ANMF Submission to ANMAC consultation

# REVIEW OF MIDWIFE ACCREDITATION STANDARDS CONSULTATION PAPER 1

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Australian Nursing & Midwifery Federation

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# INTRODUCTION

The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 275,000 nurses, midwives and carers across the country.

Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

Our strong and growing membership and integrated role as both a professional and industrial organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

Through our work with members we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

The ANMF welcomes the opportunity to provide a response to the Australian Nursing and Midwifery Accreditation Council (ANMAC) review of the *Midwife Accreditation Standards.* This review will enable ANMAC to provide accreditation standards that education providers will be required to meet in order to prepare midwives for contemporary and emerging midwifery practice. We note that the revised standards are still to be drafted, and our response therefore focuses on recommendations for inclusion, rather than on any proposed amendments and additions to the 2014 standards.

Midwives work as essential primary care providers through a woman's pregnancy, from the initial antenatal assessment to completion of care at the end of the post-partum period. A vital component of the midwifery role is leading midwifery care, working with and advocating for the woman; while pregnancy and labour are normal and natural, midwives provide midwifery care in collaboration with other maternity care providers, appropriately consulting, referring or transferring care when required. Midwives are expert in the normal, but are no less needed as expert providers of holistic care when difficulties arise during a woman's journey through pregnancy, labour, and the post-partum period. Studies have consistently demonstrated that midwifery continuity of care produces equal or better outcomes for both the woman and their baby than other models, regardless of risk level.[1]

Midwives must therefore assess and monitor the women in their care, recognise indicators of variance from the norm and any signs of deteriorating condition or risk and, while continuing care coordination, appropriately refer the woman to, and liaise and work with, other health practitioners when complications occur. Women who have pregnancy and/or labour difficulties still need and benefit from expert, competent midwifery care throughout this time and postnatally.

The ANMF position in relation to midwifery education remains steadfast. We support a system of education that incorporates robust, evidence-based theory with quality midwifery practice experience that results in midwifery students who are educationally prepared, safe and competent for the full scope of midwifery practice,[2] when eligible to apply to the NMBA for initial registration as a midwife.

To achieve this end, it should be noted that:

- the most important thing for women and babies is safe, competent care;
- there is abundant, consistent evidence, from both Australia and internationally, that midwifery continuity of care models provide best maternal and baby outcomes;
- we support all pregnant and birthing women, regardless of the presence of clinical risk factors, being able to access appropriate midwifery care;
- continuity of care is an essential component of quality midwifery practice experience and therefore innovative approaches to enable quality placements should be explored;
- there is no evidence demonstrating that graduates of current direct- or post-graduate-entry midwifery programs provide anything but safe and competent care, and therefore no benefit to increasing program length or the number of births student midwives are required to attend; and
- for best health outcomes for all Australian women, babies, and families it is essential that direct entry, dual-qualification and post-graduate pre-registration midwifery programs are of a consistently high standard, viable, robust and accessible.

The ANMAC *Midwife Accreditation Standards* currently require education providers to demonstrate how they ensure student safety and wellbeing as it relates to continuity of care experiences (CoCE's). As the student hours required to complete the stipulated CoCE's occur over and above the planned theoretical and other midwifery practice experience in the education program, it is imperative that education providers continue to closely monitor the impact of CoCE's on student study and fatigue. The revised standards should continue to require that education providers demonstrate they are monitoring student safety and wellbeing in relation to completing CoCE's to ensure this remains a valued, quality learning experience.

# Consultation questions

## *Q1. Please indicate your agreement/disagreemnt with the following statement: The midwife accreditation standards should continue to specify that students complete a minimum number of supervised midwife practice experiences.*

The current clinical practice requirements comprise:

- engaging with a minimum of 10 women for continuity of care experiences – this involves attending four antenatal visits, two postnatal visits and, for the majority of women, the labour and birth,
- attending 100 antenatal episodes of care,
- acting (under the direct supervision of a midwife) as primary or lead midwife for 30 women who experience a spontaneous vaginal birth,
- providing direct care to an additional 10 women through at least the first stage of labour,
- caring for 40 women with complex needs across pregnancy, labour, birth or the postnatal period,
- attending 100 postnatal episodes of care with women and, where possible, their babies,
- experience supporting women to feed their babies and in promoting breastfeeding (no minimum requirement),
- experience in women's health and sexual health (type and quantity not prescribed),
- experience assessing mother and baby four to six weeks postpartum - in a practice setting where possible, by simulation if not (no minimum experience prescribed),
- undertaking 20 full examinations of a newborn infant, and
- experience caring for a neonate with special care needs (no minimum time or number of episodes specified).

While we agree it is essential that newly-qualified midwives must have sufficient practice experience to work across a variety of midwifery settings, it is our long-held position that the current requirements for midwifery practice are unhelpfully prescriptive and arbitrary, with more focus on numbers and documentation than on the quality of either the experience or the care delivered. However, until quality is defined and embedded in midwifery education programs, there remains a need to maintain agreed minimum midwifery practice requirements.

Continuity of care is an intrinsic component of midwifery-led care, and we agree that CoCE's must form a part of the students' clinical experience. As acknowledged in the ANMAC *Midwife Accreditation Standards 2014* (p. 7), there is a risk of losing the value of the CoCE because of the need to meet a set number, however the quality of this learning experience is highly valued. Rather than specified numbers, the focus should instead be on active and direct participation and engagement, leading to the ability to deliver safe, competent midwifery care on registration. A key component of midwifery practice is decision-making, and this needs to be reflected in both simulation and clinical practice.

The ANMF fully supports increasing midwifery-led care, which has consistently been shown to result in lower levels of intervention without increase in mortality or morbidity.[3] However, as we work together nationally to achieve this aim, midwifery students must undertake their midwifery practice experience in an environment where some of the practice requirements are increasingly difficult to achieve.

Disappointingly, Australia is following international trends for greater birth intervention. The rate of caesarean section increased from 31% in 2007 to 35% just a decade later.[4] In 2017 just over half of Australian woman had their labour induced;[5] and in 2015 19% of vaginal births involved the use of instruments.[6]

While midwifery students can easily gain access to assisted birth, this reduction in numbers of spontaneous vaginal births makes the requirement to "act (under the direct supervision of a midwife) as primary or lead midwife for 30 women who experience a spontaneous vaginal birth" both difficult to achieve, and not reflective of the increasing rate of interventions and contemporary maternity outcomes.

The ANMF recommends that the revised standards have a focus on active and direct participation and engagement leading to clinical competence in birthing as the aim of midwifery practice experience. Midwifery students require significant midwifery practice experience to be able to provide midwifery care and to ensure they can meet the NMBA *Midwife Standards for Practice*. To this end, midwifery students must be provided with education that includes exposure to a range of midwifery practice experiences which enable them to demonstrate they are able to link theory to practice. There needs to be an active commitment to developing innovative placement models to enable students to grow their experiences in managing normal birth within the current context of increasing rates of medical intervention and lower protection of normality.

## *Q2. How can the Midwife Accreditation Standards ensure that students in pre-registration programs are educated to meet the full scope of midwifery practice?*

Any revision to accreditation standards must cohere and be consistent with the Nursing and Midwifery Board of Australia (NMBA) *Midwife Standards for Practice*. Amendments must be equitable and meaningful across all midwifery education programs to ensure midwives are educated to meet the full scope of midwifery practice. To enable midwifery students to access all learning required to work to the full scope of midwifery practice, assessment must be underpinned by the NMBA *Midwife Standards for Practice* which incorporates the International Confederation of Midwives (ICM) definition of a midwife. This definition includes, but is not limited to: perineal suturing; water immersion for labour and birth; well-woman and well-baby discharge; and the national priorities of: perinatal mental health, stillbirth, breast feeding, and the impacts of the social determinants of health (including family violence) on maternal and neonatal health and wellbeing.

The ANMF recommends that the following identified aspects of midwifery care be incorporated into midwifery education:

**a) Prescribing**

For decades, midwives have engaged in structured prescribing through the use of standing orders and protocols. Current Bachelor and Post-Graduate Diploma of Midwifery programs provide the underpinning education required to enable midwives to safely administer and prescribe medicines through the use of standing orders and protocols.

The existing ANMAC accredited and NMBA approved programs of study leading to endorsement for midwives to autonomously prescribe scheduled medicines have been in place for the last decade. Midwives with scheduled medicines endorsement safely prescribe autonomously. As midwives have a defined scope of practice, it is appropriate and timely to consider incorporating the content of the program of study leading to scheduled medicines endorsement into the preparation of midwives for practice. This move to integrate prescribing into undergraduate midwifery programs has immense potential to improve timely access to high quality, safe comprehensive midwifery care and quality use of medicines.

**b) National priorities**

We acknowledge that some midwifery education providers embed national priorities into their curriculum well. Although not needing to be taught as discrete units, the national priorities of perinatal mental health, stillbirth, breast feeding, and the impact of social determinants of health (including family violence) on maternal and neonatal health and wellbeing should be embedded throughout all midwifery education programs. The ANMF recommends that ANMAC include this as a requirement in the revised standards.

**c) Well-woman and well-baby discharge**

Many experienced midwives are already involved in well-woman and well-baby discharge. In some settings this practice is restricted by the health service rather than by midwife educational preparation. Preparing midwifery students for safe, competent and confident well-woman and well-baby discharge is an essential component of their learning, thereby enabling them to work to the full scope of midwifery practice.

**d) Perineal suturing**

Perineal assessment and care, including suturing, is an established component of midwifery scope of practice. Many midwifery education providers already provide comprehensive theory and practice relating to suturing. The revised ANMAC *Midwife Accreditation Standards* should require education providers to demonstrate that midwifery students are provided with sufficient theory and practice to provide safe and competent perineal assessment and care for women, including suturing.

## *Q3. How can the Midwife Accreditation Standards best support inter-professional learning?*

Inter-professional learning is an essential contributor to collegiality, teamwork and best outcomes for women and babies. Functioning within and as part of a multidisciplinary health care team is an integral part of midwifery practice, particularly with the increasing incidence of complicating maternal conditions including greater maternal age, multiple babies, and pre-existing and pregnancy-related conditions.

While assessment of the need for additional input, along with referral to and consultation with other health practitioners is essential to safe, competent midwifery care, it is also vital that the integrity of midwifery work is protected. We need midwives in practice to be responsible for educating, supervising and assessing midwifery students undertaking midwifery practice experience. This is not the role of other health practitioners.

It is therefore crucial that references to and guidance regarding inter-professional relationships be placed within the context of midwifery-led models of care. Additionally, while some components of midwifery pre-registration education (for example, pharmacology) may be delivered in consultation with or by other health practitioners, carriage of and responsibility for all aspects of this education must have oversight by midwife academics/educators.

## *Q4. What additional issues should be addressed in the revision of the Midwife Accreditation Standards that have not been considered in this consultation paper?*

**a) Private practice midwifery**

While the majority of women in Australia birth in a hospital setting, there is significant evidence to support midwifery-led care delivered by privately practising midwives. It is essential that midwives in Australia have the continued ability to work across all scopes of midwifery practice, whether in private practice or other models of midwifery care. Encouraging growth in the private practice midwifery model will be facilitated by offering midwifery practice learning opportunities or structured midwifery practice experience to interested midwifery students in private practice models and/or settings. With a focus on the quality of midwifery practice experiences rather than type and numbers of experiences mandated, students will be able to choose to select midwifery practice experience placement with private practice midwives, who work in collaboration with the public hospital sector, without fear that they will not meet the program requirements in less acute settings.

**b) Evidence document**

It is imperative that the evidence document accompanying the standards is robust, supports and is consistent with the standards. The ANMF strongly recommends that a draft evidence document be included with the draft standards for comment and review as part of the second stage of this consultative process.

**c) Future workforce**

2016 data[7] reveals the average midwife in Australia is almost 48 years of age, and works 19.5 clinical hours per week, a significant decrease from almost 25 hours per week only three years earlier. While current midwife levels are meeting Australia's needs, the trend of an ageing workforce working fewer hours poses the real risk that this will not be the case in the next decade. It is essential that ANMAC continue to support and facilitate the range of educational pathways to midwifery registration in order to ensure there are sufficient midwives to meet the needs of women and their babies in Australia.

# CONCLUSION

The ANMF is pleased to take this opportunity to provide advice to ANMAC regarding the review of the *Midwife Accreditation Standards*, on behalf of our midwife and midwifery student members. Members have requested that we participate in this review so that the standards for accrediting midwifery programs in this country will be attainable for students in their preparatory content, produce midwives capable of delivering all aspects of midwifery care, and reflect current and emerging evidence and best practice in midwifery.

As the largest professional and industrial body for midwives in Australia, the ANMF has a significant interest in midwifery education as it directly relates to workforce. We consider it imperative that midwifery students and midwives be equipped and enabled to provide safe and competent care to pregnant and birthing women in this country. It is our firm view that we need to prepare a workforce equipped and willing to work in regional, rural, and remote parts of Australia, to protect the viability of already vulnerable and rapidly disappearing midwifery services in these areas. Our essential message remains that midwifery programs prepare safe and competent midwives through attainable requirements which reflect contemporary practice within the context of the Australian community.

The ANMF looks forward to further participation in the next phase of consultation for the review of the Midwife Accreditation Standards.

References


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