Safer Care Victoria

Consultation response

Safer Care Victoria (SCV) is the state's lead agency for improving the quality and safety of healthcare. We support health services to monitor performance, guide best practice, and help them identify and respond to areas where they can improve.

SCV was established in January 2017 as an administrative office of the Department of Health and Human Services.

OUR PURPOSE

To enable all health services to deliver safe, high-quality care and experiences for patients, carers and staff.

WHAT WE DO

- Quality improvement
- Sentinel event reporting
- System safety reviews
- Performance monitoring
- Safety alerts and advisories
- Clinical guidance and support
- Patient feedback
- Consumer participation
- Innovation funding
- Leadership development

CONSULTATION RESPONSE

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**

Support of Option 2. We have concerns with the requirement to attend the majority of births for continuity of care (CoC) experiences and support he change to 'where possible'.

The CoC experiences are often over and above the required clinical placement hours. Therefore in between placement, study, work and general life, these students are required to find time to attend antenatal and postnatal appointments. This is while also being on call for their CoC women and attending a labour and birth that could span across 12 hours or more. SCV does not want to see

students putting themselves at risk in order to meet minimum requirements for their degree. By stating students are required to attend the labour and birth **where possible**, it enables the student to make an assessment as to whether it is safe for them to attend. It is the responsibility of the university to maintain oversight of the practise and progress of their students, it would be up to them to determine the student who had genuinely been unable to attend a birth versus one who was not completing the CoC experiences appropriately.

The term 'majority of births' is ambiguous and not quantifiable.

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

Consultation paper 2 discusses the trend away from spontaneous vaginal birth and the negative impact this has had for students to act as the primary birth attendant, and that this should be considered when setting minimum requirements.

Reducing the number of births where students are required to act as the primary birth attendant is not the solution to this issue. Midwives require unique knowledge, experience and skill to support a woman to a spontaneous vaginal birth. If the exposure for students is reduced, the ability to provide care to a woman as a registered midwife will be reduced, and the trend will continue.

It should be the aim of the undergraduate/professional entry courses to produce midwives who are educated and prepared to practise in accordance with their professional standards and scope of practice.

QUESTION 3

Should educational preparation for prescribing to the midwife's scope of practice be included in curricula of entry to-practice midwifery programs?

No

We support stakeholder views the education to prescribe should remain at postgraduate level, with an underpinning of clinical experience hours beyond initial registration.

Further research and analysis into the benefits of including 'prescribing to scope of practice' in entry to practice midwifery programs should be undertaken prior to considering including in curriculum.

QUESTION 4

What might be the implications of including preparation to prescribe in entry-to-practice midwifery programs?

- Inability to practice in accordance with education in all jurisdictions

- Distraction with mastering advanced practices (prescribing) at the cost of foundational skill consolidation
- Discrepancy with NMBA endorsement requirements
- Inequity between nurse and midwife prescribing endorsement.

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?

Yes

QUESTION 6

Are there any additional criteria that should be included?

No

QUESTION 7

Are there any criteria that could be deleted or amalgamated with another criteria?

No

QUESTION 8

Please provide any other feedback about the structure/content of the draft standards

No feedback

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?

Standardised clinical practice hours

There appears to be difference across the country in relation to the number of hours students are completing in clinical placement hours for Bachelor of Midwifery degrees (a range of 960 hours to 2000 hours). Greater consistency in clinical placement hours across education providers should be prioritised to ensure midwifery students have equal access to learning opportunities during their program of study.