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.

Noting the response to the first draft of the consultation paper and the impact on student's ability to be present for labour and birth, it seems reasonable to modify to 'attend birth – where possible' – noting this should be in the majority of cases – it would be useful to have a lower limit that is acceptable. Arguably attendance at the labour, and contact in latent phase and first stage has the most ability to improve outcomes for women.

QUESTION 2

Labour and birth care

Should the number of spontaneous vaginal births for whom the student is the primary birth attendant remain at 30 women (present requirement)?

Yes/No/Unsure

Please provide a rationale for your choice.

Given the rationale for the decreasing rate of spontaneous vaginal birth, consideration could be given to the terminology primary 'midwifery' birth attendant – whilst medical staff assume primary responsibility for assisted vaginal births the role of the primary midwife is paramount – to the women, her support team and the healthcare team. Inclusion of primary 'midwifery' attendant enables the development of skill set and experiences to adequately support new midwifery graduates.

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

The principle of ensuring graduates are prepared for practice is supported in its entirety. The detail regarding how this translates to practice settings is challenging. Given the minimal uptake of midwives prescribing, and current regulations regarding midwives prescribing – the ability for graduate midwives to consolidate this component in the curricula is very limited. This likely introduces a risk to

the new graduate. Whilst it is recognised that education programs need to prepare midwives for practice in varied practice settings, the distribution employed in services that do not support midwifery prescribing without endorsement will be a barrier to consolidating this practice.

QUESTION 4

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

Risk to graduates unable to practice to full scope as currently regulations regarding the prescription and supply of medications by a midwife employed in a public entity is restricted. Whilst there is a need to 'start somewhere', emphasis needs to be on supporting current practising midwives to prescribe and supply medications in all midwifery practice settings.

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 – noted amendments to consultation paper 1 feedback

QUESTION 7

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

No, differentiation between educational requirements and practice requirements noted.

QUESTION 8

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

Aligning the Standards in the five standard format adopted in the proposed Registered Nurse Accreditation Standards promotes consistency.

The following question seeks to provide an opportunity for the identification of issues not covered so far in the consultation process.

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?

Nil to note