Submission to ANMAC for Review of Midwifery Accreditation Standards

Question 1

Option 2 would be the best option. Australia is a vast land and whilst attending the majority of births for CoC in metropolitan areas is feasible, it is unreasonable and unattainable for those student midwives living in more remote or even rural areas.

Student midwives recruit their continuity of care women through multiple channels including social media, such as Facebook. In my local area, which is considered metro, the women the student midwives connect with could be booked at up to 6 or more hospitals, which can mean travelling up to 50 km. For those working in more rural areas, the ability to attend a hospital at short notice may mean covering a great distance, whilst the return journey is a safety issue when tired.

Women frequently do not want the student midwife at the birth as they have not built an adequate rapport with them in the short space of time during antenatal appointments. They prefer to have other support people such as sister, mother etc. If support people are restricted to two, as it is in some hospitals, then there will be no room for the CoC student midwife.

Often there is another student midwife on placement also hoping to assist with the birth through that woman too. This creates confusion and conflict in the workplace. When allocating midwives and students at the beginning of the shift, it is not usually known if a woman has a CoC student midwife coming with them.

The ability to attend where possible ensures health and safety of the student midwife, as they will feel less obligated particularly if they have already been working that day and night time approaches. It must however be stressed that a discussion should take place about the labour and birth with the woman post birth as soon as possible.

Question 2

Yes, the number should be retained at 30. Whilst acknowledging that the vaginal unassisted birth rate is dropping, this is not a reason to reduce the number required by student midwives. To do so would risk a further reduction in the rate of unassisted vaginal births. By reducing exposure to how to successfully manage vaginal births, the ability to assist a woman achieve vaginal birth when facing some difficulties/challenges will not be achieved. We should also be encouraging VBACs and if the standard is lowered then the standard will become lower. The risk to a woman undergoing a VBAC is lowered when health professionals and women have good education and exposure to the experience. We increase the risk to women if VBAC becomes a rarity. There are several options of care for women that are now restricted due to health professionals' lack of exposure and experience such as breech vaginal births and vaginal twins.

I agree about the confidence building on the number of births, not merely repetition. Having stepped into a room to take equipment in for a birth with a student midwife for whom it was her 16th birth, she felt immensely confident, patiently waiting for presenting part to maintain its descent. However, the descent of the presenting part and the perineum were far from normal. There was no recognition of what was happening, she had not recognised the scar tissue nor the need in this case for an episiotomy. Reducing the number of births risks a lack of experience in managing such complications. Junior and graduate midwives currently note a great deal of fear or trepidation when

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undertaking their birth suite rotations in the graduate year. It may have been many months since they set foot on a birth suite and if the number of births are reduced then that will only increase.

Perhaps if the clinical placement hours were increased it would make it easier for the students to attain the required number of births, whilst also increasing confidence and reducing anxiety.

Lowering the required number would also put Australia well below overseas standards compared with Europe and the UK. I acknowledge that the education and preparation is different in these countries with a much higher number of course hours required to be completed in both theory and clinical practice.

Question 3

I am unsure whether this relates to educational preparation solely or for the midwife to be able to prescribe on completion of the pre-registration program. If it is to enable them to prescribe on graduation and registration then the answer is no. It is my opinion that they are not sufficiently comfortable with medications as a graduate midwife in the initial few months without having the burden of prescription responsibilities.

More importantly, under section 94 of the Health Practitioner Regulation National Law (the National Law) they would not be eligible to apply for endorsement of scheduled medicines unless they had met the other criteria. Given that would take at least three years of full time clinical practice then one is unclear how up to date this preparation would be by the time the midwife meets this criteria.

I have discussed this with several of our midwives from graduates to some a few years out. They were all adamant that this is not what they would want and that it should be a post graduate learning. Not all midwives want to be able to prescribe and adding it to the program does not offer choice.

Medical staff have to complete between 5 and 6 years prior to be able to prescribe. Although midwives would be using a much shorter list of medications it is not simply the medication it is the interactions and precautions that are often overlooked in the beginning.

Whilst midwives have a different level of autonomy to nurses, nurses are required to undertake a program as a nurse practitioner prior to them being able to prescribe. Watering it down for midwives would leave a great deal of disparity between the professions.

Question 4

What component of the training would need to be dropped to provide space for preparation to prescribe to be included? The question needs to be answered about what is considered unnecessary currently to be taught?

Implications to include would be the impact on nursing education. Whilst this is about the accreditation of midwifery education it would lead to options to include in nursing education too.

Another is how useful would it be? How often are courses for prescribing medications updated currently? Would a time limit be set as to how long a midwife can count on this preparation to be prior learning when applying for endorsement for scheduled medicines?

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This would mean that prescribing would be split form the requirements of the registration standard for endorsement and require a change to the National Law.

Question 5

I do not feel that the draft accreditation standards cover the required knowledge or skills to ensure the graduate is adequately prepared for practice. Whilst the sections are good in that it is clearly defined, there is no mention of skills to be gained other than practice requirements for numbers.

I note that the standards are designed to reduce the level of detail, complexity and duplication while remaining flexible and responsive, however I also note the variance in practice of students have a differing emphasis at different universities. This leads to challenges when planning education needs and support for newly qualified midwives. This may be addressed in 'an essential evidence document' which will be a companion to this table of draft standards.

Question 6

It is evident in reviewing the capabilities of graduate midwives over the last few years that many are unable to perform adequate abdominal palpation, vaginal examinations and episiotomy as basic skills. I have had to put together a timeline for skills acquisition during their graduate year to ensure they are able to work to full scope of practice. They have no idea or inclination to work towards perineal suturing. This latter skill is not an expectation in the first year. If we want more continuity of care then they must acquire the full gamut. A greater emphasis needs to be placed on breast feeding education.

Standard 3: Program of study should include the following explicitly:

Professional ethics and professional legislation

Basic biophysics, biochemistry and radiology, bacteriology, virology and parasitology. The later due to Australia's vast immigrant population originating from very differing regions.

Health education and early diagnosis of disease

The rising co-morbidities of today's pregnant women are often overlooked in order to strive for normalising pregnancy care. For many women it is a normal life event, however increasing numbers of women are achieving pregnancies and maintaining them though requiring care in cardiac care unit or intensive care to ensure a safe outcome. The rising obesity rate and subsequent complications needs to be acknowledged. This is not popular with some academics.

There are sporadic areas providing student antenatal clinics though these are few and far between. The standards for education should include a mandated extensive level of antenatal surveillance experience. Most courses allocate around 8o clinical hours, so 10% of the overall. And yet pregnancy accounts for the majority of the care that midwives provide to women across the continuum of pregnancy.

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Question 7

None that should be deleted. 3.7 Principles of diversity, culture, inclusion ….etc. could be moved into the Standard 1. Safety of the public. This is fundamental to providing a safe environment for the public. Similarly the same applies to 3.10.

Question 8

Nil further

Question 9

There is some disparity around clinical hours required for completion. I see there is no mention in this review. The current 700-800 hours does not adequately prepare students for life in the real world. They struggle with shift rotations. Time management is also identified as being an issue.

I find it very disappointing that there is a lack of clinical midwifery representation amongst the PRG member list. The vast majority are academics. I am unclear how the needs of stakeholders such as employers is garnered.

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