. To enable new grads to consolidate their skills.

Reference 58 - 0.15% Coverage

availability of continuity of midiwfery care models for both clinical practice and as new graduates

Reference 59 - 0.15% Coverage

Making sure procedures are done within time frames eg removing cannulas

Reference 60 - 0.15% Coverage

Do not allow hospitals to accept clients if they do have access to doctors, anesthetists etc.

Reference 61 - 0.15% Coverage

Graduate midwife jobs

Reference 62 - 0.15% Coverage

Continuing professional development. Updating of skills and knowledge, based on latest evidence and research. Ability to undergo further professional development and advocacy for maternity and midwives as each midwife would like.

Reference 63 - 0.15% Coverage

jobs for graduates - shortage of midwives and reduced jobs- need to increase places in grad programs

Equity

<Files\\MASSurvey1> - § 3 references coded [0.45% Coverage]

Reference 1 - 0.15% Coverage

Politics - Midwives need to understand the patriarchal system we work in which denies women choices and underpays the large majority of its workforce which is female

Reference 2 - 0.15% Coverage

Awareness of broader socail and contemporary issues related to inequality and power imbalances within the health care system.

Reference 3 - 0.15% Coverage

Equity and access see issue 1,2,3

Evidence Based

<Files\\MASSurvey1> - § 25 references coded [3.66% Coverage]

Reference 1 - 0.15% Coverage

evidence based best practice

Reference 2 - 0.15% Coverage

All Registration, professional and accreditation bodies should abide by the National Midwifery Stadards for Referral and Consultation

Reference 3 - 0.15% Coverage

Evidenced based care

Reference 4 - 0.15% Coverage

To facilitate truly woman centred care and women's truly informed choice, midwives need the knowledge and skills to be able to provide evidence-based antenatal education.

Reference 5 - 0.15% Coverage

To ensure practice reflects best available evidence, midwives need the knowledge and skills associated with Implementation Science and Change Leadership to be able to move research findings into clinical care.

Reference 6 - 0.15% Coverage

access to relevant EBP policies,procedures and guidelines

Reference 7 - 0.15% Coverage

Strengthening research capabilities of learners (as consumers of research and contributing to research) – goes with managing and leading change and improving practice.

Reference 8 - 0.15% Coverage

Evidence informed practice

Reference 9 - 0.15% Coverage

Able to understand and apply evidence in practice

Reference 10 - 0.15% Coverage

Evidence base - ensuring that education meets highest standards by facilitating CoC exposure as evidenced by recent research, focus on midwifery led models of care, delivered by midwives for midwives (e.g. ensuring future of Direct Entry options)

Reference 11 - 0.15% Coverage

Use of evidence based practice

Reference 12 - 0.15% Coverage

Knowledge of the evidence and and ability to utilise the evidence into practice

Reference 13 - 0.15% Coverage

Evidence based practice

Reference 14 - 0.15% Coverage

We must continue to educate for what we know is evidence based best practice - even if many students are not seeing it in the workplace - education should not be compromised just because services do.

Reference 15 - 0.15% Coverage

Critical thinkers who engage with research (understaning the role of research in informing practice and contributing to the body of evidence.

Reference 16 - 0.15% Coverage

Translating research into practice. The delay in incorporating many innovations into practice where there is robust evidence need to be addressed.

Reference 17 - 0.15% Coverage

Strengthening research capabilities of learners (as consumers of research and contributing to research) – goes with managing and leading change and improving practice.

Reference 18 - 0.15% Coverage

Robust evidence to supportr the mandatory numbers for antenatal, postnatal and birthing experiences

Reference 19 - 0.03% Coverage

Ensure all midwifery academics have research as a component of their role so that they are actively contributing to the midwifery knowledge base

Reference 20 - 0.15% Coverage

Evidence based midwifery care

Reference 21 - 0.15% Coverage

Mandate a research project into a Nationally agreed Midwifery Curriculum./Rational - if you want to educate a midwifery workforce who is ready and able to do what is requied to sustain midwifer - MIDWIFERY MODELS OF CARE, then all midwives need to know how to evaluate care practices and conduct research that will inform and change practice. This skill should not be something that only the elete or some midwives can do. We need to get serious about midwifery and put midwives on the map so they can equally stand up againt the medical profession and say - our care is 'Scientifically' supported! - If we are serious about changing the future of midwifery in Australia for women, then we need to get seriosu about research. If you mention research to a trainee midwife, indeed most midwives on the floor of a maternity unit, they look at you as if to say, what they hell! It is midwives responiblity to advance the future of midwifery and this needs to be done through research and for each and evey

midwife taking full responsiblity for training student midwives Thanks.

Reference 22 - 0.15% Coverage

Midwifery academics should be involved in developiong the knowledge base of midiwfery (midwifery research) therefore a research component should be part of every midwifery academics role

Reference 23 - 0.15% Coverage

Educating student Midwives in line with evidence but having placement within a medicalised system

Reference 24 - 0.15% Coverage

Control of bias - presenting evidence based advice rather than own opinion

Reference 25 - 0.15% Coverage

Sound and evidence-based knowledge. Well educated on all the aspects of maternity care with up-to-date knowledge based on research and evidence.

<Files\\NSWHealthFeedbackSurvey> - § 1 reference coded [5.48% Coverage]

Reference 1 - 5.48% Coverage

Having a sound knowledge of current evidenced based midwifery practice. Midwives need to understand the physiology of normal pregnancy, labour and postpartum, as well as the physiology of the healthy newborn

- It is with the sound understanding of normal that then a midwife can identify abnormal

Four Year Degree

<Files\\MASSurvey1> - § 7 references coded [1.06% Coverage]

Reference 1 - 0.15% Coverage

Four year degree - non nurse midwives are unprepared for the complexity of many woman & unable (broadly) identify issues of concern impacting on her health and that of her baby

Reference 2 - 0.15% Coverage

a well educated and prepared new graduate - must have a 4 year degree

Reference 3 - 0.15% Coverage

a higher caliber of midwives who understand the whole body and health and how each affects eachother - 4 year degree. I have been asked what a chronic disease is a few times, experienced midwives not understanding diabetes , medications, obesity, hypertension etc

Reference 4 - 0.15% Coverage

2. Should we be reviewing our midwifery preparation courses and perhaps moving to a 4 year course to allow for education in specialised midwifery? All initial Allied Health courses are now of 4 years duration.

Reference 5 - 0.15% Coverage

Length of program - extending the undergraduate midwifery program to four years would allow for the addition of essential subjects (see below) and a more intentional clinical placement strategy (also see below).

Reference 6 - 0.15% Coverage

Limited new grad positions across the country - might be better off making BMid a 4 yr degree so they do not need new grad postilions

Reference 7 - 0.15% Coverage

Current work load for student midwives is far too much. It is quite unattainable .

Funding

<Files\\MASSurvey1> - § 1 reference coded [0.15% Coverage]

Reference 1 - 0.15% Coverage

Limited budgets

Hours

<Files\\MASSurvey1> - § 1 reference coded [0.02% Coverage]

Reference 1 - 0.02% Coverage

Mandate hours for mid education and make this commensurate with EU and NZ standards

ICM Standards

<Files\\MASSurvey1> - § 2 references coded [0.30% Coverage]

Reference 1 - 0.15% Coverage

consistency with ICM standards to enable global registration acceptance

Reference 2 - 0.15% Coverage

A midwife educated to ICM degree standards able to undertake full scope of practice at registration

Informatics

<Files\\MASSurvey1> - § 1 reference coded [0.15% Coverage]

Reference 1 - 0.15% Coverage

Informatics - we are an evolving digital society and all health professionals particularly midwives need to be aware of how and what informations, apps, technology women are using. We will eventually have an electronic health record and midwives need to know the implication for this.

Informed consent

<Files\\MASSurvey1> - § 10 references coded [1.52% Coverage]

Reference 1 - 0.15% Coverage

informed consent

Reference 2 - 0.15% Coverage

Advocacy(both for student and women)

Reference 3 - 0.15% Coverage

informed consent

Reference 4 - 0.15% Coverage

Informed Consent

Reference 5 - 0.15% Coverage

Procedures performed without asking for consent

Reference 6 - 0.15% Coverage

Pressuring labouring mothers into procedures

Reference 7 - 0.15% Coverage

Informed consent. Implied consent has no place in health care

Reference 8 - 0.15% Coverage

Informed consent vs assumed consent

Reference 9 - 0.15% Coverage

Choices in prenatal, birth and post natal care

Reference 10 - 0.15% Coverage

Respect for individual rights. Every woman has the right to bodily autonomy, must consent to each and every procedure and undertaking, regardless of the views and beliefs of their carers.

Inter-IntraProfessional

<Files\\MASSurvey1> - § 15 references coded [2.27% Coverage]

Reference 1 - 0.15% Coverage

Ensuring students/ graduates have opportunities to work to full scope of practice while encorporating intraprofessional and interprofessional learning for collaborative practice.

Reference 2 - 0.15% Coverage

professionalism and communication mulidisciplinary team

Reference 3 - 0.15% Coverage

Bringing togather universities and clinicians. The information students receive from universities and clinicians often do not match.

Reference 4 - 0.15% Coverage

multidysiplinary team learning

Reference 5 - 0.15% Coverage

Collaborative practive - need to be able to work with multi dis team - maybe some training together

Reference 6 - 0.15% Coverage

Emphasising the importance of team structure

Reference 7 - 0.15% Coverage

Multidisciplinary education - to prepare midwives to work in the clinical environment

Reference 8 - 0.15% Coverage

Working with others without being part of the patriarchy system

Reference 9 - 0.15% Coverage

Midwifery care needs to be offered to all women regardless of any risk they pose in pregnancy. This then requires the establishment of multidisciplinary teams when considering the scope of practice of the midwife.

Reference 10 - 0.15% Coverage

communication ,and team work

Reference 11 - 0.15% Coverage

Clinical time with all health care providers

Reference 12 - 0.15% Coverage

The role of women's health physios in recovery after birth

Reference 13 - 0.15% Coverage

Positive interdisciplinary collaboration

Reference 14 - 0.15% Coverage

Teamwork - work WITH the maternity team to ensure best practice

Reference 15 - 0.15% Coverage

Collaborative work, within and beyond each service

Reference 1 - 7.70% Coverage

Understand the principles of continuity of care and collaboration with other members of the multidisciplinary team

- Compassionate care and establishing a relationship of trust is essential for midwives to provide continuity of care to women, optimizing the best clinical outcome for mothers and babies
- Collaboration with other midwives, medical staff and allied health enables communication and safe clinical outcomes

Lactation-Breastfeeding

<Files\\MASSurvey1> - § 7 references coded [1.06% Coverage]

Reference 1 - 0.15% Coverage

Lactation

Reference 2 - 0.15% Coverage

Breastfeeding: Many mdiwives do not have the oppurtunity to become lactation consultants due to the sheer cost of maintaining this certification yet are expected to give sound peer reviewed and consistant education to women in regards to breastfeeding. It wouyld be an advantage to have this certification available at a reasonable cost for staff to complete, or undertake if they want to, it would also be good if thier was a lactation consultant available at all birthing faciliteis for eduation and assistance

Reference 3 - 0.15% Coverage

Breast feeding rates - money & action to improve

Reference 4 - 0.15% Coverage

Breastfeeding skills. Need a better understanding of breastfeeding issues and not to be reliant on lactation consultants. This is basic.

Reference 5 - 0.15% Coverage

greater depth of understadning around breastfeeding

Reference 6 - 0.15% Coverage

Breastfeeding, always important

Reference 7 - 0.15% Coverage

Student midwives need to be made aware of the importance of The Australian Breastfeeding Association.

Legislation

<Files\\MASSurvey1> - § 3 references coded [0.45% Coverage]

Reference 1 - 0.15% Coverage

Roles and responsibilities (law)

Reference 2 - 0.15% Coverage

understanding professional accountability and legal responsibilities

Reference 3 - 0.15% Coverage

Understanding the bigger picture of the Victorian health system.

Medicines - Medication management

<Files\\MASSurvey1> - § 9 references coded [1.36% Coverage]

Reference 1 - 0.15% Coverage

Pharmacology and diagnostics to prepare the future workforce to work within the primary care space

Reference 2 - 0.15% Coverage

Preparing midwives for endorsement. Need to include pharmacology & diagnostics units as part of initial registration.

Reference 3 - 0.15% Coverage

Medications - co-morbidities increasing in pregnant woman. Need more of an understanding of these instead of just midwifery medications

Reference 4 - 0.15% Coverage

improved medication safety education and adminstration practice

Reference 5 - 0.15% Coverage

Must have general nursing as well. When midwives are trained only as midwives in Australia they lack depth and general nursing skills such as post-operative care, deteriorating patients and many medications

Reference 6 - 0.15% Coverage

Future proofing their training, for example to include PBS and MBS endorsements as an elective module during their undergrad or postgrad training.

Reference 7 - 0.15% Coverage

Pharmacolgy add to curriculum midwives can be suitably trained to be independently working or more supportive in the hospital sysrem

Reference 8 - 0.15% Coverage

Diagnosis and prescribing add to curriculum as previous

Reference 9 - 0.15% Coverage

Medication charting- making sure not to double up and if you sign off on giving a patient something make sure it has actually been given

Mental Health

<Files\\MASSurvey1> - § 2 references coded [0.30% Coverage]

Reference 1 - 0.15% Coverage

Expansion of knowledge and clinical experience caring for women with mental health issues. The increasing prevalence of mild to severe mental illnesses amongst childbearing women is significant. Midwives need the skills to develop an approrpiate therapeutic relationship with these women, which is not currently emphasised sufficiently in the curriculum.

Reference 2 - 0.15% Coverage

Growing mental health issues require improved foundations in midwifery education

Midwifery lead

<Files\\MASSurvey1> - § 4 references coded [0.49% Coverage]

Reference 1 - 0.15% Coverage

Enhanced connection/linkage between universities and health services to ensure students have consistency with their academic and practical learnings. Students needs the health and education systems to collaborate.

Reference 2 - 0.15% Coverage

Schools of Nursing and Midwifery require a Head of School that is both a nurse and midwife or two seperate heads so that midwifery is represented by a midwife head.

Reference 3 - 0.04% Coverage

Ensure mid courses have a mid leader not in name only but in practice so we ensure that midwives continue to shape midwifery curricula, content and processes

Reference 4 - 0.15% Coverage

The profession of midwifery must be able to shape the content and processes of midwifery curricula (not another profession) therefore programs in midwifery must be able to demonstrate not only a midwifery lead in name but midwifery leadership in practice.

Midwifery vs Nursing

<Files\\MASSurvey1> - § 10 references coded [1.52% Coverage]

Reference 1 - 0.15% Coverage

Midwifery must be recognised as a separate profession to nursing at all levels of education, health services and policy - Nurses can not speak on behalf of midwives just as midwives cannot speak on behalf of nurses

Reference 2 - 0.15% Coverage

Outcomes in all areas of midwifery education should be presented seperately from nursing outcomes

Reference 3 - 0.15% Coverage

Midwifery is its own unique profession. Midwifery to some degree is still seen as an offshoot of nursing and this has to be removed in order to lift the profession of midwifery.

Reference 4 - 0.15% Coverage

Too much focus on nurses being midwives currently. Nurses and midwives are combining two three year degrees into four years. They seem to be missing a lot of information in this condensing. They have less depth and seem to have less questioning minds. I spoke to an academic who had taught in both systems and she felt that the four year degree was very shallow. I am very concerned about this. We need to have graduates who have a good understanding of the profession and a depth of knowledge. Also they need to have current experience as graduates, not diluted by recent nursing placements.

Reference 5 - 0.15% Coverage

Take nursing out of midwifery. They are two seperate professions but yet nurses only need to do a graduate certificate to become a midwife. They need to do a full three years midwifery training

Reference 6 - 0.15% Coverage

Separation of midwifery from nursing

Reference 7 - 0.15% Coverage

Universities- Midwivery needs to be acknowledged as seporate from Nursing in both regulation and educationla instutions. Currently, in universities, midwifery is subsumed into the school of nursing and the net effect of this is that it is treated as a boutique program and therefore given minimal resourcing. This needs to change. In the national curriculum, there needs to be greater claritity stipulated around a standard that not only states the teacher to student ratio numbers but also, mechanisms that enable the educators maintain clinical currency by working alongside students in placement settings. Further, midwifery education, needs to be a school in its own right and have a mandated research arm. Thanks

Reference 8 - 0.15% Coverage

Focus upon single not duel registration to promote & respect difference to nursing

Reference 9 - 0.15% Coverage

Perceptions of what a midwife is! Not a nurse

Reference 10 - 0.15% Coverage

To break away from nursing

Models of Care

<Files\\MASSurvey1> - § 12 references coded [1.81% Coverage]

Reference 1 - 0.15% Coverage

Standard 5: Include in curriculum what it means to assess and plan for care, the suitability of types of care for women and families offered in both medical and midwifery models of care, especially where access to support is limited. Planning care or at least having a working knowledge of why models of care are offered and when they are not safe or have elements of unreasonable risk to the woman and family.

Reference 2 - 0.15% Coverage

. Theory and practice components of the curriculum based upon the Framework for quality maternal newborn care based on The Lancet series. This research provided evidence for what constitutes quality care for women and babies across the continuum of needs and can be a guide for educating our future midwives.

Reference 3 - 0.15% Coverage

Teaching what 'being with a woman means'. Too often I see midwives monitoring CTG's from the nurses station and not providing ongoing support to women. I feel we have lost some of the personal touches of midwifery in a high risk, high pressure environment. Good midwifery care is ensuring women feel supported regardless of there birth. The importance of supporting a woman through a 'normal low risk' birth all the way through to a Cat 1 caeser.

Reference 4 - 0.15% Coverage

Educating for midwifery led care.

Reference 5 - 0.15% Coverage

Improving the practice environment – optimal support for students by well prepared midwifery practice midwives. There are a number of other elements that come into this, a safe environment, quality learning experiences, models of care (continuity) that are congruent with best practice are some of the elements

Reference 6 - 0.15% Coverage

Theory and practice components of the curriculum based upon the Framework for quality maternal newborn care based on The Lancet series. This research provided evidence for what constitutes quality care for women and babies across the continuum of needs and can be a guide for educating our future midwives.

Reference 7 - 0.15% Coverage

Midwifery students require greater access to continuity of care models for clinical practice

Reference 8 - 0.15% Coverage

All women should have access to a known midwife who can support and advocate for their pregnancy, birth and postnatal needs.

Reference 9 - 0.15% Coverage

Antenatal care and education, including midwifery models of care. More support for group midwifery practice

Reference 10 - 0.15% Coverage

Recognition of the increasingly complex health needs of women and the need for graduates to have the ability to provide safe care to all women across all models of care

Reference 11 - 0.15% Coverage

Continuing implementation of midwifery models of care - there is a swing in the health care system towards risk averse care. While health care providers discuss midwifery care as a viable option, implementation of midwifery care models remains fragmented

Reference 12 - 0.15% Coverage

Midwifery Models of Care/Rational: Currently, the roll out of midwifey models of care is in its infancy across the country. Not all public hospital services have embraced midwifery models of care and they do not exist in the private obstetric hospital systems. This means, there are very few midwives and service providers experienced midwifery models of care and the reality is - students do not gain quality experience in these models. The COC experiences that students engage in, plays lip service to the prinicple and philosopy of midwifery continuity of care. It is curretnly just another thing to tick off and not a quality learning exercise. Another underpinning reason for this is: 97% of our women are accessing medical obstetric models and the system and focus of care irrespective, is management of minimal risks and disease and illness prevention and management. The COC experience minimum requirements has bee so watered down - its hardly worth the effort and student fight to get out of doing even the minimum requirements - and this is because the value of the value of been downgraded significantly in educations requirements.

Pathways

<Files\\MASSurvey1> - § 6 references coded [0.91% Coverage]

Reference 1 - 0.15% Coverage

Suitability. We intake many student Midwives who have little or no communication skills, no interest in the wider picture of midwifery every year. How can you just leave it up to an ATAR score to get into such a program as Midwifery. We need passionate midwives with a personality to meet the needs of the job. I would like to see universities interview students and maybe consider lowering the ATAR score.

Reference 2 - 0.15% Coverage

Re-Entry Programs for all States

Reference 3 - 0.15% Coverage

Promote privately practicing Midwives in their role in low risk midwifery care

Reference 4 - 0.15% Coverage

Suitability - interviews should be conducted prior to admission to a midwifery program to ensure suitability, given midwives work with vulnerable people groups and work with autonomy.

Reference 5 - 0.15% Coverage

Selecting our trainees based on long term outlook for the practitioner using intelligence and aptitude testing

Reference 6 - 0.15% Coverage

re-entry to the register standards

Philosophy

<Files\\MASSurvey1> - § 3 references coded [0.36% Coverage]

Reference 1 - 0.15% Coverage

Ensuring the philosophy of midwifery care is integrated throughout the curriculum

Reference 2 - 0.15% Coverage

Midwifery philosophy and approach

Reference 3 - 0.06% Coverage

Maintaining the vision of midwifery.

Politics

<Files\\MASSurvey1> - § 6 references coded [0.91% Coverage]

Reference 1 - 0.15% Coverage

Ensure that midwives are represented by midwives on every board and governing body. Nursing continues to take these roles on for midwifery and this is a disinsentive for midwifery and midwives becoming autonomous strong health professions

Reference 2 - 0.15% Coverage

high quality experienced midwives on governing boards

Reference 3 - 0.15% Coverage

Midwifery leadership

Reference 4 - 0.15% Coverage

Encouraging political action to promote Midwifery led continuity of care in an increasing obstetric risk based model of care

Reference 5 - 0.15% Coverage

falling birth rate

Reference 6 - 0.15% Coverage

Midwives must be in a position to stand up and challenge the high rates of intervention- epidurals and unnecessary cesarean births- the midwife of the future nees to be savvy and political and be prepared to be part of the change

Prescribing

<Files\\MASSurvey1> - § 2 references coded [0.30% Coverage]

Reference 1 - 0.15% Coverage

The possibility of incorporating prescribing requirements within the curriculum

Reference 2 - 0.15% Coverage

Pharmacology and diagnostics to prepare the future workforce to work within the primary care space

Relationships

<Files\\MASSurvey1> - § 2 references coded [0.30% Coverage]

Reference 1 - 0.15% Coverage

Professional relationships

Reference 2 - 0.15% Coverage

Partnering with consumers, beyond the immediate midwife-woman relationship.

Resilience

<Files\\MASSurvey1> - § 10 references coded [1.45% Coverage]

Reference 1 - 0.15% Coverage

Supporting/fostering resilience in students. Recent research highlights that early career midwives are more at risk of leaving the profession because of dissatisfaction with, among other issues, the restraints they experience in the present practice environment to provide quality care for women and babies. Students also highlight the challenges of completing the degree. How can we better support them?

Reference 2 - 0.09% Coverage

Want to be able to retain them in midwifery once graduated- so building resilience, mental health promotion, leadership skills etc

Reference 3 - 0.15% Coverage

Retention- unrealistic expectations of midwifery and low resillience

Reference 4 - 0.15% Coverage

Lack of resilience

Reference 5 - 0.15% Coverage

Support and foster resillience in students. Restraints in the practice environment to enable students to experience or provide quality care for women and babies and the ongoing issues of bullying are significnant negatives for growing strong woman-centred midwives

Reference 6 - 0.15% Coverage

Safe practitioners who are both clinically and emotionally competent to care for the woman and her family. As well as developing safe clinical competency, a focus on emotional competency and resilience would enhance safe practice.

Reference 7 - 0.15% Coverage

Supporting/fostering resilience in students. Recent research highlights that early career midwives are more at risk of leaving the profession because of dissatisfaction with, among other issues, the restraints they experience in the present practice environment to provide quality care for women and babies. Students also highlight the challenges of completing the degree. How can we better support them?

Reference 8 - 0.15% Coverage

resiliency

Reference 9 - 0.15% Coverage

Stop the culture of bullying students. At times this feels endemic. It would be better to educate rather than intimidate or belittle

Reference 10 - 0.15% Coverage

Confidence - managing self a in multi disciplinary team

Risk management

<Files\\MASSurvey1> - § 6 references coded [0.91% Coverage]

Reference 1 - 0.15% Coverage

Knowledge of risk management in antenatal care

Reference 2 - 0.15% Coverage

Preparing students to be safe novice practitioners (or above) rather than 'good students', they need to be able to practice safely and yet with some confidence

Reference 3 - 0.15% Coverage

Encouraging political action to promote Midwifery led continuity of care in an increasing obstetric risk based model of care

Reference 4 - 0.15% Coverage

Risk management

Reference 5 - 0.15% Coverage

The first birth is very important for mothers, it is the on they base having future children off. Don't treat first time mum's as low risk. They are an unknown quantity.

Reference 6 - 0.15% Coverage

Obstetrical violence

Rural and Remote

<Files\\MASSurvey1> - § 14 references coded [2.12% Coverage]

Reference 1 - 0.15% Coverage

accessibility for rural and remote students

Reference 2 - 0.15% Coverage

Assist Rural & Remote Hospital Centres in Midwufery Care

Reference 3 - 0.15% Coverage

Working in rural settings - not just mid team focused. Understanding scope of practice and how to say no.

Reference 4 - 0.15% Coverage

subjects 'global ' issues and not highlighting the challenges of the rural family in accesing healthcare in Australia especially for metro students

Reference 5 - 0.15% Coverage

Lack of midwives in regional areas. This is the biggest issue facing the midwifery profession.

Reference 6 - 0.15% Coverage

Preparing the rural workforce. Single Registration Midwives who work in country hospitals will also be required to provide some care to non maternity patients under the guidance of a registered nurse.

Reference 7 - 0.15% Coverage

Providing a skilled midwifery workforce for remote, rural and regional areas must be prioritized.

Reference 8 - 0.15% Coverage

cost of specialists (eg. PIPER in Victoria) to present to rural students - this disadvantages rural universities and students, and is inequitable given that metro universities and students have better and cheaper access to specialised education.

Reference 9 - 0.15% Coverage

availability of tertiary centre placements for rural students - it would be a dstinct advantage for rural students to experience a tertiary centre placement given that they refer women and babies to these centres, however it would appear that nearly all tertiary centres in Melbourne have pre-existing arrangements with some metro universities and will not take students from other universities.

Reference 10 - 0.15% Coverage

Needs to be a program where more midwives can be trained to fill workforce shortages. We have massive shortages in rural and city hospitals. We need to be able to train many more to fill the gaps that are going to occur in the next ten years.

Reference 11 - 0.15% Coverage

Distance blended delivery for those wanting to access the course from remote and rural, making it an easier pathway

Reference 12 - 0.15% Coverage

Collaborate with all institutions to provide substantial rural placements. Too many of our graduating midwives are confined to the tertiary system and have no experience outside of this.

Reference 13 - 0.15% Coverage

adequate preparation to work in rural and remote areas

Reference 14 - 0.15% Coverage

Current training is far too difficult to reach for people living in the country.

Safety and Quality

<Files\\MASSurvey1> - § 6 references coded [0.91% Coverage]

Reference 1 - 0.15% Coverage

Safety and quality in midwifery care - an important component of midwifery care including the need for midwives to think about their practice in the context

Reference 2 - 0.15% Coverage

Preparing students to be safe novice practitioners (or above) rather than 'good students', they need to be able to practice safely and yet with some confidence

Reference 3 - 0.15% Coverage

Safe practice, workforce prepared, accountable and resilient as a integral part of a sustainable workforce

Reference 4 - 0.15% Coverage

Safety - ensure the primary goal is always healthy women and babies

Reference 5 - 0.15% Coverage

Competent and safe practitioner

Reference 6 - 0.15% Coverage

Being prepared for continuous safety and quality improvement, moving from a ‘project’ approach to a ‘Q and S is everyone’s business every day’ approach.

Scope of Practice

<Files\\MASSurvey1> - § 20 references coded [3.03% Coverage]

Reference 1 - 0.15% Coverage

Ensuring students/ graduates have opportunities to work to full scope of practice while encorporating intraprofessional and interprofessional learning for collaborative practice.

Reference 2 - 0.15% Coverage

Standard 3: Emphasis on the midwife role that as a health professional with a therapeutic relationship with a woman and family. At times although midwives may work in medical models the midwife is equally accountable as if they were caring for the woman and family independantly and responsible for the safety and advocacy of care of women and families. to be educated to actively engaging in maintaining professional knowledge and skills.

Reference 3 - 0.15% Coverage

Understanding of role of midwife in a variety of settings.

Reference 4 - 0.15% Coverage

Graduate midwives with skills required for care across the continuum and midwifery led care to include IV cannulation, perineal suturing, water birth, prescribing and ordering diagnostics

Reference 5 - 0.15% Coverage

Learning and applying the widest scope of practice possible- many institutions narrow the scope of practice for midwvies due to politics, inter-orifessional issues or convenience and this will limit the location and depth of services offered into the future

Reference 6 - 0.15% Coverage

Scope of practice - midwives need a subject specific to women's health in order to ensure they are equipped to work to their full scope, including pre-conception care.

Reference 7 - 0.15% Coverage

Lack of clarity re the scope of practice

Reference 8 - 0.15% Coverage

Scope of practice issues

Reference 9 - 0.15% Coverage

All midwifery students should be taught to work to the full definition of the midwife as per the ICM international definition. This means midwifery students should graduate competent in providing care as the lead care provider, and able to perform perineal suturing, venepuncture, IV cannulation, speculum examination, cervical screening

Reference 10 - 0.15% Coverage

independent practice - need to graduate with skills such as perineal suturing, prescribing and IV cannulation

Reference 11 - 0.15% Coverage

understanding professional accountability and legal responsibilities

Reference 12 - 0.15% Coverage

Enhancement of private practice and midwifery autonomy

Reference 13 - 0.15% Coverage

Professional expectations

Reference 14 - 0.15% Coverage

A midwife educated to ICM degree standards able to undertake full scope of practice at registration

Reference 15 - 0.15% Coverage

The midwiery scope of practice involves significant responsibililty. It is impossible to prepare a midwife for this role in 12 months regardless of experience in another profession. Abolish the 12 month course for RNs

Reference 16 - 0.15% Coverage

Don't downplay difficult births. Don't downplay difficulties during birth. Make sure birth notes are truthful and don't omit errors.

Reference 17 - 0.15% Coverage

Ability to work to full scope on CompetItion of course ie in private practice

Reference 18 - 0.15% Coverage

To educate midwives for independent practise

Reference 19 - 0.15% Coverage

Moving forward - embrace the future of maternity care, technology and diversity among patient populations needs.

Reference 20 - 0.15% Coverage

Independent midwives

Reference 1 - 10.06% Coverage

Gain the education, exposure and experience to practice to the full scope of the midwife A thorough understanding of the ACM consultation guidelines ensures holistic care of the mother and baby, including midwifery led care for the low risk woman, and collaborative care for the women who presents or develops risk

- It is imperative that all midwives understand what is expected of them to meet the professional standards, legislative requirements and state/local expectations of guidelines and policy to provide safe, contemporary midwifery care

Simulation

<Files\\MASSurvey1> - § 1 reference coded [0.15% Coverage]

Reference 1 - 0.15% Coverage

The role of simulation needs to be considered , how can we know that simulation is good enough"practice" and IF we find out how will this knowledge impact our education programs?

Standards for Practice

<Files\\MASSurvey1> - § 1 reference coded [0.15% Coverage]

Reference 1 - 0.15% Coverage

Issues 1- 5 are framed around NMBA Oct 2018 Midwife Standards for Practice. Starting with Standard 2: to enhance , articulate the purpose and value of a midwifery future workforce education needs to focus on modelling and supporting both professional relationships & partnerships. this begins in designing curriculum that incoporates the midwife role as a professional attitude that interacts effectively with other professionals. This requires developing sound critical thinking and communication skills.

Stillbirth

<Files\\MASSurvey1> - § 1 reference coded [0.15% Coverage]

Reference 1 - 0.15% Coverage

Education for midwives to discuss risk of and strategies for preventing stillbirth (This is a recommendation rising from the senate inquiry report (see recommendaation 11 https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Stillbirth_Research_and_Education/Stillbirth/Report)

Student numbers

<Files\\MASSurvey1> - § 4 references coded [0.61% Coverage]

Reference 1 - 0.15% Coverage

To ensure optimal practice learning, midwifery course student numbers must reflect practice site capacity.

Reference 2 - 0.15% Coverage

numbers of students being put through: difficulty in getting their "numbers" in time, or o focus on thq quantity of their experience vs the quality of their opportunities eg continuity of midwives as well as clients

Reference 3 - 0.15% Coverage

increased student numbers -no consistency with midwives

Reference 4 - 0.15% Coverage

the viability and sustainability of programs with increasing demand for students form the university perspective but student placement numbers dependant on birthing rates

Support

<Files\\MASSurvey1> - § 22 references coded [3.33% Coverage]

Reference 1 - 0.15% Coverage

Opportunities to debrief and talk to a trustworthy person about issues and experiences

Reference 2 - 0.15% Coverage

accessibility for rural and remote students

Reference 3 - 0.15% Coverage

identifying and supporting Aboriginal students

Reference 4 - 0.15% Coverage

supporting students into continuity of care models once qualified

Reference 5 - 0.15% Coverage

Mentoring within health facilities for new Graduates adds support

Reference 6 - 0.15% Coverage

Need to ensure adequate clinical supervision and assessment in an emotionally and culturally secure manner.

Reference 7 - 0.15% Coverage

The impact of placement on income, working around placement/classes is extremely difficult. Students on placement should receive some payment - apprentices do.

Reference 8 - 0.15% Coverage

To mitigate burnout and workforce attrition, midwives need the knowledge and skills to support their own and their colleagues' emotional wellbeing

Reference 9 - 0.15% Coverage

More educational support for new graduates & junior staff. A physical presence that supports the midwives practice by an educator. Currently this supervision & mentoring is extremely difficult to achieve due to the volume of new & studying midwives educators are unable to assist them. This results in poor outcomes & traumatic expreiences for women & the learner resulting in PTSD, counselling, leaving midwifery. Resources all wasted as the support is not in place. Without serious resourcing it is a box ticking exercise. In short women will have a poorer experience & midwifery will be poorer for the lack of support

Reference 10 - 0.15% Coverage

Providing adequate support in a changing birth environment due to changing risk profiles of birthing women. Establishing realistic expectations and ensuring debriefing skills and general coping skills are developed.

Reference 11 - 0.15% Coverage

Self care and maintaining empathy in a challenging work environment

Reference 12 - 0.15% Coverage

How to advocate for midwifery care. Too many midwives are not strong enough in their conviction to midwifery and in fact operate more like obstetric nurses

Reference 13 - 0.15% Coverage

Education and emotional support services to assist midwives to provide emotional support whilst caring for parents following traumatic labour and birth including stillbirth (see also recommendation 11 of the Senate inquiry)

Reference 14 - 0.15% Coverage

Supporting/fostering resilience in students. Recent research highlights that early career midwives are more at risk of leaving the profession because of dissatisfaction with, among other issues, the restraints they experience in the present practice environment to provide quality care for women and babies. Students also highlight the challenges of completing the degree. How can we better support them?

Reference 15 - 0.15% Coverage

Preventing burnout, work life balance, how to structure your work life/rostering, opportunities available

Reference 16 - 0.15% Coverage

The significant impact that needing to follow women through COCE has on students and their abilities to maintain a balanced life during their studies

Reference 17 - 0.15% Coverage

The burden of the workload on students with the current requirements and how this is a disincentive to doing midwifery study

Reference 18 - 0.15% Coverage

Supporting women outside the social norm without judgment- working with and supporting healthy choices- this takes issue 2 and 1 into consideration. We are still a society that judges people from low socio economic goups.

Reference 19 - 0.15% Coverage

complexity and number of clinical experience requirements. Students are mostly mature age and have family responsibilities and part time work. They find it stressful to study, attend allocated placement shifts and be "with-woman" when undertaking their CCE. Most have part time work to juggle to feed themselves and family.

Reference 20 - 0.15% Coverage

Always offer a debrief as standard. Make a mandatory form that mothers have to fill out before they leave on the birth and other matters concerning birth and staff performance treatment. Ask mothers if they are ok. Screen for trauma. Don't ignore. Don't cover up or minimise.

Reference 21 - 0.15% Coverage

Being aware that, given the stats, most women have experienced some sort of abuse or assault in their life. Ensure policies and procedures reflect this

Reference 22 - 0.15% Coverage

Supportive care - being supportive of every woman and her baby and compassionate

Women Centred

<Files\\MASSurvey1> - § 28 references coded [4.24% Coverage]

Reference 1 - 0.15% Coverage

A woman-centred philosophy to promote a woman's' self-efficacy and autonomy. So that expectations and context are defined by the woman herself

Reference 2 - 0.15% Coverage

woman centred care

Reference 3 - 0.15% Coverage

To facilitate truly woman centred care and women's truly informed choice, midwives need the knowledge and skills to be able to provide evidence-based antenatal education.

Reference 4 - 0.15% Coverage

Teaching what 'being with a woman means'. Too often I see midwives monitoring CTG's from the nurses station and not providing ongoing support to women. I feel we have lost some of the personal touches of midwifery in a high risk, high pressure environment. Good midwifery care is ensuring women feel supported regardless of there birth. The importance of supporting a woman through a 'normal low risk' birth all the way through to a Cat 1 caeser.

Reference 5 - 0.15% Coverage

Balancing the Standards with the preferences of the birthing woman. There is ever more focus on person centred care and midwives naturally gravitate to meeting their woman's needs but this must be tempered with the safety concerns and potential harm to the unborn child & intrapartum stage.

Reference 6 - 0.15% Coverage

Woman centred care

Reference 7 - 0.15% Coverage

woman centred care

Reference 8 - 0.15% Coverage

Woman centred practicitioners (midwifery education needs to be grounded in woman centred care and be authentically embeded throughout the midwife's education)

Reference 9 - 0.15% Coverage

Understanding woman centred care from a local to global level. Political, cultural influences that influence the profession and the woman.

Reference 10 - 0.15% Coverage

Fundamentally grounded as woman centred practitionere

Reference 11 - 0.15% Coverage

Midwifery is a woman centred profession that puts the woman as the main decision maker in their pregnancy, birth, and postnatal experience.

Reference 12 - 0.15% Coverage

women centred care

Reference 13 - 0.15% Coverage

Woman Centredness - pregnancy care becoming very medical based, need to ensure midwives can advocate for women, discuss options with them and support their wishes.

Reference 14 - 0.15% Coverage

Woman centered care needs to be encouraged so women can regain the ability to birth their babies

Reference 15 - 0.15% Coverage

Understanding of the centrality of the woman.Midwives need to be very cognisant of the importance of woman centred care

Reference 16 - 0.15% Coverage

need to understand that birth is more than just a physiological event- that it is spiritual, cultural, emotional, mental and that in order to provide safe care these need to be acknowledged and respected

Reference 17 - 0.15% Coverage

Supporting women with fear of birth particularly focusing on the role social media is undermining women's trust in their own bodies

Reference 18 - 0.15% Coverage

Considering the 'whole woman', not just a person having a baby, but the 'why' behind every decision she makes.

Reference 19 - 0.15% Coverage

Clear focus on women centered natural physiological birth. Birthing has shifted from a natural and healthy process- women are now expecting pain free births and need support and education to make a shift to natural and healthy

Reference 20 - 0.15% Coverage

Woman centred care

Reference 21 - 0.15% Coverage

Promotion of wellness health women centred not sickness model

Reference 22 - 0.15% Coverage

While we teach woman-centredness and holistic ways of being with women, we give numbers of tasks to be achieved within a time frame which focuses student on task completion not the woman

Reference 23 - 0.15% Coverage

Woman know their own bodies

Reference 24 - 0.15% Coverage

If midwifery run - seek doctors if requested by the mother. My midwife refused during the whole 8 hour labour maintaining that a doctor was not available. It was a smaller hospital however there were doctors in the emergency. I was left in unmanaged pain and felt like I was going to die.

Reference 25 - 0.15% Coverage

The first birth is very important for mothers, it is the on they base having future children off. Don't treat first time mum's as low risk. They are an unknown quantity.

Reference 26 - 0.15% Coverage

Always offer a debrief as standard. Make a mandatory form that mothers have to fill out before they leave on the birth and other matters concerning birth and staff performance treatment. Ask mothers if they are ok. Screen for trauma. Don't ignore. Don't cover up or minimise.

Reference 27 - 0.15% Coverage

Listen to the mother

Reference 28 - 0.15% Coverage

Respect for individual rights. Every woman has the right to bodily autonomy, must consent to each and every procedure and undertaking, regardless of the views and beliefs of their carers.