Accreditation standards review

Written submission form

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Standards Review
4 September 2017

School of Nursing and Midwifery

ANMAC Midwifery Education Standards Review: Midwifery academic team's response to Consultation paper 1

Globally there is acknowledgement that strengthening midwifery education is needed to ensure women and babies are provided with quality care, to save the lives of women and newborns, and to promote health and wellbeing (Strengthening quality midwifery education for Universal Health Coverage 2030: Framework for Action (WHO, 2019)).

The guiding principle underpinning our response to the review of ANMAC Midwifery Education Standards is to strengthen midwifery education to enable midwives to reach and contribute their full potential in promoting the health of women and babies.

A response to each question is provided below.

Q 1. Minimum number of supervised midwifery practice experiences.
We **strongly agree** that the midwife accreditation standards should continue to specify that students complete a minimum number of supervised midwifery practice experiences.

Embedded and deep learning
The discussion paper stated that "some authors [22, 23] question the usefulness of specifying a set number of clinical experiences, or a prescribed percentage of hours (quantity), rather than focussing on the quality of practice experiences (pg11)."
It is a falsehood to dichotomise quality and quantity. Midwifery students need both quality of practice experiences and sufficient practice to gain competency and confidence. Learning, and embedding learning, through repetition (practice) / exposure/ immersion is well established educational theory. In the health and social sciences, there is a wide variation in the human condition, including wide variation of normal, and to understand this diversity requires exposure, which requires time.

In addition, without specifying a set number of clinical experiences or prescribing percentages of hours; in our experience across a range of institutions, University authorities might imagine that teaching hours or clinical supervision can be reduced because there is no specified time or experience required. Specification does not only ensure the quality of teaching and learning but protects that experience within an environment where not all staff of the institution understand its importance.

International evidence for mandated experiences/ exposure
In the UK, following an extensive consultation period it was decided to continue to comply with EU standards of minimum practice experience (i.e. 100 antenatal visits etc,). This evidence of professional and consumer views should not be disregarded lightly in revising

the Australian standards. We support mandating that midwifery students in Australia have the guaranteed exposure to clinical learning opportunities and recommend that these be increased (and not decreased) to capture the primary carer role of the midwife (see below).

Prioritising women and babies and improving the quality of health service delivery

The Midwifery Education Standards should be built around the needs of women and babies for quality midwifery maternal and newborn care and not around current length of existing programs. In the ANMAC discussion paper the consultation process provides an opportunity to, "evaluate whether the expectations upon education providers to meet revised standards are reasonable in terms of benefits and burdens". While this is important, the overarching concern should be to prepare graduates to be able to meet the needs of women, babies and families, and to actively participate in ensuring maternity services align with what women want and need and the evidence about how best to design maternity services. Educating midwives for Continuity of Midwifery Care is best practice, given the overwhelming evidence of the lifesaving benefits for women and their infants. As a wealthy country, Australia could be a world leader in midwifery education standards, providing a role model in sustainability and addressing the global goal of fetal, infant and maternal safety and wellbeing for developing countries.

Managing access to clinical practice in a competitive environment

There is a tendency to respond to the pressures for securing adequate numbers and quality of clinical placements for students to suggest that clinical practice experiences or hours are reduced. While competition for clinical places is a reality, this response is reactive. An alternative approach would be to reduce the number of programs leading to registration to facilitate more efficient use/ coordination of available clinical placement time, structuring and delivering theoretical learning differently to create flexibility, better use of community options, and/ or creating university midwifery clinics and student-led MGP/ clinics in the health service. Discussion with health service partners may also be required to prioritise the needs of midwifery students as midwives are the primary care provider for childbearing women. Other similar professions, for example medicine, has the same problems but does not stop or reduce students but works creatively to get the most qualified graduates required and give them experiences that do this.

Optimising clinical education

Actions to optimise the clinical education component of midwifery programs should be a priority. We advocate increasing the number of continuity of care experiences (COCE). Midwifery programs should be transitioning students towards caseload midwifery and building programs around access to this deep learning experience rather than tacking it on to theory and shift based clinical practice. We see the successive reduction in COCE experiences over the last two revisions of the ANMAC standards as reactive and premature.

Griffith University BMid program requires midwifery students to undertake 20 COCE. Students report this is a capstone learning experience and our comprehensive program of research confirms that students highly value it. We have addressed many of the barriers reported by students and academics from other universities, informally and through the literature. These barriers have been removed through the enactment of strong internal leadership and direction within the university, development and support of strong

partnerships with maternity service providers and by embedding learning and teaching design innovations into our program.

We recommend that Continuity of Care Experiences return to requiring a minimum of 20 and:

- maintain a minimum of 4 antenatal visits,
- requirement greater than 70% attendance at the birth
- increase to a minimum of 3 postnatal visits, one of which must be undertaken in the community between 4-8 weeks post birth (and may include midwifery/GP 6-week visit, child/youth/family health visit.

COCE represents evidence-based care, is the only real expression of relationship-based care and is the only practice experience that mimics the model of care the midwifery students need to be prepared for (i.e. to work in COC models). Practice and simulation should prepare students as realistically as possible, for the competencies and capabilities they will require on graduation. Domination of clinical practice in shift work models will not achieve this.

Increasing prevalence of women and families with complex needs

Repeated exposure to women and babies across the childbearing continuum and repeated opportunities to support women through pregnancy, labour, birth, breastfeeding and the transition to motherhood enables students to gain a depth and breadth of learning. Needing to care for increasingly diverse women with increasingly complex needs, requires assurance that students obtain an adequate view of the health picture of women in Australia. Planned, quality, mandated experience ensures this exposure. We argue that increased diversity/ complexity indicates the need for more clinical experiences not less. Complexity should not only be viewed as complex medical conditions. It should also be viewed in relation to social and psychological complexity.

Protecting and promoting normality across the childbearing continuum

It is very important not to dilute the opportunity for midwifery students to undertake and become competent in midwifery care to support normality in pregnancy, labour and birth and postpartum including breast feeding. The unique role of the midwife in the promotion and protection of normality and provision of expert care for women to achieve normal/ physiological birth should be reflected in the revised standards and provision for midwifery students to attain competency in this assured. Again normality, is starting to be valued in health systems, concerned with rising costs. The more normal outcomes, reduce Caesarean section rates and better healthier babies improves health outcomes and reduces cost. Midwifery education programs can contribute to this as they prepare a constant workforce to deliver this service.

There have been arguments that the climbing caesarean section rate reduces opportunities for midwifery students to gain access to normal births. The overall increase in the birth rate in Australia mitigates this. Importantly, if we are to address the medicalisation of childbirth and the rising CS rate then midwives need to be skilled in normal birth. and health services increasingly value this.

Caring for women experiencing normal birth is essential. If the student and graduate have limited understanding of normality, they will be less skilled in providing pregnancy care as they will not really know the preparation women need to navigate labour to achieve the best possible outcomes and opportunity for a normal birth.

Additional clinical experiences/ competencies

If midwives are to fulfil their full scope of practice as defined by the International Confederation of Midwives (ICM), in addition to the current minimum and mandated experiences and increasing COCE to 20, these additional skills should be included in the standards and students should be required to demonstrate competency in clinical practice (not only in simulation):

- perineal care and suturing,
- cannulation and venepuncture,
- prescribing,
- full newborn examination,
- vaginal examination including Bishops score and prostin administration
- full sexual health screening, abortion care, and family planning

With these additional requirements and volume of learning, the length of program needs to be considered. The Council of Deans of Nursing and Midwifery have been discussing a 4-year Bachelor of Nursing and it is timely for this to be considered for midwifery. The Nordic countries are well known for their positive outcomes for women and families. For many years the Nordic countries rank most highly as the best place to be a mother. The Nordic Midwives Association (NJF) have recently agreed and published a Statement calling for a 5-year direct entry master's program as initial preparation leading to registration for midwives (see Nordic Midwives Association Statement – Appendix A).

Q 2. Meet full scope of midwifery practice

The Midwifery Education Standards should be built around the ICM definition of the full scope of practice for a midwife.

In Australia, and elsewhere, the scope of practice has frequently been limited by the employer and to some extend by custom and practice (culture of health care), however, this is changing with the roll-out and scale- up of continuity of care models and improved understanding of the benefits of midwifery care and continuity of midwifery care for women, babies and families, the health system and the working lives of midwives.

Many health services and universities are looking to ANMAC to provide strong standards so that access to clinical practice experiences for midwifery students is protected and the quality graduates will make a difference to service provision.

Q 3. Interprofessional learning

Interprofessional Learning (IPL) is valuable. The woman should remain at the centre of care when planning or providing IPL opportunities. The Lancet series on Midwifery published the Quality Maternal and Newborn Care (QNMC) framework (Renfrew et al., 2014). The QNMC framework and the accompanying "integrality" model could be used as a framework for IPL.

It can be difficult to implement IPL in on campus activities as students in different programs, and sometimes across different campuses of the one university and working from different timetables need to be organised to come to a face to face sessions.

Developing learning outcomes associated with the mandated continuity of care experiences (COCE) facilitates the implementation of IPL. COC experiences provide for students to follow the woman across the complexity spectrum which inevitably exposes the student to an interprofessional environment in the context of the woman's/ baby's needs. This contextualised learning, just-in-time, active learning will aid deep learning and retention.

Students should also be provided opportunities to engage in industry/venue IPL education workshops, such as PROMPT.

Q 4. What additional issues not in consultation paper

Midwifery leadership - Program lead

The revised standards should be strengthened with regard to leadership of pre-registration midwifery programs. The Standards should be specific about who should lead the program and who should teach the program/s. The Standards should define 'contemporary' (7.6 "… strong links with *contemporary midwifery education and research*") and 'active involvement' (7.6 "…maintains *active involvement* in the midwifery profession") for the leader of program.

We recommend that as a minimum standard the program lead should 1) be a midwife, and 2) hold a tertiary appointment level at Associate Professor (inc PhD), and 3) have a defined and visible role within the university. Findings from a recent Delphi study conducted with Australian and New Zealand academics found that lack of visible midwifery leadership was a key challenge facing midwifery education. This limits the opportunity to advocate for best practice and adequate resources in midwifery education within the university sector where midwifery is often a minority group- often consumed within nursing.

The profession should discuss and decide whether midwifery academics should be undertaking clinical practice and, if so, the Standards should reflect when and how this should happen.

First Peoples and midwifery

The Midwifery Education Standards need strengthening in relation to the cultural safety preparation of students. This was a major theme emerging from the recent Delphi study conducted with Australian and New Zealand academics. We should be asking at every review of the Standards, "are we doing enough?" "What else should we be doing?" and "Are First Peoples leading the development of cultural safety in the curriculum with non-Indigenous academics as active partners?"

In line with CATSINaM Position Statement: Embedding Cultural Safety across Australian Nursing and Midwifery, we recommend a nationally consistent and adequately resourced approach to cultural safety training across midwifery programs in Australia.

We support CATSINaM's recommendation to apply the Nursing and Midwifery Aboriginal and Torres Strait Islander Health Curriculum Framework (CATSINAM, January 2017) in all midwifery programs.

It should be explicit that the First Peoples health curricula is included in a contemporary conceptual framework and program development and structure for the midwifery program. (current Standard 2).

We support inclusion of a discrete course as currently stated in Standard 4.7 "Inclusion of a discrete subject specifically addressing Aboriginal and Torres Strait Islander peoples' history, health, wellness and culture…". We recommend that this is strengthened to include that this discrete subject should be "… in the context of midwifery practice." This current text "Midwifery practice issues relevant to Aboriginal and Torres Strait Islander peoples and communities are also appropriately embedded in other subjects across the curriculum" , should remain.

Current standard 6.8 states, "Affirmative action strategies are adopted to support the enrolment of Aboriginal and Torres Strait Islander students and a range of supports are provided to students." This is insufficient and needs strengthening in consultation with First Peoples groups including CATSINaM.

Current standard 7.4 states "Staff recruitment strategies are: a) culturally inclusive and reflect population diversity b) take affirmative action to encourage participation from Aboriginal and Torres Strait Islander peoples." This is insufficient and needs strengthening in consultation with First Peoples groups including CATSINaM. Targets should be set to ensure number of academics and students at least matches the demographics of the Australian community.

The revised standards should make specific statements about the cultural competency of academics. Current standard 8.8 "Academics, midwives and other health professionals engaged in supervising, supporting and/or assessing students during midwifery practice experiences are adequately prepared for the role and seek to incorporate cultural, contemporary and evidence-based Australian and international perspectives on midwifery practice." This needs to be more explicit with regards to the cultural capability development of academics and health professionals.

<u>Changing health needs of women and babies</u>

The statistics related to the health status of pregnant women provided in the consultation paper indicate women have increasing prevalence of complex health problems. Using a biomedical model as a basis for service provision has not impacted on the health issues related to social determinants of health or lifestyle issues for pregnant women or the wider population. A primary care approach, using a social model of health, holds more promise. Strengthening midwives' ability as primary care providers should be a priority in the revised Midwifery Education Standards. Coupled with this is the need to strengthen opportunities for students to practice in and out of hospital and community settings.

Workforce modelling and future needs

While current data provided in the consultation paper indicates that Australia is graduating about the right number of midwives and there is no projected workforce shortage, there are serious limitations on the workforce data for midwifery in Australia. The discussion paper refers to published studies indicating the highest risk of leaving the profession is 4-8 years following graduation and that the main driving reason is unhappiness with the quality of care they are able to provide. It seems that we are preparing midwives for evidence-based practice, yet they are frequently unable to practice in this way within the health care system. The revised Midwifery Education Standards should prepare graduates not only to provide technically competent and woman centred care, but to be able to influence the design and implementation of maternal and newborn services. As such, a much greater emphasis on change management and leadership, even in pre-registration programs, is needed. For maternity services we argue this requires a transformative change processes based on critical theory. This is required to counter, or re-balance, the dominant biomedical approaches to health and health care.

Length of programs: alignment with international standards

There is currently wide variation in the length of programs leading to registration as a midwife, yet all programs meet ANMAC Midwifery Education Standards with the mandated 50:50 theory/ practice split and mandated number of practice experiences. This must mean that the volume of learning relative to time, and the quality of learning, must also be highly variable.

The theory/ practice split should remain 50:50 and the minimum length of program should be aligned with the ICM Global Standards for Midwifery Education of a minimum length for direct entry program of 3 years and minimum length for qual for post-nursing programs of 18 months. The consensus international view is that this is the minimum length of program for safe competent midwifery practice (ICM Global Standards for Midwifery Education (amended 2013). At present, some programs in Australia do not meet this minimum international standard. This deficit should be addressed.

ANMAC should consider a Bachelor of Midwifery as the single mode of entry to registration as a midwife. The usual recognition of prior learning frameworks would apply. The current situation divides the profession. Students often have no choice, by virtue of where they live, other than to undertake a dual BN/BM or to study nursing first. Both these options are more expensive and more time consuming. The evidence from students and graduates who are undertaking dual nursing/ midwifery degrees is that given the opportunity, a large majority preference midwifery and on graduation choose to work in midwifery and not nursing.

Optimising clinical education

While clinical practice experiences are such a large and vital component of midwifery programs, very little attention is given to determining the quality of this learning environment. At Griffith University we have developed and tested a tool to measure the quality of the clinical learning environment. It is called MidSTEP. Most Trans-Tasman Midwifery Education Consortium university partners are now using the tool with their students to assess the quality of the clinical learning environment. We recommend that the revised Standards include robust mechanisms to measure the quality of the clinical learning environment as a basis for ongoing improvements in this aspect of student learning.

There should be minimum standards for the clinical environment support provided to students by the university and the health service.

Currently the ANMAC standards are too open for interpretation and variation in relation to assuring quality of clinical education.

Rural midwifery workforce and dual registration

Much of the discussion posed within the previous review of standards and the current contemporary discussion on why we should retain short post nursing registration programs, and offer dual degrees are crafted by some around the argument that this is the only way to secure a sustainable workforce in rural and remote areas of Australia. We would refute this and say on the contrary the solution to the rural workforce shortage is to offer Bachelor of Midwifery programs that are delivered in a flexible mode enabling local residents to undertake study to become a midwife in their own communities. There is international evidence supporting the success of this strategy, and we are seeing the successful implementation of caseload models across rural Queensland as the availability of competent and confident midwives to work in these models increases.

We accept that some rural services are still struggling to reorient maternity services to contemporary evidence-based midwifery models of care. For example, there is limited movement in rural Victoria to implement continuity of midwifery care with most health services continuing to provide shift based fragmented care. These services continue to preference dual registered nurse/ midwives for flexible deployment of staff to meet inpatient needs. Shortages of midwives dominates service planning discussions rather than redesigning services. Health services are looking to recruit overseas midwives/ nurses to sustain the current maternity services models (ref: reports from Griffith University P/G Primary Maternity Care students – Victorian cohort). There is no evidence to support the idea that dual degree and PG programs leading to registration as nurse and midwife are preventing rural workforce shortages in Victoria. It is noteworthy that Victoria is the state that emphasises the nursing degree as the preparation for midwifery; it is unique across the country in this respect.

This contrasts with other rural communities where the redesign of maternity care to provide continuity of midwifery care is well advanced. In a recently finalised Queensland Health Rural Summit, there were multiple examples of rural services who provided continuity of midwifery care and were sustainable. Some rural services have reopened maternity services because they implemented this model. Other services are being re-opened because they are implementing COC models (i.e. the COC model enables them to re-open). BMid students are placed in many of these services and employed on graduation to work in these facilities and models. A single path to registration as a midwife should be considered and debated nationally with reference to the international picture.

Evolving health technologies

The Standards should address the need for the future midwife to be competent in use of emerging health technologies. We are aware that the technological advance in healthcare is evolving rapidly- and that students who will be entering programs directed by these revised standards will be entering a practice environment that will potentially be even more

technologically driven. This is another reason why students need consistent immersion in the practice environment, so they experience learning in action holistically- as they see the application of technology in real time as it expands.

In order to build their confidence with technology in the work place programs should demonstrate they are providing students with the opportunity to immerse in and with technology within their program. We cannot assume that our learners will be digital natives (a person born or brought up during the age of digital technology and so familiar with computers and the Internet from an early age.) When assessing resources available to programs it is imperative that we ensure adequate support is available to staff and students to enable them to engage in a meaningful way with evolving learning technologies and learning management systems.

Where adequate resources and support are available the use of evolving technologies and virtual environments, e.g. First Life could be used for IPL and for alternate approaches to 'supervised practice' of student midwives (especially those nearing graduation).

Appendix A: Stakeholder list and Reach

This list seems to be taken from an appendix of stakeholders for nursing with a couple of maternity / midwifery groups added in. There are also key maternity consumer groups missing – Maternity Coalition Australia, Maternity Consumer Network, Mothers and Babies Australia.

Seeking consultation from groups that have limited understanding of midwifery or maternity care/ services in Australia or internationally is inappropriate and potentially creates a confusing/ confounding picture. For example, what relevant and informed feedback is the Australasian Hepatology Association going to be able to provide about midwifery and midwifery education standards? The name of the Queensland Nurses **and Midwives** Union needs updating (it is no longer the Queensland Nurses Union).

Consultation process

It is noted that the consultation process is ongoing and to date there has been a short one-off survey with a 2 weeks consultation period.

There seem to have been no consultation on a five standard framework and whether this is appropriate of even if the current nine standards are meeting the needs of the profession and childbearing women. There does not seem to have been any research undertaken on the framework for the standards.

There seems no process available for open debate and blue-sky thinking about the midwife of the future and the relationship of this to the midwifery education standards in Australia.

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Appendix A: Nordic Midwives Association Statement

Confederation of the Nordic Midwives Associations (NJF)

STATEMENT

The world community looks to Midwives in the Nordic countries to innovate, show best practice and put women and babies at the center of care.

We call on each of the Nordic governments to deliver on the following initiatives to strengthen midwifery, enabling midwives to provide quality care for women and their families within sexual and reproductive services.

1. Every woman should have access to a midwife throughout her life cycle, including:

- Sexual counselling
- Pre-pregnancy
- Throughout pregnancy
- During labor and birth
- After birth according to her needs
- Women's health counselling

Access should be provided regardless of citizenship/residency status.

2. Midwifery care should promote normal labor and birth, based on evidence (quantitative and qualitative studies as well as best practice) and women's individual choices and needs.

3. Every pregnant woman should have access to continuity of midwifery care and carer. This is a key strategy in a) promoting better maternity outcomes and b) addressing workforce issues.

4. Midwifery education and regulation should be based on a Direct Entry 5-year master's program. Strengthening Nordic midwifery education will enable midwives to fulfill the potential of midwifery in the Nordic countries and internationally.

5. A funding model for individualized maternity care should be used. The current funding model promotes medicalized, and/or centralized maternity care including birth care which adversely impact the health and wellbeing of mothers and babies.

June 2018