Australian Nursing & Midwifery Accreditation Council

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Accreditation standards review

Written submission form

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Standards Review
17 December 2019

La Trobe University, School of Nursing & Midwifery is grateful for the opportunity to make a submission in response to the 'Review of Midwife Accreditation Standards' Consultation Paper Version 2. La Trobe University provides both undergraduate and postgraduate courses that are approved programs for general registration as a midwife. We deliver these courses in both a metropolitan and rural/regional context which uniquely positions us to understand the broader midwifery requirements in both specialised and general maternity units. We have considered this review with the following central tenant: that midwives are critical to the delivery of safe maternity care enabling maternal and newborn wellbeing regardless of the choice of birth environment.

Our team has also contributed to the submission provided by Nicky Hartney on behalf of the Victorian Midwifery Academics (MIDAC) organisation.

Contributors to this submission were:

Lisa McKenna, Christine East, Helen McLachlan, Michelle Newton, Stefanie Zugna, Sharon Mumford, Charlie Smithson, Rebecca Hyde, Fiona Faulks, Helen Nightingale, Deborah Birrell, Heather Grimes, and Maureen Dillon.

Please find our response to the consultation questions below.

Question 1
Continuity of care experiences Please choose one of the following options for student engagement with women during continuity of care experiences. Option 1 –attend the labour and birth for a majority of women (present requirement) or Option 2 –attend the labour and birth where possible Please select one 1. Option 1 2. Option 2 3. Don't know/unsure Please provide a rationale for your choice
We support **Option 2** The present requirement is problematic if a student does not meet the requirement to attend the majority of labour and births late or near completion of their course as it is a clinical requirement that cannot be achieved quickly. Students should attend the labour and birth where possible, however there are many reasons out of a student's control that means they are unable to attend the birth. The student should have a valid reason for not being able to attend the birth. Some examples include:

- the health service or individual private obstetrician not allowing the student to attend the birth (e.g. at caesarean section, another student already present)
- women not notifying the student when they go into labour
- student already on a clinical shift in another health service
- university required attendance such as clinical assessments and exams
- precipitate labour or birth before arrival;
- students having to leave for health and safety reasons after being with the woman in labour for a long period of time (ie more than 12 hours)

We have concerns about safety for students who may need to attend COC births after completing shifts/working longer than 12 hours. Students may not necessarily (depending on individual university policy) have protections in place as paid employees do.

Question 2
Labour and birth care Should the number of spontaneous vaginal births for whom the student is primary birth attendant remain at 30 women (present requirement)? Yes/No/Unsure Please provide a rationale for your choice.

No. We believe the focus on being the primary birth attendant is incorrectly weighted for the following reasons:

- as the majority of interventions occur in the labour period, the focus for students should be on labour care, with an aim of improving practice in the labour period.
- students are regularly sent into births for second stage having never met the women, nor provided any care – just to meet numbers. This is the antithesis of woman-centred care and is against the high level evidence regarding continuous support in labour; and continuity of care.
- health services are finding it increasingly difficult for students to achieve 30 spontaneous vaginal births due to rising intervention rates. This is the case in many settings, and especially in regional Victoria where health services are taking less students for placement due to their reduced numbers of women having SVBs. This is particularly concerning because we have midwifery workforce shortages, and health service closures related to staff shortages.
- there was no evidence that supported the increase to 30 births and there is no evidence of improved standards of practice for graduates of programs where this has been a requirement.
- the standards are 'minimum'. Individual universities can include a higher number in their curricula if they would like to, where the clinical placement providers can support more the minimum requirement for births.

As such, we would like to see a reduction on the current requirement of students being the primary birth attendant, with a reciprocal increase in the number of women where students provide direct and active care in labour.

Therefore, we would like to Standard 3.12d amended:

- increase the number of women where students provide direct and active care in labour from 10 to 20
- reduce the number of SVB from 30 to 20

Question 3
Should educational preparation for prescribing to the midwife's scope of practice be included in curricula of entry-to-practice midwifery programs? Yes/No/Unsure
No. We believe that prescribing is an advanced midwifery skill that is not appropriate in an entry-to-practice program.

Question 4
What might be the implications of including preparation to prescribe in entry-to-practice midwifery programs?
Some implications include: - Midwives are currently unable to prescribe in the public/ private hospital system, therefore students would have a skill that is impractical to the majority that will go on to work in the hospital system. - The current lack of expertise in the current midwifery workforce to supervise or assess the competency of students prescribing would mean significant upskilling of the current workforce would be required prior to the implementation of this standard. In addition, if the students cannot prescribe in the hospital system where they are doing the majority of their clinical placement, they will not be able to consolidate this skill practically. - The volume of theory required could potentially increase course duration (our understanding from existing subjects/courses is that the theoretical load is extensive).

Question 5
Do the draft accreditation standards cover the required knowledge, skills and attitudes to ensure that the graduate meets the NMBA Midwife standards for practice?
No. We believe that the draft accreditation standards do not adequately cover the required knowledge and skills required in an outpatient antenatal setting. Currently, there is significant variation in how students are accruing their 100 antenatal visit attendances, as this can currently be achieved in inpatient antenatal care or attendance at childbirth education sessions. Students are potentially graduating with very little exposure to an outpatient antenatal setting which puts them at risk of not being able to meet many of the standards for practice.

Question 6
Are there any additional criteria that should be included?
Yes. As outlined above, we believe the standards do not adequately cover the required knowledge and skills required in an outpatient antenatal setting. We propose that there should be a minimum number of outpatient antenatal appointments that the student must observe, and perform.

Question 7
Are there any criteria that could be deleted or amalgamated with another criteria?
Yes. As per response to question 2 above, we suggest an amalgamation of 3.12d and suggest the following wording: Provide direct and active care to 40 women during the first, second and third stage of labour. This will include the student being the primary birth attendant for 20 women who experience a spontaneous vaginal birth.

Question 8
Please provide any other feedback about the structure/content of the draft standards
We acknowledge the importance of standard 3.5d (integrated knowledge of care across the childbearing continuum within the scope of midwifery practice including: - social and emotional wellbeing of women - complex family health, domestic violence, stillbirth and family bereavement care - perinatal mental health). We do, however, question why the standards have focused on these points whilst many other important aspects of the curriculum were excluded. We believe that standards should be generic enough that contemporary issues are captured without needing to be specified as in 3.5d.

Question 9
Are there further issues that should be addressed in the revision of the Midwife Accreditation Standards that have not been discussed so far in the consultation process?
No