

Accreditation standards review

Written submission form

First Name	Laura
Surname	Bignell
Individual or organisation?	Organisation
Organisation (if relevant)	Royal Women's Hospital, Melbourne, Victoria
Position in organisation	Chief Midwifery & Nursing Officer
Email	Laura.bignell@thewomens.org.au
Preferred contact number	03 8345 2012

Please select one of the following:

- This is a public submission. It does not contain 'in confidence' material and can be loaded on the ANMAC website
- This submission contains 'in confidence' material and cannot be loaded on the ANMAC website.

Thank you for the opportunity to respond to the midwifery accreditation standards review.

The Midwife Accreditation Standards should continue to specify that students complete a minimum number of supervised midwifery practice experiences.

Our view is that both supervised practice experiences as well as some required hours are preferred. While we know that hours of clinical placement do not necessarily reflect experience, e.g. there may be occasions where there are many hours spent in a ward or unit where there is limited opportunity to care for women because of a quiet shift, we support minimum placement requirements and minimum supervised practice experience requirements.

Regarding the numbers of minimum requirements, we support all the current ones except the current number of Continuity of Care experiences (COCEs) – which is discussed further below. We support maintaining all other minimums e.g. for antenatal care (100 episodes); complex care (40 women); and postnatal care (100 episodes), and also for students being primary accoucheur for 30 spontaneous vaginal births. We also strongly advocate that competency be assessed as well – and not just assumed based on number of either experiences or hours.

As a major tertiary women’s hospital, we feel strongly that newly graduated midwives need to have been exposed to these minimum requirements in order to provide a solid foundation for what will be required of them as beginner registered clinicians. We need to know what we can expect them to have done and to be very clear about the minimums. If it were based only on hours and not minimum requirements we would find that very difficult from an industry point of view – and it would introduce quite a level of clinical risk for our service. It would also affect the numbers of new graduates we could take – and really decrease these.

How can the Midwife Accreditation Standards ensure that students in pre-registration programs are educated to meet the full scope of midwifery practice?

We support having students who graduate with strong foundational skills that mean they are able to practice as independent beginning level clinicians. While there are a number of skills that can be added during their graduate year or later, as employers we need new midwives to have a clear understanding of (and skills in) all the areas that make up the scope of practice (albeit at a beginner level).

There are three areas often discussed in relation to achieving midwifery graduate registration and if these should be included in the initial midwifery course – medication endorsement/prescribing, perineal suturing, and IV cannulation.

From our point of view medication endorsement/prescribing is not required to be employed as a midwife at the Women’s, and we support leaving this skill as a post-registration program. IV cannulation skills can easily be taught in the clinical setting, and we consider that can readily be undertaken post-registration – or basic skills taught for this (and perhaps simulation), with competencies not mandated during the course.

Perineal suturing skills are something that would be good to include in the pre-registration program if that was feasible – but we are conscious this might be difficult to achieve.

Perhaps the inclusion of beginning/basic level theoretical and lab based/sim practice in the Standards, with the option that where possible and practical students can consolidate in clinical practice - for example there may be a lot of opportunity for suturing competency attainment in placements after instrumental births - where the student may not get to 'count' the birth, but could be able to undertake supervised suturing to become competent. But this should be optional as may not be achievable everywhere, yet would provide the foundations, and for those who had the opportunity, could be achieved during their midwifery education. We would support this way for the other very relevant skills of artificial rupture of the membrane and application of fetal scalp electrodes.

How can the Midwife Accreditation Standards best support inter-professional learning?

We think this is already satisfactory.

What additional issues should be addressed in the revision of the Midwife Accreditation Standards that have not been considered in this consultation paper?

We have several other suggestions for the review.

An area of continuing concern for us is the number of COCEs required of the students. As a major provider of clinical places, we can see that there is a huge amount of stress for the students in relation to achieving their COCEs. While we fully support students have COCEs in their programs given the strong evidence of benefit for women, we think the number required is too high - and would advocate for 1-2 per year regardless of the years enrolled. The current requirements mean students have limited down time, they cannot always be reliable in their paid outside work (which they need to survive), they miss university requirements, and sometimes miss scheduled clinical placement hours. All this amounts to a very stressful experience for students, yet there is no evidence to our knowledge that increased COCEs result in any better philosophy of midwifery nor any more likelihood to work in COC models post-registration. COCEs are a relational experience, and we think that having fewer COCEs is likely to support a greater depth and quality of relationship with women, and avoid some of the many challenges with students unable to attend the birth and to provide hands on care. We recommend that the Standards could be revised to be consistent with UK standards which state "all students experience continuity of carer and follow a number of women throughout the continuum of care.

Another area we feel strongly about is that consideration be given to some way of incorporating paid employment for student midwives during their pre-registration requirements. There have been models tested in various states, and in Victoria at least there is provision in the EBA for employing student midwives. We would be happy to discuss this further if that would be of benefit.

A final point - we believe that it is important that somewhere in the Standards that the issue of quality of clinical placements is addressed.

Thank you again for the opportunity to contribute to the Standards Review.