Australian College of Midwives
SUBMISSION
Review of the ANMAC Midwife Accreditation Standards - Consultation paper 1

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QUESTION 1 Please indicate your agreement/disagreement with the following statement. "The midwife accreditation standards should continue to specify that students complete a minimum number of supervised midwifery practice experiences."	RESPONSES: ~~Strongly Disagree~~ ~~Disagree~~ ~~Unsure/Don't Know~~ Agree ~~Strongly Agree~~
In the space provided please provide a rationale for your choice.	There needs to be a minimum standard for either hours or experiences. In comparison to similar international standards (UK and NZ) the number of hours/experiences for Australian students is already woefully lacking and a further reduction risks compromising the graduates. In the absence of conclusive research evidence of minimum clinical placement hours and practice experience graduates of the BMid program appear to be safe and effective new midwives, based on them gaining employment and positive feedback from industry. As stated in the discussion paper: "Requiring students to complete specified numbers of experiences is not merely a task-oriented exercise, but is also a confidence building approach, with students more confident in their competence as they successfully complete more experiences" ACM would argue that hours do not necessarily provide the necessary skills and experiences and so we should maintain the current numbers of experiences. Whilst there is a risk that there will be a focus on numbers and quantity over quality, and even though each experience may not provide in-depth quality experience at least it does determine that the student will be present and exposed to this set number. Hopefully it will be more, but experience opportunities cannot be controlled. They arise randomly and there may be competition for the opportunities.

	Every experience provides the student with a wide range of clinical experiences and increases their confidence. Having to fulfil a certain number of experiences ensures demonstration of essential knowledge and skills can be achieved. Without this number requirements will be diluted and the new midwifery workforce may not be equipped or have the skills to provide midwifery care. An alternative to address this issue would be to consider something like an intern year that is part of the education process and thus guaranteed to all as a year of consolidation. Another alternative would be to change the way that the clinical practice is undertaken, such that the students were immersed in evidence-based practices such as midwifery continuity of care models for clinical placement across their learning (as per the NZ model). It is possible to shift the focus from the hospital setting and the experiences to the provision of woman-centred care. This would require innovative thinking by education providers to develop continuity of care (CoC) models where existing health service options were insufficient as well as support from the health sector to increase midwifery CoC models. The outcome would be an increase in the quality experiences which leads to competent practice. The Continuity of Care experiences were designed to provide the students with experience in developing meaningful relationships and experiencing continuity of care as a midwifery model of care that the research identifies as best practice. ACM would be supportive of a return to a minimum of 20 COCE with a requirement for the education providers to place a greater emphasis on ensuring students are provided opportunities across their learning to midwifery continuity of care models. The COCE should not be reduced any further than the current minimum. Additional focus needs to be placed on the postnatal period. Consider increasing appointments required to attend per COCE to 4.

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QUESTION 2 How can the Midwife Accreditation Standards ensure that students in pre-registration programs are educated to meet the full scope of midwifery practice?	The Standards should be developed to ensure that the graduates meet the international scope of practice/definition of a midwife as defined by the ICM. Industry needs to be aware that the Graduates will be beginner practitioners in this space, but skilled in the full scope of midwifery. Meeting the ICM standards would mean that the courses need to ensure that students are taught the required skills for perineal care and repair, cannulation, prescribing, full newborn examination at discharge, family planning and inserting long-acting contraceptives (such as Implanon) and abortion care. There will need to be further discussion of individual aspects of clinical skills as these all require varying training in relation to theory and clinical supervision opportunities. The minimum duration of the course is as such a fundamental issue that must be addressed as is the feasibility of shorter courses should the extended skills be included as a requirement. One of the issues with providing education to meet the full scope of midwifery practice is the practical component of learning skills such as cannulation and perineal repair. Ideally there needs to be extended clinical practice time for students to develop skills. This might require education providers to think creatively as to how this can be achieved in the current health setting. Alternatively, an intern year at the end of the course would enable all students access to a period of clinical consolidation. Midwifery has had a prescribing formulary for 10 years. It has been working successfully. Midwives have been shown to be capable in this space. It is time to bring the units of study (pharmacology and screening and diagnostics that are of the same level and quality as those leading to endorsement) within the Bachelor of Midwifery so that all qualifying midwives are able to provide prescribing, screening and diagnostic services across the health services. Provision of comprehensive education, including simulation in cannulation, phlebotomy and suturing and demonstration of rigour,

	knowledge and skills, followed up by demonstration of competency in the clinical area are required to consolidate and validate the learning. ACM believe that immersing students in midwifery led continuity of care models, not only supports best practice, but will also increase student's exposure to the diversity of clinical experiences. It is also fundamentally important that students have experience working with Aboriginal and Torres Strait Islander women (where possibly in birthing on country models of care). In an ideal situation, the students could to be aligned with a midwife and a number of women per year in their degree, they would gain experience across the continuum of pregnancy and birth care, thereby achieving the required competencies but within the context of providing quality care to women. Clinical placement hours could be an addition to the continuity experiences to ensure consolidation of skills, but again for the experience of working in maternity, not to achieve competencies. If we ensure the midwives of tomorrow have been educated to practice in continuity models we will be growing our future workforce based on best practice, as well as increasing women's access to continuity of care. The collective voice of these student/graduate midwives demanding that these models be implemented will be loud and powerful. Of note, as the accreditation organisation ANMAC is recognised as the governing body who safe guard against programs being watered down to save money at higher education institution levels. Having an organisation that stipulates the national standard for education providers to follow supports academics at university level. Education providers to ensure students have access to all models of care during their clinical placements, including home births. This will require work with insurance companies.

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QUESTION 3 How can the Midwife Accreditation Standards best support inter-professional learning?	The definition of IPL is 'to learn from, with and about'. To support this concept the midwifery accreditation standards should include the requirement for midwifery students to undertake set learning with students of other disciplines they will commonly collaborate with i.e. nursing, medical, paramedicine. Ensure that it is included in the Standards as a requirement. Do not stipulate the how and when, but leave that to the flexibility and creativity of the education provider. Ensure there is adequate assessment of the IPL by the students, midwives, academics and other health professionals. Allow for lived experience as well as simulation IPL to be undertaken – the IPL could even be a joint simulation activity. By including collaborative interprofessional care provision in midwifery programs and by providing interprofessional opportunities in the clinical area and in simulation (with physios, social workers, psychologists). Allow for the use of online technologies for interaction with other professionals. By encouraging recruitment of a wide variety of Continuity of Care Experiences which take the students into different areas of practice, e.g. adolescents, diabetics, women with drug and alcohol issues, medical disorders, etc. Encourage education providers to support arenas to foster collaborative learning within undergraduate curricula – with other disciplines at the university including midwifery students to midwives, midwifery students to other health profession students (vice versa), other health professions to midwifery students. Examples of IPL could be provided by ANMAC as best practice.

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QUESTION 4 What additional issues should be addressed in the revision of the Midwife Accreditation Standards that have not been considered in this consultation paper?	Promotion of the student exchange between tertiary and regional and remote settings between universities to enable the student to gain exposure to diverse settings in Australia. Ensure that Aboriginal and Torres Strait Islander peoples' specific content is included in all midwifery courses. Education providers to ensure the cultural competence of academics. The Head of Midwifery needs to be a Midwife and the role needs to be a decision-making role for the course/program. The role should ideally be held by an individual with a PhD. Increasing students access to continuity of care models. Increasing community-based placements. Increase the focus on the postnatal period.