Australian Nursing & Midwifery Accreditation Council

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Review of the midwifery accreditation standards

Consultation paper 2

October 2013

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Published by the Australian Nursing and Midwifery Accreditation Council, Canberra, subject to NMBA approval

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Consultation paper 2

Introduction

This is a review of the Australian Nursing and Midwifery Council (ANMC)[1] *Midwives: Standards and Criteria for the Accreditation of Nursing and Midwifery Courses (2010)*[2] (midwifery accreditation standards) leading to registration, enrolment, endorsement and authorisation to practice in Australia.

Under the *Health Practitioner Regulation National Law Act* (National Law) the Australian Nursing and Midwifery Accreditation Council (ANMAC) is responsible for developing and reviewing accreditation standards.

Aim of the review

The aim of this review is to examine and update the midwifery accreditation standards in light of Australia's move to the National Registration and Accreditation Scheme (NRAS) for health practitioners. NRAS started on 1 July 2010. It was established by state and territory governments through the introduction of consistent legislation in all jurisdictions.

As part of the review ANMAC will examine and synthesise current evidence and feedback to refine and improve the midwifery accreditation standards to safeguard and promote the health, safety and wellbeing of those Australians requiring midwifery care.

The work of the jurisdictions, communities, members of the midwifery profession and the representatives of the Australian College of Midwives in developing the current midwifery accreditation standards is recognised and valued. The review of these standards builds on this platform. ANMAC's process used to review of the *Registered Nurse Accreditation Standards* (2012) is the model used for this review. This model builds on previous learning, enhances the review process and upholds consistency across the development of all accreditation standards.

ANMAC is committed to constructive and respectful engagement with stakeholders when undertaking any review and developing all accreditation standards. Consequently, there has been extensive consultation with stakeholders and multiple opportunities for engagement during the review. This consultation, combined with a review of the literature, will ensure the midwifery accreditation standards are contemporary, comprehensive, clearly articulated and nationally consistent.

The existing *Standards and Criteria for the Accreditation of Nursing and Midwifery Courses: Midwives (2009)* can be accessed on ANMAC's website. These are being reviewed with the support of the Nursing and Midwifery Board of Australia (NMBA), which ultimately approves the standards as the basis for the qualification leading to entry to the register as a midwife.

[1] The Australian Nursing and Midwifery Council (ANMC) evolved into ANMAC following approval as the accrediting authority for nursing and midwifery. ANMC authored the original set of Accreditation Standards as well as the National Competency Standards for nursing and midwifery.

[2] Australian Nursing and Midwifery Council, *Midwives Standards and Criteria for the Accreditation of Nursing and Midwifery Courses Leading to Registration, Enrolment, Endorsement and Authorisation in Australia with Evidence Guide*. Canberra, 2010.

Appendix A includes more detailed information about the regulatory context of these standards.

Purpose of the consultation paper

The consultation paper outlines the aim, objectives and context of the review. It describes the consultation process and proposes key areas for interested stakeholders to consider.

To be effective, the review had to optimise the critical input of organisations and individuals with an interest in the education of midwives. This paper was therefore distributed to organisations and individuals interested in the practice of midwifery, midwifery education and the midwifery accreditation standards, who may wish to make a contribution in writing or by participating in scheduled consultation forums.

Attached to Consultation Paper 2 is the second version of the draft midwifery accreditation standards, provided for reflection, review and discussion (Appendix D). Questions asked as part of the review are placed throughout the consultation paper to prompt deliberation on significant issues and provide an opportunity for feedback on latest revisions to the standards. How feedback is to be provided and incorporated is outlined in 'The consultation process'.

The final published version of the midwifery accreditation standards will be based on the best available evidence and, where possible, consensus from experts and stakeholders in the relevant fields derived from the consultation process.

Context of the review

In 2010, ANMAC became the independent accrediting authority for nursing and midwifery programs of study. This arrangement was renewed in 2013 for a five-year period. ANMAC is responsible for maintaining and developing the integrity of accreditation standards for the professions under its mandate. In addition:

> In developing an accreditation standard for a health profession, an accreditation authority must undertake wide-ranging consultation about the content of the standard.[3]

The current accreditation standards for midwives were developed by ANMC in 2009, with minor changes in 2010, and subsequent approval by the NMBA that same year. ANMAC is now reviewing these standards as the external accreditation entity[4] responsible for reviewing and developing all midwifery accreditation standards for entry programs leading to registration in Australia.

ANMAC's aim is to achieve the primary objective of the National Law which is[5]:

> … to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered.

[3] AHPRA (2009), *Health Practitioner Regulation Law Act*, as in force in each state and territory. Viewed at: www.ahpra.gov.au/Legislation-and-publications/Legislation.aspx on 6 May, 2013.

[4] Ibid., Section 43.

[5] Ibid.

The process of reviewing and developing the midwifery accreditation standards is robust and uses iterative steps to ensure the final outcome has no surprises for stakeholders. It is critical to assess whether the standards are complete, with sufficient evidence and information to address all domains necessary to assure the NMBA and the Australian community that a graduate of an accredited midwifery entry to practice program is fit to be registered and can practice in a safe and competent manner. The review enables stakeholders to consider if the revised standards and accompanying criteria are accurate and relevant to a changing Australian health care system and education environment. The review's consultative process also provides an opportunity to evaluate whether it is reasonable to expect education providers to achieve each accreditation standard and its accompanying criteria.

Under Section 49(1) of the National Law, graduates of programs of study will not be eligible for registration or endorsement unless the program of study undertaken is accredited by an approved accreditation authority and by the NMBA as meeting the education requirements for registration as a registered midwife.[6]

Once approved by the NMBA, ANMAC will use the revised midwifery accreditation standards to assess education programs. The objective of entry-level programs is to ensure graduates can meet NMBA-approved competencies[7] to practice safely and competently in the current Australian health environment.

There are three pathways to enter the midwifery profession—a Bachelor of Midwifery program, a dual degree program combining midwifery and nursing degrees, and a postgraduate program in midwifery for registered nurses. All programs leading to registration as a midwife must meet the midwifery accreditation standards.

Successful completion of a program allows the graduate to apply for registration with the Australian Health Practitioners Regulatory Authority (AHPRA) as a midwife.

Consultation process

An Expert Advisory Group was established by the ANMAC Board to advise ANMAC during the review:

- Dr Joanne Gray, ANMAC, Expert Advisory Group Chair
- Ms Roz Donnellan-Fernandez, Australian College of Midwives nominee
- Ms Janice Butt, ACM: Midwifery Education Advisory Committee nominee
- Ms Alison McMillan, Australian and New Zealand Council of Chief Nurses and Midwives nominee
- Ms O'Bray Smith, Australian Nursing and Midwifery Federation nominee
- Ms Karen Atkinson, Congress of Aboriginal and Torres Strait Islander Nurses and Midwives nominee
- Professor Sue McDonald, Council of Deans of Nursing and Midwifery nominee

[6] AHPRA (2009), *Health Practitioner Regulation Law Act*, as in force in each state and territory. Viewed at: www.ahpra.gov.au/Legislation-and-publications/Legislation.aspx on 6 May, 2013.

[7] ANMC, *National Competency Standards for the Midwife*, 2006.

- Associate Professor Lee Stewart, James Cook University, educationalist for dual degree (nursing and midwifery) programs
- Professor Caroline Homer, University of Technology Sydney, educationalist for entry to practice midwifery programs
- Mr Bruce Teakle, Maternity Coalition nominee
- Ms Jan White, Maternity Services Inter-Jurisdictional Committee nominee
- Associate Professor Graeme Boardley, Women's Healthcare Australasia nominee
- Associate Professor Jan Taylor, ANMAC, Midwife Accreditation Committee Chair
- Professor Bob Meyenn, ANMAC, Standards Accreditation and Assessment Committee Chair
- Ms Amanda Adrian, ANMAC, Chief Executive Officer
- Ms Donna Mowbray, ANMAC, Executive Director Accreditation and Assessment Services
- Ms Kate Jackson, ANMAC, (Retired) Acting Manager of Accreditation Services
- Ms Margaret Gatling, ANMAC, Associate Director for Professional Programs
- Dr Ann Alder, ANMAC, Associate Director for Professional Programs
- Ms Jackie Doolan, ANMAC, Standards Development and Review Co-ordinator.

The Expert Advisory Group developed a project plan for the review of the midwifery accreditation standards at its first meeting on 20 February 2013. A list of key stakeholders was also identified by this group for the purposes of participation in the consultation process (Appendix B).

The initial round of consultation is now complete. Consultation included dissemination of Consultation Paper 1, Version 1 of the draft midwifery accreditation standards and an associated survey. Identified stakeholders were also invited to participate in two initial consultation forums—Brisbane on 21 August and Perth on 23 August 2013.

Next round of consultation

Feedback from the initial consultation forums and survey informed the development of Consultation Paper 2. The consultation paper will be circulated to stakeholders for comment and will also be accessible on the ANMAC website. The paper and Version 2 of the draft midwifery accreditation standards will be discussed at further forums and focus groups, with the final forum planned for Melbourne in December 2013.

This second round of the consultation on the draft midwifery accreditation standards includes:

- Consultation forums:

Adelaide	22 October.
Sydney	30 October.

- Regional, rural or remote focus groups:

Launceston	9 October.
Townsville	11 October.

Wagga Wagga	15 October.
Darwin	31 October.

- Final summative forum:

Melbourne	11 December.

Stakeholders and other interested parties will also be able to provide written feedback after the second consultation paper is disseminated:

- Consultation Paper 2 questions are available as an electronic survey by way of: http://www.surveymonkey.com/s/Midwifery_Accreditation_Standards_Review_2
- Alternatively, submissions may be sent to the following dedicated email address: standardsreview@anmac.org.au
- Please submit responses by **close of business 25 November 2013** so ANMAC can prepare for the final summative consultative forum, to be held in Melbourne 11 December 2013.
- Consultation Paper 2 and Version 2 of the draft midwifery accreditation standards will be posted on the ANMAC website and accessible via the quick link 'standards under review' tab or via: www.anmac.org.au/standardsreview/Midwifery_Accreditation_Standards

Objectives of the review

This review aims to establish a revised set of midwifery accreditation standards that:

- meet the objectives and guiding principles of the National Law
- contemporary and aligned with emerging research, policy and relevant industry guidance
- ensure midwives are suitably educated and qualified to practice in a safe, competent and ethical manner
- are acceptable to the community in supporting safe, quality maternity care
- are acceptable and supported by the profession and relevant education providers
- are underpinned by the *ANMAC Protocol for Accreditation Standards*.

Shaded boxes throughout this document provide sections of Version 2 of the draft midwifery accreditation standards and specific questions. These questions can be answered using the online survey link: http://www.surveymonkey.com/s/Midwifery_Accreditation_Standards_Review_2

Considerations in development of standards

ANMAC has developed a protocol to be used in revising standards to ensure consistency of process and, where relevant, structure and content.

While ANMAC, the NMBA and nursing and midwifery stakeholders acknowledge the discreteness of the nursing and midwifery professions, they also acknowledge the common areas of professional education.

In 2011–12 ANMAC commissioned the review of the accreditation standards for registered nurses. The ANMAC Registered Nurse Accreditation Standards 2012[8] were approved by the NMBA in 2012. The generic structure used for the registered nurse standards is now being applied to the review and development of the midwifery accreditation standards. This structure has been included in all draft versions of the midwifery accreditation standards with language adjusted so it is relevant and appropriate to midwifery practice and education.

Literature search

ANMAC commissioned a literature search to inform Consultation Paper 1 and the work of the Expert Advisory Group. The CINAHL[9] and Medline databases were searched using combinations of the following terms (as presented):

accreditation	criteria	“midwi* training”
"authentic learning environment*"	credentialing	pre-registration
beginning practice	"fitness for practice"	"professional experience"
"clinical hours"	"fit to practice"	simulation
"clinical practicum hours"	"follow through*"	"situated learning"
"clinical placement"	"hospital placement"	standards
clinical requirement	"legitimate peripheral participation"	theory practice
competenc*	“midwi* education	transition”
"continuity of care"		

Searches were limited to English papers published from 2007.

The search also included all state and territory health department websites for relevant policy and other documents.

Other documents were provided by professional networks and identified when searching the bibliographies of relevant articles.

[8] ANMAC, *Registered Nurse Accreditation Standards*. Canberra, 2012.

[9] The Cumulative Index to Nursing and Allied Health Literature is an index of English-language and selected other-language journal articles about nursing, allied health, biomedicine and health care.

The Australian midwifery landscape in 2013 and beyond

ANMAC is reviewing and developing the accreditation standards leading to registration as a midwife in Australia in the context of Australia's current national and international health, education and social policy environment.

A number of major reforms in the governing, funding and providing health services are underway in Australia. Also, a number of new national agencies[10] have been established over the past three years. The formation of HWA, for example, has developed and influenced the role and number of midwives operating in the broader system of professional health service delivery. A similar reform has taken place in the education sector over this period.[11]

Maturation of midwifery as a discrete profession continues in Australia. The midwifery landscape today is characterised by:

- increasing high-level evidence concluding that most women should be offered midwife-led continuity models of care because these are associated with less interventions, including less pre-term birth, epidurals, episiotomies and instrumental births[12]
- increasing maternal age, with 13.7 per cent of mothers who gave birth in 2009 aged 35 years or older[13]
- a 'baby boom in 2010, with 297 900 births registered in Australia—the highest ever recorded in a calendar year[14]
- high rates of interventions, with 31.5 per cent of all births in 2009 occurring by caesarean section[15]
- increasing rates of maternal obesity and increasing rates of chronic illness[16]
- women requesting more options for maternity care, particularly those focusing on continuity of care[17]
- increasing focus on placing maternal care in a wellness model and shifting the balance of care away from acute services to community-based
- an increase in the use of technology and the emergence of electronic health care records

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[10] For example: Independent Hospital Pricing Authority; National Performance Authority; Australian Commission on Safety and Quality in Health Care; Australian National Preventive Health Agency; Health Workforce Australia—HWA.

[11] Australian Government, *Review of Australian Higher Education–Final Report*, 2008. Viewed at: www.innovation.gov.au/HigherEducation/Documents/Review/Subs2008/091ANorton.pdf on 6 May, 2013.

[12] Sandall J, Solanti H, Gates S, Shennan A. & Devane D. 'Midwife-led continuity models versus other models of care for childbearing women'. *Cochrane Database of Systematic Reviews 2013*, Issue 8. Art. no.: CD004667. DOI: 10.1002/14651858. CD004667.pun3.

[13] Li Z., McNally L. & Sullivan EA. *Australia's Mothers and Babies, 2009*. Canberra: Australian Institute of Health and Welfare, 2011.

[14] Australian Bureau of Statistics, *Year Book Australia, 2012*. Viewed at: www.abs.gov.au/aussats/abs@.nsf/Lookup/by%20Subject/1301.0~2012~Main%20Features~Births~51 on 15 March, 2013.

[15] Ibid.

[16] Australian Health Ministers' Conference, *National Maternity Services Plan*. 2010.

[17] Ibid.

- a decline in the availability of maternity services in rural and remote areas[18]
- a projected short-term oversupply of midwives—based on Australian Institute of Health and Welfare data—that peaks in 2016 and is balanced by 2025.[19] (Awaiting release of data from Health Workforce Australia.)
- increasing numbers of registered midwives practising without a nursing registration, although the contribution to total midwifery registrations was only 4.5 per cent in 2011[20]
- changing arrangements in delivering maternity care through:
  - the introduction of caseload midwifery models of care
  - changes to industrial awards
  - introduction of endorsed eligible midwives with prescribing and hospital visiting rights, professional indemnity insurance and Medicare rebates when in a collaborative arrangement with a medical practitioner or as per other legislated conditions.[21,22]

The 2010 National Maternity Services Plan identifies the five-year vision for maternity services as:

> Maternity care will be woman-centred, reflecting the needs of each woman within a safe and sustainable quality system. All Australian women will have access to high-quality, evidence-based, culturally competent maternity care in a range of settings close to where they live. Provision of such maternity care will contribute to closing the gap between the health outcomes of Aboriginal and Torres Strait Islander people and non-Indigenous Australians. Appropriately trained and qualified maternity health professionals will be available to provide continuous maternity care to all women.[23]

Thus, the revised standards must facilitate the preparation of midwives to assist in achieving this vision and producing competent, safe practitioners for the current, contemporary maternity environment.

Key aspects of the accreditation standards requiring further consideration by stakeholders

The Consultation Paper 1, associated survey and Version 1 of the draft midwifery accreditation standards were available for public review for six weeks up to 23 July 2013. A summary of

[18] Ibid

[19] Health Workforce Australia, *Health Workforce 2025 –Doctors, Nurses and Midwives,* Volume 1. Adelaide, 2012.

[20] Health Workforce Australia, *Health Workforce Series—Health Workforce by Numbers*, Issue 1, Adelaide, 2013.

[21] Australian Government Department of Health, *Eligible Midwives Questions and Answers,* 2012. Viewed at www.health.gov.au/internet/main/publishing.nsf/Content/midwives-nurse-pract-qanda on 6 May 2013.

[22] Health Insurance Amendment (Midwives) Regulation 2013 (SLI NO 186 OF 2013), Explanatory Statement, Select Legislative Instrument 2013 No. 186, Health Insurance Act 1973; View at www.austlii.edu.au/au/legis/cth/num_reg_es/hiar2013n186o2013514.html

[23] Australian Health Ministers Conference, *National Maternity Services Plan*. 2010.

stakeholder responses to this initial phase was developed, a condensed version of which is in Appendix C.

This round of consultation was followed by two forums enabling stakeholders to share opinions and debate the major issues identified in written submissions and survey responses. The Expert Advisory Group considered the information gathered during these processes and used it to guide Version 2 of the draft midwifery accreditation standards.

Competence and midwifery practice experience

Review of the literature on competence and midwifery practice experience was discussed in Consultation Paper 1[24] and used to inform some of the initial survey questions.

Feedback from the survey questions indicated key points of difference relating to these areas:

1. competency assessment
2. minimum midwifery practice requirements, including continuity of care experiences (CoCE)
3. minimum practice hours.

This table outlines the three proposed approaches developed during consultation, with the key concepts, benefits and risks.

Approach 1—competency assessment		
Key concepts	**Benefits**	**Risks**
• remove midwifery practice experience stipulations from the standards • use a competency-based approach to manage the midwifery practice experience component of curricula • support CoCE, as a valuable learning experience that contributes to competent midwifery practice • allow universities to self-regulate curricula to ensure graduate outcomes meet registration requirements	• use competency assessment as an outcome measure of student learning objectives • supports adult learning principles • accommodates differences in mode and rate of student learning • emphasises quality rather than quantity of experiences • increases flexibility of midwifery curricula • potential to improve program viability • potential to encourage the development of standardised and	• issue with subjectivity / quality of assessment process and assessors • lack of continuity of preceptorship • lack of validated instruments to measure competency • inconsistent standard of midwifery practice experience across programs and universities • potential for students to be assessed as competent with inadequate exposure to midwifery practice experience • negotiation and/or articulation of midwifery practice placement needs

[24] Review of the midwifery accreditation standards, Consultation Paper 1, 2013, pp. 9–21.

Approach 1—competency assessment		
Key concepts	**Benefits**	**Risks**
	validated midwifery assessment tool	becomes problematic • stakeholder feedback (viewed as professional judgement) indicates a lack of support for removal of all minimum requirements

Approach 2—minimum midwifery practice requirements		
Key concepts	**Benefits**	**Risks**
• maintain midwifery practice experience stipulations within standards • base midwifery practice experience component of curricula on CoCE and other midwifery practice experiences to ensure exposure to midwifery scope of practice and development of competency • use National competency Standards for the Midwife to assess competency as a learning outcome • universities are required to be responsive to both funding and regulatory drivers	• more experience promotes depth of clinical learning • more experience may assist to attain competence • prevents students with inadequate midwifery practice experience being assessed as competent • provides a consistent standard of midwifery practice experience across programs and universities • ensures equity across midwifery practice experience goals • facilitates negotiation and/ or articulation of midwifery practice placement needs for education providers students and service providers • strategy is used by a number of regulatory bodies • stakeholder feedback supports inclusion in	• quantum of experiences is not a measure of competent practice • no evidence to guide type or numbers of experiences • students 'chase the numbers' rather than focus on quality of experience • too many requirements can generate academic, social and financial burdens for students—this relates particularly to numbers and hours of CoCE • education providers can misinterpret requirements • a generic minimum number of practice experiences when combined with varying program lengths may influence student workloads • variances in midwifery practice settings limit access to some midwifery practice experiences

Approach 2—minimum midwifery practice requirements		
Key concepts	**Benefits**	**Risks**
	standards	• reduces midwifery curricula flexibility • potential to affect program viability

Approach 3—minimum practice hours		
Key concepts	**Benefits**	**Risks**
• base midwifery practice experience component of curricula on a minimum number of midwifery practice hours • stipulate sufficient minimum hours to support adequate exposure to midwifery practice experiences, including CoCE • use to support competency based or minimum practice requirement approaches	• ensures consistency of minimum midwifery practice hours within and across programs • may increase focus on the quality of midwifery practice placements • assists universities and health services to commit appropriate funding and resources • protects against erosion of midwifery practice placement time • may assist in determination of theory to practice ratios • inclusion in standards supported by stakeholder feedback	• no evidence to guide optimum number of clinical practice hours • midwifery practice hours do not equate to quality midwifery practice experiences • unlike minimum practice requirements, hours cannot be used to evaluate students' exposure to midwifery practice experience learning opportunities • identifying a generic minimum number of hours is problematic due to multiple program lengths • use of theory practice ratios more flexible than minimum hours and accommodating of varying program lengths

In the absence of high-level evidence demonstrating that one approach is better than another, ANMAC has taken the view that these approaches need not be mutually exclusive when incorporated into the standards. In fact, selected concepts from each approach may:

- increase the utility of the standards by addressing the varying needs of stakeholders
- strengthen midwifery curricula to facilitate student achievement of safe and competent practice.

Version 2 of the draft midwifery accreditation standards attempts to incorporate the strengths of these three approaches while mitigating, where possible, potential risks.

Figure 1 illustrates a conceptual model for how essential elements of these three approaches can be combined to support the design and development of midwifery curricula. Elements

within this model may also be considered pillars that support ANMAC's objective of ensuring midwives are 'suitably trained and qualified to practise in a competent and ethical manner'.[25]

Figure 1. Conceptual model for design and development of midwifery practice experience

* ANMC, National Competency Standards for the Midwife, 2006.

Survey questions are designed to gain feedback on the incorporation of the following concepts into Version 2 of the draft midwifery accreditation standards:

1. competency assessment as an outcome measure of clinical learning
2. CoCE and other midwifery practice requirements
3. minimum numbers of midwifery experience practice hours and/or practice to theory ratio.

[25] AHPRA, *Health Practitioner Regulation Law Act, 2009*, as in force in each state and territory. Viewed at www.ahpra.gov.au/Legislation-and-publications/Legislation.aspx on 6 May, 2013

Important background information for each of the survey questions is provided in the next section.

1. Competency assessment as an outcome measure of clinical learning

The criteria listed in the box below relate to competency assessment and were included in Version 1 of the draft midwifery standards. In Version 2 the only change has been the rewording of criterion 5.4 in line with stakeholder feedback to emphasise formative as well as summative assessment of midwifery practice experience. Criterion 5.4 now reads, with new wording in italics:

> Both formative and summative assessment types and tasks exist *across midwifery practice experience and theoretical components of the* program to enhance individual and collective learning as well as inform student progression.

Version 2 DRAFT midwifery accreditation standards.

Proposed criteria to guide the use of competency assessment as a measure of clinical learning outcomes. (Standard 5 stem, Criteria 5.4, 5.5, 5.7, 5.8, 5.9, 5.10, 5.13; 8.6, 8.7 and 8.8)

- Standard stem: The curriculum incorporates a variety of approaches to assessment that suit the nature of the learning experience and robustly measure achievement of required learning outcomes, including a summative assessment of student performance against the National Competency Standards for the Midwife.

The program provider demonstrates:

- both formative and summative assessment types and tasks exist across clinical and theoretical components of the program to enhance individual and collective learning as well as inform student progression
- a variety of assessment approaches across a range of contexts to evaluate competence in the essential knowledge and skills and behaviours required for midwifery practice
- appropriate assessment is used in midwifery practice experience to evaluate students ability to meet the National Competency Standards for the Midwife
- ultimate accountability for the assessment of students in relation to their midwifery practice experience
- assessments include the appraisal of competence in pharmacokinetics, pharmacodynamics and the quality use of medicines
- evidence of procedural controls, fairness, reliability, validity and transparency in assessing students
- a summative assessment of students' achievement of competence against the National Competency Standards for the Midwife is conducted by a midwife in an Australian midwifery practice setting before program completion
- clearly articulated models of supervision, support, facilitation and assessment are in

place for all midwifery experience practice settings, including for continuity of care experiences, so students can achieve required learning outcomes and National Competency Standards for the Midwife

- that academics, midwives and other health professionals engaged in supervising, supporting and/or assessing students during midwifery practice experiences are appropriately prepared for the role and seek to incorporate contemporary, evidenced based and international perspectives on midwifery practice
- assessment of midwifery competence, including continuity of care experiences, within the context of the midwifery practice experience is undertaken by a midwife.

QUESTION 1:

Do the above criteria collectively provide sufficient support for the assessment of competency in midwifery practice as an outcome of learning?

(Standard 5 Stem, Criteria 5.4, 5.5, 5.7, 5.8, 5.9, 5.10, 5.13; 8.6, 8.7 and 8.8)

a) Yes

b) No

If you answered 'no', please identify how you would amend the content of the criteria.

2. Minimum midwifery practice requirements

Respondent feedback revealed that specific wording and changes in definition are required to make some minimum midwifery practice requirements clearer. 'Being with woman giving birth' and what constitutes 'engagement' in CoCE are two examples of wording that is open to misinterpretation and could therefore result in inconsistent midwifery practice experiences. The need to be clear on phrases such as 'complex needs' and 'special needs' is also important, particularly for planning of midwifery practice experiences. Version 2 of the draft midwifery accreditation standards aims to address these issues.

Consultation and feedback also indicated mixed perspectives on the appropriateness of numbers for antenatal and postnatal visits and for care of women with complex needs. Some feedback indicated halving current minimum requirements and some supported not changing these requirements. Overlaying this was a reoccurring theme that emerged during consultation—the need to ensure midwifery students are adequately prepared to care for women with complex needs, including those with co-morbidities such as obesity, hypertension and diabetes.

After considering all feedback, ANMAC recommends that to maximise opportunities for student experience in these areas, the current number of minimum midwifery practice requirements should be maintained. The standards also continue to emphasise normal childbirth since this is both foundational and developmental knowledge that supports undertaking more complex care.

Other changes to minimum midwifery practice requirements:

- 'Caring for women requiring medical and surgical care' has been subsumed into 'Care of women experiencing complex needs' as a result of defining the term 'complex needs'.
- Examination of the newborn has been quantified to further support this experience in light of feedback that midwives in continuity models of cares are becoming increasingly responsible for the first examination of the baby before discharge.
- Experience in supporting women to infant feed, particularly to breastfeed, has been added in line with feedback to strengthen this area of midwifery practice experience.
- The midwifery practice requirement that listed various antenatal, simulated and postnatal activities or care experiences (see Version 1 of the draft midwifery accreditation standards) has been removed in line with feedback that content was covered within midwifery curricula.

Being with woman giving birth

Feedback on this practice requirement identified a number of issues. The main issue being that the requirement for 40 normal births, with no recognition of labour, was considered 'birth-centric' and did not value the importance of care provided during labour. In response to feedback changes have been made to:

- decrease the ambiguity of the students' role
- clarify what aspects of the labour and birth are to be included
- acknowledge the valuable learning opportunities associated with caring for women during the first and second stages of labour, regardless of birth outcome
- incorporate valuable learning gained from managing a third stage of labour that ends in either a physiological or surgical outcome
- emphasise the importance of the midwifery student's role in evaluating maternal and neonatal postnatal adaptation.

Version 2 DRAFT midwifery accreditation standards.

PROPOSED CRITERIA REVISION to Standard 8 minimum midwifery practice requirement relating to being with woman giving birth:

1.* Act as the primary accoucheur for 30 women who experience a spontaneous vaginal birth, which may include women being followed as part of continuity of care experiences. This also involves:

a) managing the third stage of labour, including the student providing all care as appropriate if a manual removal of placenta is required

b) facilitating initial mother and baby interaction

c) monitoring the postnatal adaptation of mother and baby.

2.* Provide direct and active care to an additional 10 women during labour and, where possible, during birth regardless of mode.

*Footnotes in Standard 8 minimum practice requirements have more information.

QUESTION 2:

Do the revisions to these minimum midwifery practice requirements provide appropriate and sufficient clinical learning opportunities for midwifery students?

a) Yes

b) No

If you answered 'no', please identify how you would amend the content of the criteria.

QUESTION 3:

Do the wording revisions promote understanding of these midwifery practice requirements?

a) Yes

b) No

If you answered 'no', please identify how you would improve the clarity of the wording.

Engagement in continuity of care experiences

Changes to this minimum midwifery practice requirement were guided by feedback from Question 4 in the initial survey (Appendix C). This revised version is intended to:

- acknowledge the educational value of the CoCE and benefits for women in terms of childbirth outcomes[26][27]
- lessen the emphasis on numbers to:
  - promote the quality of the learning experience
  - decrease the burden reported by students
- support a woman's choice not to have the student attend the birth, without disadvantaging the student
- promote the safety of women and students
- clarify what constitutes a CoCE.

[26] Sandall J, Solanti H, Gates S, Shennan A. &, Devane D. 'Midwife-led continuity models versus other models of care for childbearing women.' *Cochrane Database of Systematic Reviews 2013*, Issue 8. Art. no.: CD004667. DOI: 10.1002/14651858. CD004667.pun3.

[27] Tracy S, Hartz D, Tracy M, Allan J, Forti A, Hall B, White J, Lainchbury A, Stapleton H, Beckmann M, Homer C, Foureur M, Welsh A, Kildea S. Caseload midwifery care versus standard maternity care for women of any risk: M@NGO, a randomised controlled trial. *The Lancet*, 17 September 2013. DOI: 10.1016/50140-6736(13)61406-3

Version 2 DRAFT midwifery accreditation standards.

PROPOSED CRITERIA REVISION to Standard 8 minimum midwifery practice requirement relating to continuity of care experiences:

1. Experience in woman-centred care as part of continuity of care experiences. The student is supported to:

a) establish, maintain and conclude a professional relationship while experiencing continuity with individual women through pregnancy, labour and birth, and the postnatal period, regardless of model of care

b) provide midwifery care within a professional practice setting and under the supervision of a midwife or other relevant registered practitioner (for example, medical officer qualified in obstetrics, child health nurse or physiotherapist)

c) engage with 15 women during pregnancy, labour and birth and the postpartum, according to individual circumstances. This involves attending a minimum of four antenatal visits, two postnatal visits and may or may not include attendance at the labour and birth

d) maintain a record of engagement that incorporates regular reflection and review by the education or health service provider.

QUESTION 4:

Do the revisions to this minimum midwifery practice requirement provide appropriate and sufficient clinical learning opportunities for midwifery students?

a) Yes

b) No

If you answered 'no', please identify how you would amend the content of the criteria.

QUESTION 5:

Do the wording revisions promote understanding of requirements for continuity of care experiences?

a) Yes

b) No

If you answered 'no', please identify how you would improve the clarity of the wording.

The complete list of proposed minimum midwifery practice requirements and other wording or content changes is in Appendix D–Version 2, DRAFT midwifery accreditation standards.

The following glossary additions to the standards are meant to explain 'complex needs' and 'special needs' as terms used in the minimum practice requirements.

Additional inclusions into the glossary are meanings for 'accoucheur', 'spontaneous vaginal birth' and 'quality use of medicines' (Appendix D–Version 2, DRAFT midwifery accreditation standards).

Version 2 DRAFT midwifery accreditation standards.

PROPOSED GLOSSARY ADDITION to support the minimum midwifery practice requirement - Experience of caring for women with complex needs across pregnancy, labour, birth or the postnatal period, which may include women being followed as part of continuity of care experiences or women receiving direct and active care from the student during labour or birth.

> Complex needs—relates to women requiring care beyond what would be considered routine or normal. For examples of women with complex needs refer to Codes B and C in the current *Australian College of Midwives National Midwifery Guidelines for Consultation and Referral*. Examples are inclusive of situations where women may be experiencing risks to social and psychological wellbeing or requiring medical or surgical care.

QUESTION 6:

Is this an appropriate definition for the term 'complex needs'?

a) Yes

b) No

If you answered 'no', please identify how you would amend the content of the definition.

Version 2 DRAFT midwifery accreditation standards.

PROPOSED GLOSSARY ADDITION to support the minimum midwifery practice requirement - Experience in the care of babies with special needs.

> Special needs—relates to babies experiencing a deviation from physiological functioning or normal postnatal adaptation and who require care beyond what is considered normal or routine. For examples of babies with special needs refer to postpartum infant clinical indications, Codes B and C, in the current Australian College of Midwives National Midwifery Guidelines for Consultation and Referral. Midwifery practice experience placement in a special care nursery is considered optimal, but not mandatory.

QUESTION 7:

Is this an appropriate definition for the term 'special needs'?

a) Yes

b) No

If you answered 'no', please identify how you would amend the content of the definition.

3. Minimum practice hours

Feedback from the initial survey indicates that with Standard 3–Program development and structure, there is support for using minimum practice hours and a theory-to-practice ratio, with a preference for a balanced theory-to-practice ratio. International benchmarks, though silent on minimum practice hours, provide informed estimates for theory to practice ratios and midwifery program length. [28,29] No high level evidence exists to support these benchmarks or the optimal use of minimal practice when developing entry to practice midwifery programs.

Feedback during consultation suggested there is an expectation for midwifery graduates to demonstrate competence across the full scope of midwifery practice. This includes a capacity to participate in continuity models of care. Minimal hours of midwifery practice experience within programs, therefore, need to realistically reflect the time it takes to develop a scope of practice that enables midwifery graduates to:

> … be recognised as a responsible and accountable professional who works in partnership with each woman to give the necessary support, care and advice during pregnancy, labour, the postpartum period, to conduct births **on the midwife's own responsibility** and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency procedures. [30]

Further, many reported that specifying minimum hours was problematic due to the varying lengths of entry to practice programs. Others recommended midwifery practice hours be integrated throughout the program, take place in a variety of settings and exclude simulation. With these issues in mind, ANMAC is seeking more feedback from stakeholders to help develop this section of the standards.

QUESTION 8:

In relation to Standard 3. Program development and structure, the most appropriate guidance would be to include a:

a) Theory to practice ratio, only

b) Specified minimum number of midwifery practice hours, only

c) Combination of theory/practice ratio and a minimum number of midwifery practice hours

If you selected (b) or (c) please refer to question 9.

[28] International confederation of Midwives, Global Standards for Midwifery Education, 2010, Brisbane, Australia

[29] World Health Organization (WHO) (2009). *Global standards for the initial education of professional nurses and midwives*. Geneva: WHO. Viewed at www.who.ch on 29 September 2013.

[30] International Confederation of Midwives, Definition of the Midwife—Scope of Practice, 2005, Brisbane, Australia.

Version 2 DRAFT midwifery accreditation standards.

PROPOSED CRITERION to set a minimum number of hours for midwifery practice experience for all entry to practice midwifery programs. (Criteria 3.9)

The program provider demonstrates:

- A minimum number of 1200 hours of midwifery practice experience, not inclusive of simulation activities, incorporated across the program in a variety of care settings, to enable students to meet the National Competency Standards for the Midwife as well as achieve the minimum midwifery practice requirements as stipulated in Standard 8.

QUESTION 9:

Does this criterion provide appropriate guidance for the inclusion of minimum hours of midwifery practice for all entry to practice midwifery programs?

a) Yes

b) No

If you answered 'no', please identify how you would amend the wording of the criterion.

Conclusion

The review of ANMAC's midwifery accreditation standards will update the standards as part of the transition to the National Registration and Accreditation Scheme. Open and transparent consultation will ensure the revised standards are nationally consistent, contemporary, comprehensive, clearly articulated and respected by the profession and relevant education providers.

The outcome of the review will be revised midwifery accreditation standards that protect the public and are acceptable to the community, the midwifery profession, related jurisdictions, employers and relevant education providers.

The ANMAC Board will oversee the review. The review itself will be coordinated by the Expert Advisory Group appointed by the ANMAC Board and led by ANMAC's Executive Director Accreditation and Assessment Services.

Revised midwifery accreditation standards are expected to be released in February or March 2014 subject to NMBA approval.

Appendix A. The 'National Law'

On 14 July 2006, The Council of Australian Governments agreed to establish a single national registration scheme for health professionals, beginning with the nine professional groups then registered in all jurisdictions. The Council of Australian Governments further agreed to establish a single national accreditation scheme for health education and training, to simplify and improve the consistency of current arrangements.[31] Bills were successively put before state and territory parliaments, starting with Queensland, to enact the legislation known as the *Health Practitioner Regulation National Law Act 2009 Qld* (or the 'National Law') to establish the scheme**.** The Act provides for the adoption of a national law to establish a national registration and accreditation scheme for health practitioners. The object, objectives and guiding principles are articulated in Section 4 Part 1 and reproduced below with phrases relating to accreditation of education providers and programs of study highlighted.[32]

1. The object of this Law is to establish a national registration and accreditation scheme for:
    a) the regulation of health practitioners
    b) the registration of students undertaking—
        I. programs of study that provide a qualification for registration in a health profession; or
        II. clinical training in a health profession.
2. The objectives of the national registration and accreditation scheme are:
    a) to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered
    b) to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction
    c) to facilitate the provision of high quality education and training of health practitioners
    d) to facilitate the rigorous and responsive assessment of overseas-trained health practitioners; and
    e) to facilitate access to services provided by health practitioners in accordance with the public interest
    f) to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.
3. The guiding principles of the national registration and accreditation scheme are as follows:
    a) the scheme is to operate in a transparent, accountable, efficient, effective and fair way

[31] Council of Australian Governments. *Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions*. 2008.

[32] *Health Practitioner Regulation National Law Act 2009 Qld*.

b) fees required to be paid under the scheme are to be reasonable having regard to the efficient and effective operation of the scheme
c) restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.

Following the introduction of the National Law, the Australian Nursing and Midwifery Council (ANMC) was approved under the National Registration and Accreditation Scheme (NRAS) as the independent accreditation authority, starting on 1 July 2010, for all nursing and midwifery education providers and programs of study leading to registration and endorsement in Australia.

Subsequently, ANMC changed its name to the Australian Nursing and Midwifery Accreditation Council (ANMAC) to reflect its principle role as an accrediting authority. Along with responsibility for accrediting education providers and programs of study leading to a qualification in the professions of nursing and midwifery, the Council has legislated responsibility for regular review and improvement of the accreditation standards underpinning this accreditation function for all professional categories under its mandate.[33]

Professional education accreditation is concerned with the quality of the profession and its work, from the perspective of the public interest and community safety. It is part of a broader process of assuring the community that, having completed an accredited education program, beginning professional practitioners have achieved agreed professional outcomes and are able to practise in a safe and competent manner equipped with the necessary foundation knowledge, professional attitudes and essential skills. This process itself however, relies on two other fundamental building blocks:

1. That the education providers themselves are authorised to issue the relevant qualification and are evaluated to assure continued quality learning outcomes for their graduates.

   Qualifications are specified, classified and defined by the Australian Qualifications Framework (AQF)[34] and their associated register lists Authorised Issuing Organisations. The Tertiary Education Quality and Standards Agency (TEQSA) has responsibility for evaluating all higher education providers for quality assurance purposes and protecting the integrity of the Australian higher education system (Section 5 has more information on TEQSA).

2. That there exists a set of agreed and contemporary competency standards for the profession, against which the capability of graduates can be assessed.

   The Nursing and Midwifery Board of Australia (NMBA) adopted the ANMC's National Competency Standards for enrolled and registered nurses, midwives and nurse practitioners in 2010.[35] These standards articulate the core competencies by which individual performance is assessed to obtain and retain a licence to practice, issued by the NMBA, as an enrolled nurse, registered nurse, registered midwife and nurse

[33] *Health Practitioner Regulation National Law Act 2009 Qld*.

[34] Australian Qualifications Framework Council. *Australian Qualification Framework 2011*.

[35] ANMAC. Registered Nurse Accreditation Standards. Canberra 2012.

practitioner in Australia. However, these competency standards are used not only by the NMBA for health professionals to self-assess their competence as part of the annual renewal of licence process, but also to assess:

- nurses and midwives educated overseas seeking to work in Australia
- nurses and midwives returning to work after breaks in service
- the performance of nurses and midwives involved in professional conduct matters.

Higher education providers use the National Competency Standards when developing nursing and midwifery curricula and to assess student performance; as do employers when evaluating graduate performance.

The accreditation process ANMAC administers is an efficient and effective proxy for externally assessing each graduate against the relevant competency standards. Professional course accreditation must ensure the necessary professional standards are protected, while not inhibiting diversity and innovation or constraining continuous quality improvement. However, it is critical that the relevant professional accreditation standards be regularly reviewed to ensure continued relevance in light of changes in pertinent health and education legislation, policy, delivery and/or ethos.

Appendix B. Consultation forum—key stakeholder list

Other interested parties or individuals not listed here are able to provide feedback by:

- Answering questions from Consultation Paper 2 via the following link: www.surveymonkey.com/s/Midwifery_Accreditation_Standards_Review_2 **by close of business 25 November 2013**
- Submitting comments via the following dedicated email address: standardsreview@anmac.org.au.

Table 1: Consultation forum—key stakeholder list

Principal agents	Stakeholder consultation	Expert Advisory Group
Australian Commission on Safety and Quality in Health Care	ACM	ACM
AHPRA	ACM: Midwifery Education Advisory Committee	ACM: Midwifery Education Advisory Committee
ANMAC	Australian Society of Independent Midwives	Australia and New Zealand Council of Chief Nurses
Australian Government Department of Health	Australian & New Zealand Council of Chief Nurses	Australian Nursing and Midwifery Federation
Ministerial Council for Tertiary Education and Employment	Australian Nursing and Midwifery Federation	Congress of Aboriginal and Torres Strait Islander Nurses
NMBA)	Commonwealth Chief Nurse	Council of Deans of Nursing and Midwifery
Standing Council of Health	Congress of Aboriginal and Torres Strait Islander Nurses and Midwives	Educationalists for Entry to Practice Midwifery Programs including Dual Degree
TEQSA	Consumer Health Forum of Australia	Maternity Coalition
Australian Health Ministers' Advisory Council	Council of Deans of Nursing and Midwifery	Maternity Service Inter-Jurisdictional Committee
	Council of Remote Area Nurses of Australia plus Remote Health Professionals	Women's Healthcare Australasia
	Forum of Australian Health Professionals Councils	ANMAC, Chief Executive Officer
	Health Workforce Australia	ANMAC, Executive Director Accreditation and Assessment Services
	Maternity Coalition	ANMAC, Associate Director for Professional Programs (2)
	Maternity Service Inter-Jurisdictional Committee	ANMAC, Acting Manager of Accreditation Services
	Midwifery Academics Victoria	ANMAC, Standards Review and Development Co-ordinator
	Midwifery Council of New Zealand	
	National Association of Childbirth Educators	
	National Midwifery Network (Midwifery Advisors for States and Territories)	
	National Rural Health Alliance	
	Nursing Council of New Zealand	
	Women's Healthcare Australasia	

Appendix C. Condensed feedback summary

This section reports major themes and trends in the opinions identified in responses to the electronic survey. Expert Advisory Group responses to feedback are also provided.

A total of 607 respondents started the survey and 351 finished it. Response data, including tables and graphs, were imported from a summary report generated by Survey Monkey©[36]. Free text responses were categorised using Survey Monkey© and were reviewed and validated by ANMAC staff.

ANMAC received eight individual submissions and 18 submissions from organisations. Not all submissions addressed every question and so numbers of submission responses varying across questions. Permission to publish submissions was not negotiated or provided. Organisations included:

- Australian Catholic University
- Australian College of Midwives—Midwifery Education Advisory Committee
- Australian College of Midwives—Western Australia
- Australian Nursing & Midwifery Federation
- Barwon Health
- Consumer Health Forum of Australasia
- Council of Deans of Nursing and Midwifery
- Department of Health and Human Services—Tasmania Government
- Department of Health— Northern Territory Government
- Department of Health—Victoria Government
- Health Workforce Australia
- La Trobe University
- Midwifery Academics Victoria
- Midwifery Council of New Zealand
- Nursing and Midwifery Board of Australia
- Nursing and Midwifery Office—New South Wales Government
- Women's Healthcare Australasia.

Question 1

When responding to this survey, which of the following options best categorises your primary role?

[36] Survey monkey is a private company that provides web-based survey solutions for organisations, companies or individuals to gather the insights they need to make more informed decisions.

Survey (601 respondents): 81.6 per cent of respondents identified within the top three categories of 'midwife clinician' (45.3 per cent), 'midwifery student' (19.1 per cent) or 'midwife educator or facilitator' (16.3 per cent).

6.3 per cent of respondents identified as 'education providers', 4.8 per cent as 'health service managers' and 8.2 per cent were in the remaining categories, 3 per cent of which identified as 'consumers'.

Submissions: Individuals identified as consumer, student, educators/facilitators and educator/researcher.

ACTION: Note demographics.

Question 2

Are the proposed criteria (2.4 (i) and (h), 3.5 and 8.4) collectively appropriate to enable intraprofessional and interprofessional learning?

Survey (492 respondents): The majority of respondents (90.7 per cent) agreed that specified draft criteria were appropriate to enable interprofessional and intraprofessional learning.

Submissions: The 12 organisations that addressed this question all agreed the criteria were appropriate. One organisation suggested wording changes.

Themes: Reporting of various operational issues or barriers to implementation of this type of learning.

ACTION: None required.

Question 3

Do these criteria (8.3, 8.4, 8.5 and 8.6) collectively provide sufficient guidance for curriculum design and planned midwifery practice experience placement to develop student competency in midwifery practice across all-risk models of care?

Survey (363 respondents): 89.3 per cent of respondents agreed that criteria 8.3, 8.4, 8.5 and 8.6 would provide sufficient guidance. 10.7 per cent of respondents considered the criteria to be insufficient.

Submissions: Fourteen organisations addressed this question and 12 agreed the specified draft criteria were appropriate. Suggestions for change included the need to articulate structured supervision, include standards to address the current practice environment, and some wording and terminology refinements.

Themes: Issues with quality or number of clinical placements; funding and arrangements for clinical supervision; need for more theoretical content relating to medical and surgical conditions in Bachelor of Midwifery curricula.

ACTION: Review wording and content of relevant sections of Standard 8.

Question 4

Should minimum requirements for what constitutes 'engagement' in continuity of care experience (CoCE) be stipulated within the midwifery accreditation standards?

Survey (359 respondents): 65.2 per cent of respondents supported the need to stipulate what constitutes 'engagement' in CoCE.

Submissions: Fourteen organisations addressed this question. One of these organisation responded with two views; one from the majority of members and another from a minority of members. Nine organisations (including an organisation's majority of members) supported a level of stipulation for what constitutes engagement. Six did not support stipulation. Four submissions did not answer the question.

Themes:

CoCE—valuable learning experiences provided; standards need to promote quality of learning over quantity; student burden needs to be reduced; promote women's safety; reduce number and/or hours of CoCE; increase flexibility and remove stipulations.

Antenatal—more support for early second trimester start of engagement and slightly more support for three or less visits; suggested cut off for recruitment ranged from 30–36 weeks of pregnancy.

Intrapartum—calls for more definitional flexibility to allow for factors that may impede student attendance or active participation.

Postnatal—more support for three or less visits and care concluding at six weeks.

ACTION: Review feedback and revise relevant sections of Standard 8. Seek stakeholder feedback.

Question 5

During midwifery students' practice experience, does the current standard definition match what is being regarded as 'being with woman' during labour?

Survey (361 respondents): Results indicate significant difference in the interpretation of the definition 'being with woman' giving birth. 41.8 per cent of respondents reported that students' practice experience did not match the current standard definition.

Submissions: Fourteen organisations addressed this question. Only one organisation agreed that the standard definition matched clinical experience.

T**hemes:** More flexible definition and clarify expectations of student role, that is, as an *accoucheur* or active participant.

ACTION: Review feedback and revise definition in Standard 8. Seek stakeholder feedback.

Question 6

Should a list of minimum requirements for midwifery practice experiences (type and number) continue to be stipulated in the midwifery accreditation standards for use across all entry to practice midwifery programs?

Survey (362 respondents): 98.9 per cent of respondents supported the concept of minimum requirements for midwifery practice experiences being stipulated in the midwifery

accreditation standards. However, 35.4 per cent of these supported only 'some' minimum requirements being stipulated.

Submissions: Seven organisations supported stipulation of minimum requirements. Six did not support stipulation, however, five of these made suggestions regarding changes to the minimum requirements if retained within the standards. Two organisations called for minimum requirements to be removed and replaced with a competency approach. Three submissions did not answer the question.

Themes: Two alternate themes emerged in relation to numbering practice requirements:

Supported—helps to develop competency, ensures consistency, prevents students with inadequate experience being deemed competent and provides students with equitable learning goals.

Not supported—a quantum of numbers does not measure competency, insufficient evidence to support use of numbers, focus standards on the quality of learning and assessment of competency.

ACTION: Continue to stipulate some of the minimum requirements. Seek stakeholder feedback.

Question 7

Please review this list of minimum midwifery practice requirements and identify any change you consider may be necessary to the type and/or minimum number of experiences required.

Survey (363 respondents): 83 per cent or more of survey respondents indicated there was no need to change 18 of the 24 proposed minimum practice requirements. However, 68 per cent supported changing the current number and 61 per cent supported changing the hours assigned to CoCE. Opinion was almost divided on whether the following minimum practice requirements need to be changed, with these percentages *not* supporting change:

- antenatal visit numbers (56%)
- postnatal visit numbers (56%)
- number of births as *accoucheur* (47%)
- (number of care episodes for women experiencing complexity (51%).

Survey themes:

CoCE numbers and hours: Only 17 per cent of respondents quantified suggested changes to CoCE. Of these most recommended reducing CoCE experiences to 10. The next largest group recommended reducing to 5 and the next largest to 15. For CoCE hours, most recommended the removal of CoCE hours and the next largest group recommended a reduction to 10 hours.

Antenatal and postnatal visits: Of the respondents wanting a reduction most suggested 50 visits.

'Being with woman' giving birth: Suggestions for clearer, more flexible definition (Q6) and a reduction in number.

Submissions: These responses are from organisations or individuals answering 'yes' to Question 6 and offering suggestions for changes to minimum requirements. See Questions 4 or 6 for responses relating to non-stipulation of minimum requirements or CoCEs.

CoCE numbers: Four organisations suggested a reduction in CoCE to 15 experiences. One organisation supported an increase; another was unsure as to an appropriate number.

CoCE hours: Two organisations supported removal of hours, 1 suggested replacement with care episodes and 2 suggested a reduction to 10 hours. One individual supported the continuation of 20 hours.

Antenatal and postnatal visits: Six organisations questioned evidence to support the use of numbers, however, went on to suggest a reduction by half if numbers were retained. Four organisations and one individual saw no need for change.

'Being with woman' in labour: Seven organisations suggested a clearer definition that included the students' role as the *accoucheur* or active participant in complex, and in some cases, assisted births. The same number, if minimum requirements were retained, supported a reduction to 20 births as *accoucheur*. One organisation supported 30 births. Two organisations opted for 40 with a reduction to 30 births as *accoucheur*, if these were offset by additional experiences in caring for women in labour. One organisation commented 40 experiences was excessive.

Care for women with complex needs: One organisation suggested a reduction to 20 episodes. Another requested a definition of complex care and thought the number of episodes, at 40, was excessive. Three organisations supported keeping the criteria the same.

Minimum requirement number nine: Six organisations identified scope of practice issues with one or more of these criteria. Three organisations recommended the requirement be removed. Two organisations suggested specification of numbers.

ACTION: Review wording, type and numbers of minimum requirements. Seek stakeholder feedback.

Question 8

Is this standalone criterion (4.5) required to facilitate the development of a woman-centred approach in midwifery practice? (358 respondents)

Survey (358 respondents): More than 92 per cent of respondents agreed that including this criterion would facilitate the development of a woman-centred approach in midwifery practice. The remainder considered it unnecessary.

Submissions: All 14 organisations that answered this question supported inclusion of this criterion into the standard.

Theme: Suggestions for wording or terminology changes.

ACTION: Review wording.

Question 9

What should the midwifery accreditation standards specify in regard to postgraduate program minimum length?

Survey (360 respondents): Nearly half (49.4 per cent) of respondents supported a 12-month postgraduate program, closely following by 41.7 per cent supporting an 18-month program, and 8.9 per cent an alternate program length.

Submissions: Four organisations supported and 18 month postgraduate program and six supported 12 months. One organisation reported a split opinion between 12 and 18 months. One organisation preferred a competency approach.

Themes: Twelve month midwifery program would support the development of a skilled workforce for regional maternity services. This program was considered attractive to students and there is no evidence to indicate longer postgraduate programs improved student outcomes. Whereas, others thought the eighteen month program provided sufficient time to cover current program requirements and facilitated comprehensive midwifery knowledge and competent practice. Additionally, the eighteen month program met the International Confederation of Midwives recommendation for length of program.

ACTION: Maintain current wording of Standard 3.7.

Question 10

Should the ratio of theory to practice in the curriculum be specified within the midwifery accreditation standards?

Survey (357 respondents): More than 80 per cent of respondents thought the ratio of theory-to-practice should be specified with the midwifery accreditation standards.

Submissions: Fourteen organisations answered the question with 11 supporting specifying the ratio of theory-to-practice and 3 not supporting. Reasons included preference for a competency approach or that quantification was problematic.

Themes: Specification would ensure sufficient and balanced midwifery practice experience. It would also facilitate consistency across all programs and ensure sound theoretical basis to practice. Some thought benefits of a specified ratio were not evident and could potentially reduce program flexibility.

ACTION: Support for continued inclusion. Seek stakeholder feedback and consider in conjunction with response to Question 12.

Question 11

What should be the ratio of theory to practice?

Survey (331 respondents): Opinion was almost divided, 46.8 per cent supported a 50:50 ratio and 40.8 per cent supported a 40:50 ratio. An alternative ratio was favoured by 12.4 per cent of respondents, with most suggesting a clinical component greater than 50 per cent.

Submissions: Of the 10 organisations that supported specification of a ratio six opted for a ratio of 50 to 50 and four opted for a ratio of 40 to 50.

ACTION: If ratio specification retained maintain current wording of Standard 3.8.

Question 12

Is a criterion that specifies the minimum number of hours for midwifery practice (clinical) experience required in the midwifery accreditation standards?

Survey (357 respondents): 70.6 per cent supported the inclusion of minimum numbers of midwifery practice experience hours in the midwifery accreditation standards. Specifying hours was not considered necessary by 29.4 per cent of respondents.

Submissions: Four organisations supported specifying a minimum number of practice hours. 10 organisations did not support specification with three organisations preferring a competency based approach to programs and one suggesting that increased prescription within the standards risked program viability. Additionally two of these organisations stated variables such as differences in entry to practice programs made quantification of minimum hours problematic.

Themes: Some stated they did not know an appropriate minimum number of hours for midwifery practice. Suggestions for the minimum number of hours ranged from one hundred to five thousand hours. Others suggested calculations based on program length or planned placements. There was some support around a minimum of 1000–1200 hours. No consensus on minimum number of hours was determined.

ACTION: Support for inclusion. Seek stakeholder feedback and consider in conjunction with response to Question 10.

Question 13

To facilitate effective embedding of simulation activities in midwifery curricula should the midwifery accreditation standards be explicit about the use of simulation in terms of clinical or theoretical hours?

Survey (354 respondents): Respondents were divided in their responses to this question. 54.4 per cent wanted the standards to be explicit on the use of simulation activities.

Submissions: Thirteen organisations supported stipulating simulation within the standards. Of these, two supported developing simulation so that it would support clinical practice, another thought simulation could be used to decrease clinical time and increase competency in less common practice areas such as emergency care. One organisation suggested specific standards be developed to support the quality use and assessment of simulation.

Themes: Simulation was considered a useful adjunct to clinical learning, particularly for emergency care. Most respondents thought simulation should be stipulated so it did not replace clinical hours in midwifery curricula.

ACTION: Review wording in relevant criteria.

Question 14

Are these criteria (1.5, 3.1 and 4.7) collectively sufficient to support the development of culturally competent midwifery practice?

Survey (351 respondents): 81.8 per cent of respondents agreed that the specified draft criteria were collectively sufficient to support the development of culturally safe midwifery practice. 18.2 per cent of respondents thought they were insufficient to support the intended goal.

Submissions: Six organisations thought these criteria were sufficient. Four felt other cultural groups should be considered to ensure culturally safe midwifery practice. Five did not support the concept of a discrete Aboriginal and Torres Strait Islander subject.

Themes: Criteria did not address cultural diversity of Australian population and a broader cultural focus would support development of culturally competent midwifery practice. Content should be integrated across the curriculum rather than provided as one discrete subject. Some suggested wording changes.

ACTION: None required. Criterion 4.6 already refers to the diversity of Australian cultural population and the development of cultural safety.

Question 15

Are these criteria (6.8 and 7.4) collectively sufficient to support Aboriginal and Torres Strait Islander people entering the midwifery workforce?

Survey (350 respondents): Most (96.3 per cent) agreed that the specified draft criteria were collectively sufficient to support Aboriginal and Torres Strait Islander people in entering the midwifery workforce. Only 3.7 per cent of respondents did not agree.

Submissions: All 14 organisations that answered this question supported the collective sufficiency of the criteria to achieve its stated goal.

ACTION: None required.

Question 16

Do these criteria (criteria 3.3, 3.12, 4.1, 4.2, 4.6, 8.3, 8.4 and draft minimum midwifery practice experience requirements 5, 6 and 8) provide sufficient guidance for curriculum design and midwifery practice experience placements to support the development of student competency in the care of women and babies with complex needs?

Survey (352 respondents): More than 83 per cent of respondents considered the specified draft criteria sufficient to guide midwifery curriculum design, including midwifery practice experience placements.

Submissions: Twelve of the 16 organisations that answered this question thought the criteria provided sufficient guidance. The other four organisations identified a number of issues with the criteria including: lack of clarity of the wording, lack of clinical placements, lack of geographically diverse placements and the need for content to guide assessment, management and referral of high risk mothers.

Themes: Registered nurses skills in complex care should be recognised in relevant midwifery curricula. Some clinical settings have limited access to women and babies with complex needs. Complex needs should be defined. Experience in special care nursery and breastfeeding should be added.

ACTION: Review wording and content of relevant criteria.

Question 17

Do the midwifery accreditation standards need to give separate and specific guidance to the education provider for the Bachelor of Midwifery, dual degrees (nursing and midwifery) or postgraduate midwifery programs?

Survey (349 respondents): 65.6 per cent of respondents stated it was not necessary for the standards to provide separate and specific guidance to education providers.

Submissions: Of the 15 organisations that answered this question 13 did not support separate and specific guidance to education providers, one supported separate guidance (particularly for the dual degree) and three stated education providers needed formal guidance on how to amalgamate ANMAC standards in dual degree programs, principally to support preparation for accreditation.

Themes: The main reason respondents gave for supporting separate guidance was to acknowledge differences in learning needs between postgraduate and undergraduate students. This was described mostly in terms of postgraduate students' having prior skill acquisition and undergraduate students' needing generic health care skill development. The main reason respondents gave for maintaining one standard was to ensure a consistent standard of midwifery practice across all programs.

ACTION: Maintain one standard.

Question 18

Should the midwifery accreditation standards contain specific criteria for the Bachelor of Midwifery component of the dual degree in terms of, for example, length of program or sequencing and proportion of midwifery practice experience?

Survey (346 respondents): Most respondents (91 per cent) did not want the midwifery accreditation standards to contain such specific criteria.

Submissions: Of the 14 organisations that answered this question, 12 did not want the standards to contain specific criteria and two did support this inclusion. An individual submission stated specific guidance was not necessary as there is no evidence to suggest one pathway to beginning practice was better or worse than another.

Themes: Diverse opinions offered on sequencing and proportion of midwifery practice experience and on program length with no major theme identified. Suggestions for program length ranged from three to five years. It was again suggested that ANMAC develop a principle paper to guide curricula integration within dual degrees.

ACTION: Maintain one standard.

Question 19

Is this proposed criterion (3.12) sufficient to facilitate the midwifery student's transition to practice as a graduate midwife?

Survey (346 respondents): The majority (88 per cent) of respondents believed the specified criterion was sufficient to facilitate student midwife transition to practice. Twelve per cent of respondents identified the criterion to be insufficient.

Submissions: Of the 15 organisations that answered this question, 14 agreed that this criterion was sufficient to facilitate transition to practice and one thought emphasis should be given to continuity of care.

Themes: Equal emphasis should be given to situating placements and assessment throughout programs. Type, quality and sequencing of clinical placements identified as factors that affect transition to practice. Need to ensure quality of summative assessment.

ACTION: None required.

Question 20

Within the context of accreditation standards for entry to practice midwifery programs: Are there other areas where Version 1 of the draft midwifery accreditation standards require amendment or change to ensure they adequately prepare midwives for beginning practice in the context of contemporary Australian maternity services?

Themes: Reponses from the survey and submissions were diverse and mostly identified issues with specific criteria or with principles that underpin the standards. Only a few themes emerged, which included concern for the needs of rural and regional programs, the number of minimum practice requirements and the quality of clinical supervision and support.

ACTION: Review individual comments and evaluate need for change in relevant areas of the standards.

Appendix D. Version 2—DRAFT midwifery accreditation standards

Standard 1: Governance

The education provider has established governance arrangements for the midwifery program of study that develop and deliver a sustainable, high-quality education experience for students, to enable them to meet the National Competency Standards for the Midwife.

Criteria

The education provider must provide evidence of:

1.1 Current registration by the Tertiary Education Quality and Standards Agency (TEQSA) as an Australian University or other Higher Education Providers.[37]

1.2 Current accreditation of the midwifery program of study by the University (or TEQSA for non-self-accrediting Higher Education Providers) detailing the expiry date and any recommendations, conditions and progress reports related to the school.

1.3 Meeting the Australian Qualifications Framework (AQF) requirements for the award of Bachelor (level 8) as a minimum.

1.4 Current, documented academic governance structure for the university or other higher education provider and the school conducting the program (program provider) which ensures academic oversight of the program.

1.5 Terms of reference for relevant school committees and advisory and/or consultative groups, include direct consumer involvement and partnerships with Aboriginal and Torres Strait Islander health professionals and communities.

1.6 Staff delegations, reporting relationships, and the role of persons or committees in decision making related to the program.

1.7 Governance arrangements between the university or higher education provider and the school that ensure responsiveness to requirements for ongoing compliance with accreditation standards.

[37] For explanation of provider categories see: TEQSA (2011), Higher Education (Threshold Standards) 2011 Legislative Instrument, Chapter 2. Viewed at www.teqsa.gov.au/higher-education-standards-framework on 2 October 2013.

1.8 Policies relating to credit transfer or the recognition of prior learning that are consistent with AQF national principles and the graduate's ability to meet the National Competency Standards for the Midwife for professional registration.

Standard 2: Curriculum conceptual framework

The program provider makes explicit, and uses a contemporary conceptual framework for the Midwifery program of study that encompasses the educational philosophy underpinning design and delivery and the philosophical approach to midwifery practice.

Criteria

The program provider demonstrates:

2.1 A clearly documented and explained conceptual framework for the program, including a curriculum underpinned by:

a. a woman-centred midwifery philosophy

b. philosophy of midwifery continuity of care

c. primary health care principles

d. an education philosophy.

2.2 The incorporation of contemporary Australian and international best practice teaching, learning and assessment methodologies and technologies to enhance the delivery of curriculum content, accommodate differences in student learning styles, stimulate student engagement and learning.

2.3 A program of study that is congruent with contemporary and evidence-based approaches to midwifery practice and education and is also underpinned by principles of safety, quality and risk management.

2.4 Teaching and learning approaches that:

a. enable achievement of stated learning outcomes

b. facilitate the integration of theory and practice

c. scaffold learning appropriately throughout the program

d. encourage the development and application of critical thinking and reflective frameworks

e. engender deep rather than surface learning

f. encourage students to become self-directed learners

g. embed recognition that graduates of the program take professional responsibility for continuing competence and life-long learning

h. instil students with the desire and capacity to continue to use and learn from research throughout their careers

i. promote emotional intelligence, communication, collaboration and teamwork, cultural safety, ethical practice and leadership skills expected of midwives

j. incorporate an understanding of, and engagement with, intraprofessional and interprofessional learning for collaborative practice.

Standard 3: Program development and structure

The program of study is developed in collaboration with key stakeholders reflecting contemporary trends in midwifery and education; complying in length and structure with the Australian Qualifications Framework (AQF) for the qualification offered and enabling graduates to meet the National Competency Standards for the Midwife. Midwifery practice experience is sufficient to enable safe and competent midwifery practice by program completion.

Criteria

The program provider demonstrates:

3.1 Consultative and collaborative approaches to curriculum design and program organisation between academic staff, those working in health disciplines, students, consumers and other key stakeholders including Aboriginal and Torres Strait Islander health professionals and communities.

3.2 Contemporary midwifery and education practice in the development and design of the curriculum.

3.3 A map of subjects against the National Competency Standards for the Midwife which clearly identifies the links between learning outcomes, assessments and required graduate competencies.

3.4 Descriptions of curriculum content and the rationale for its extent, depth and sequencing in relation to the knowledge, skills and behaviours expected of students at each stage of the program.

3.5 Opportunities for student interaction with other health professions to support understanding of the multi-professional health care environment and facilitate interprofessional learning for collaborative practice.

3.6 The program ensures sufficient midwifery practice experience placement that may occur across the calendar year to enable optimal exposure to midwifery continuity of care experiences.

3.7 The minimum length of the pre-registration midwifery program for registered nurses must be at least 12 months full time.

3.8 Theory and practice must be integrated throughout midwifery programs in equal proportions (50 per cent theory and 50 per cent practice). **Inclusion to be determined*

3.9 A minimum number of 1200 hours of midwifery practice experience, not inclusive of simulation activities, incorporated into the program across a variety of care settings and sufficient for students to meet the National Competency Standards for the Midwife as well as achieve the minimum midwifery practice requirements as stipulated in Standard 8. **Inclusion to be determined*

3.10 Content and sequencing of the program of study prepares students for midwifery practice experience and, wherever possible, includes opportunities for simulated learning.

3.11 Midwifery practice experience is included as soon as is practically possible in the first year of study to facilitate early engagement with the professional context of midwifery.

3.12 Midwifery practice experience in Australia is included towards the end of the program to consolidate the acquisition of competence and facilitate transition to practice. A summative assessment is made at this time against all National Competency Standards for the Midwife in a midwifery practice setting.

3.13 Equivalence of subject outcomes for programs taught in Australia in all delivery modes in which the program is offered (subjects delivered on-campus or in mixed mode, by distance or by e-learning methods).

3.14 Where the structure of the program allows for multiple entry pathways for which students receive block credit or advanced standing (other than on an individual basis), evidence that each pathway meets the National Accreditation Standards.

Standard 4: Program content

The program content delivered by the program provider comprehensively addresses the National Competency Standards for the Midwife and incorporates Australian and international best practice perspectives on midwifery as well as existing and emerging regional, national and international health priorities.

Criteria

The program provider demonstrates:

4.1 A comprehensive curriculum document, based on the conceptual framework discussed in Standard 2 that includes:

a. program structure and delivery modes

b. subject outlines

c. linkages between subject objectives, learning outcomes and their assessment and the National Competency Standards for the Midwife

d. teaching and learning strategies

e. a midwifery practice experience plan across a variety of midwifery practice settings.

4.2 The central focus of the program is on contemporary midwifery practice; this comprises how woman-centred midwifery care, midwifery continuity of care and primary health care principles underpin the National Competency Standards for the Midwife and how regional, national and international maternity care priorities, research, policy and reform are incorporated.

4.3 Research and evidence-based inquiry underpins all elements of curriculum content and delivery.

4.4 Program content should include but not be limited to supporting the development and application of knowledge and skills in:

a. critical analysis and evaluation

b. reflective practice

c. professional advocacy

d. responsibility and accountability

e. quality improvement methodologies

f. research appreciation and translation

g. legal and ethical issues in health care and research

h. health informatics and health technology.

4.5 Inclusion of content that develops understanding and appreciation of consumers' perspectives of maternity care, the woman's right to make choices and the role of the midwife to provide relevant information relating to safety and care alternatives and to support the woman's informed choice.

4.6 Inclusion of content giving students an appreciation of the diversity of Australian culture, in order to develop and engender their knowledge of cultural respect and safety.

4.7 Inclusion of a discrete subject specifically addressing Aboriginal and Torres Strait Islander peoples' history, health, wellness and culture. Midwifery practice issues relevant to Aboriginal and Torres Strait Islander peoples and communities are also appropriately embedded in other subjects across the curriculum.

4.8 Equivalence of theory or midwifery practice experience gained outside Australia in terms of subject objectives, learning outcomes and assessment. Learning experiences outside Australia must not exceed one semester.[38]

[38] An explanation of learning experiences outside Australia is in ANMAC explanatory note: 'Offshore components in accredited Australian Programs of Study, April 2013. Viewed at www.anmac.org.au/document/accreditation-explanatory-note-offshore-components-accredited-australian-programs-study on 2 October 2013

Standard 5: Student assessment

The curriculum incorporates a variety of approaches to assessment that suit the nature of the learning experience and robustly measure achievement of required learning outcomes, including a summative assessment of student performance against the National Competency Standards for the Midwife.

Criteria

The program provider demonstrates:

5.1 A consistent approach to student assessment across teaching sites and modalities that is periodically reviewed and updated.

5.2 Clear statements about assessment and progression rules and requirements provided to students at the start of each subject.

5.3 The level, number and context of assessments are consistent with determining the achievement of the stated learning outcomes.

5.4 Both formative and summative assessment types and tasks exist across the midwifery practice experience and theoretical components of the program to enhance individual and collective learning as well as inform student progression.

5.5 A variety of assessment approaches across a range of contexts to evaluate competence in the essential knowledge, skills and behaviours required for midwifery practice.

5.6 Students' communication competence and English language proficiency are assessed before undertaking midwifery practice experience.

5.7 Appropriate assessment is used in midwifery practice experience to evaluate student ability to meet the National Competency Standards for the Midwife.

5.8 Ultimate accountability for the assessment of students in relation to their midwifery practice experience.

5.9 Assessments include the appraisal of competence in pharmacokinetics, pharmacodynamics and the quality use of medicines.

5.10 Evidence of procedural controls, fairness, reliability, validity and transparency in assessing students.

5.11 Processes to ensure the integrity of any online assessment.

5.12 Collaboration between students, health service providers and academics in selecting and implementing assessment methods.

5.13 A summative assessment of students' achievement of competence against the National Competency Standards for the Midwife is conducted by a Registered Midwife in an Australian midwifery practice setting before program completion.

Standard 6: Students

The program provider's approach to attracting, enrolling, supporting and assessing students is underpinned by values of transparency, authenticity, equal opportunity and an appreciation of social and cultural diversity.

Criteria

The program provider demonstrates:

6.1 Applicants are informed of the following before accepting an offer of enrolment:

a. modes for program delivery and location of midwifery practice experience placements

b. specific requirements for entry to the program of study including English language proficiency

c. compliance with the National Law by registering students with the NMBA

d. compliance with the National Law by notifying the Australian Health Practitioner Regulation Agency if a student undertaking midwifery practice experience has an impairment that may place the public at risk of harm

e. specific requirements for right of entry to health services for midwifery practice experience placements (including, fitness for practice, immunisation and criminal history)

f. continuity of care experience requirements and implications for academic and personal life

g. requirements for registration as a midwife by the NMBA including, but not limited to, the explicit registration standard on English language skills.

6.2 Students are selected for the program based on clear, justifiable and published admission criteria.

6.3 Students have sufficient English language proficiency and communication skills to be able to successfully undertake academic experience and midwifery practice experience requirements throughout the program.

6.4 Students are informed about, and have access to, appropriate support services including counselling, health care and academic advisory services.

6.5 Processes to enable early identification and support for students who are not performing well academically or have professional conduct issues.

6.6 All students have equal opportunity to attain the National Competency Standards for the Midwife. The mode or location of program delivery should not influence this opportunity.

6.7 Processes for student representation and feedback in matters relating to governance and program management, content, delivery and evaluation.

6.8 Aboriginal and Torres Strait Islander peoples are encouraged to enrol and a range of support needs are provided to those students.

6.9 Other groups underrepresented in the midwifery profession, especially those from culturally, socially and linguistically diverse backgrounds, are encouraged to enrol and support needs are provided to those students.

6.10 People with diverse academic, work and life experiences are encouraged to enrol in the program.

Standard 7: Resources

The program provider has adequate facilities, equipment and teaching resources, as well as staff who are qualified, capable and sufficient in number, to enable students to attain the National Competency Standards for the Midwife.

Criteria

The program provider demonstrates:

7.1 Staff, facilities, equipment and other teaching resources are sufficient in quality and quantity for the anticipated student population and any planned increase.

7.2 Students have sufficient and timely access to academic and clinical teaching staff to support their learning.

7.3 A balance of academic, clinical, technical and administrative staff appropriate to meeting teaching, research and governance commitments.

7.4 Staff recruitment strategies:

a. are culturally inclusive and reflect population diversity

b. take affirmative action to encourage participation from Aboriginal and Torres Strait Islander peoples.

7.5 Documented position descriptions for teaching staff, clearly articulating roles, reporting relationships, responsibilities and accountabilities.

7.6 The Head of Discipline responsible for midwifery curriculum development holds current Australian general registration as a Midwife with no conditions relating to conduct, holds a relevant post graduate qualification, maintains active involvement in the midwifery profession and has strong links with contemporary midwifery education and research.

7.7 Staff teaching, supervising and assessing midwifery practice related subjects have current Australian general registration as a Midwife with no conditions relating to conduct with relevant clinical and academic preparation and experience.

7.8 Academic staff are qualified in midwifery for their level of teaching, to at least one tertiary qualification standard higher than the program of study being taught or with equivalent

midwifery practice experience. For staff teaching in an entry to practice Masters program, this requires a relevant post-graduate qualification or equivalent midwifery practice experience.

7.9 In cases where an academic staff member's tertiary qualifications do not include midwifery, their qualifications and experience are relevant to the subject(s) they are teaching.

7.10 Processes to ensure academic staff demonstrate a sound understanding of contemporary midwifery research, scholarship and practice in the subject(s) they teach.

7.11 Teaching and learning takes place in an active research environment where academic staff are engaged in research and/or scholarship and/or generating new knowledge. Areas of interest, publications, grants and conference papers are documented.

7.12 Policies and processes to verify and monitor the academic and professional credentials, including current general registration as a Midwife with no conditions relating to conduct of current and incoming staff and to evaluate their performance and development needs.

Standard 8: Management of midwifery practice experience

The program provider ensures that every student is given a variety of supervised midwifery practice experiences conducted in environments providing suitable opportunities and conditions for students to attain the National Competency Standards for the Midwife.

Criteria

The program provider demonstrates:

8.1 Constructive relationships and clear contractual arrangements with all health providers where students gain their midwifery practice experience and processes to ensure these are regularly evaluated and updated.

8.2 Risk management strategies in all environments where students are placed to gain their midwifery practice experience and processes to ensure these are regularly reviewed and updated.

8.3 Midwifery practice experiences provide timely opportunities for experiential learning of curriculum content that is progressively linked to the attainment of the National Competency Standards for the Midwife.

8.4 Each student is provided with a variety of midwifery practice experiences with opportunities for intraprofessional and interprofessional learning and the development of knowledge, skills and behaviours for collaborative practice.

8.5 Effective and ethical[39] recruitment processes that enable women to participate freely and confidentially in the continuity of care experiences for students and enable students to engage readily with women who consent to participate.

8.6 Clearly articulated models of supervision, support, facilitation and assessment are in place for all midwifery practice experience settings, including for continuity of care experiences, so students can achieve the required learning outcomes and National Competency Standards for the Midwife.

[39] For an explanation of what is considered ethical midwifery practice see: *Code of professional conduct for midwives in Australia* viewed at www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx#codeofethics on 2 October 2013

8.7 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 contemporary and evidence-based Australian and international perspectives on midwifery practice.

8.8 Assessment of midwifery competence within the context of the midwifery practice experience is undertaken by a Registered Midwife, including continuity of care experiences.

8.9 Appropriate resources are provided, monitored and evaluated to support students while on midwifery practice experience.

DRAFT MINIMUM MIDWIFERY PRACTICE REQUIREMENTS
(Please read footnotes)

The program provider is required to demonstrate the inclusion of periods of midwifery practice experience in their program so students can complete all these minimum supervised midwifery practice experience requirements, regardless of the length of program.

1. Experience in woman-centred care as part of continuity of care experiences. The student is supported to:

a) establish, maintain and conclude a professional relationship while experiencing continuity with individual women through pregnancy, labour and birth, and the postnatal period, regardless of model of care

b) provide midwifery care within a professional practice setting and under the supervision of a midwife or other relevant registered practitioner (for example, medical officer qualified in obstetrics, child health nurse or physiotherapist)

c) engage with 15 women during pregnancy, labour and birth and the postpartum, according to individual circumstances, which involves attending four antenatal visits, two postnatal visits and may or may not include attendance at the labour and birth.

d) maintain a record of engagement that incorporates regular reflection and review by the education or health service provider.

2. Attendance at 100 antenatal episodes of care[40], which may include women the student is following as part of their continuity of care experiences.

3. Attendance at 100 postnatal episodes of care with women and, where possible, their newborn babies, which may include women the student is following as part of their continuity of care experiences.

[40] 'Episodes of care' may include multiple episodes of care for the same women where her care needs have altered, for example, as a result of a natural progression through the antenatal or postnatal periods or due to evolving complex needs.

4. Act as the primary accoucheur for 30 women who experience a spontaneous vaginal birth which may include women being followed as part of continuity of care experiences. This also involves:

a) managing the third stage of labour, including the student implementing all strategies to attempt delivery of the placenta when manual removal is required

b) facilitating initial mother and baby interaction

c) monitoring the postnatal adaptation of mother and baby.

5. Provide direct and active care to an additional 10 women during labour and, where possible, during birth regardless of mode.

6. Experience of caring for 40 women with complex needs across pregnancy, labour, birth or the postnatal period, which may include women the student is following as part of their continuity of care experiences.[41]

7. Experience in undertaking 20 examinations of the new born.[42]

8. Experience in care of babies with special needs.

9. Experience in women's health and sexual health.

10. Experience in supporting women to infant feed and in applying the World Health Organisation's ten steps to successful breastfeeding.[43]

[41] Also includes women with complex needs who received direct and active care from the student during midwifery practice experiences associated with minimum practice requirements 1, 2, 3, 4 or 5.

[42] This minimum practice requirement refers to initial or ongoing neonatal examinations and may include babies examined as part of intrapartum or postnatal episodes of care or during CoCE.

[43] For an explanation of the 10 steps to successful breastfeeding see: UNICEF, Information Newsline, Ten *Steps to Successful Breastfeeding*. Viewed at www.unicef.org/newsline/tenstps.htm on 2 October 2013.

Standard 9: Quality improvement and risk management

The program provider is able to assess and address risks to the program, its outcomes and students, and has a primary focus on continually improving the quality of the teaching and learning experience for students and the competence of graduates.

Criteria

The program provider demonstrates:

9.1 Responsibility and control of program development, monitoring, review, evaluation and quality improvement is delegated to the Midwifery school with oversight by the academic board or equivalent.

9.2 Regular evaluation of academic and clinical supervisor effectiveness using feedback from students and other sources; systems to monitor and, where necessary, improve staff performance.

9.3 Professional and academic development of staff to advance knowledge and competence in teaching effectiveness and assessment.

9.4 Feedback gained from the quality cycle involves stakeholders, including consumers and is incorporated into the program of study to improve the experience of theory and practice learning for students.

Glossary and abbreviations

Academic staff—education provider employees who meet the requirements established in Standard 7 (must be registered and hold a relevant qualification higher than that for which the students they instruct are studying) and who are engaged in teaching, supervising, supporting and/or assessing students in relation to their acquiring required skills, knowledge, attitudes and graduate competency outcomes.[44]

Accoucheur—the colloquial meaning is a midwife, of any gender, responsible for 'catching' the baby. The French meaning is a male midwife or man who assists women in birth. *Accoucheuse* is the French word for midwife.

Advanced standing—refers to the recognition of prior learning through experience and/or studies.

AHPRA—the Australian Health Practitioner Regulation Agency is an organisation responsible for the implementation of the NRAS across Australia. AHPRA supports the National Health Practitioner Boards in implementing the scheme.

ANMAC—the Australian Nursing and Midwifery Accreditation Council is the independent accrediting authority for nursing and midwifery under the NRAS. ANMAC sets standards for accreditation and accredits nursing and midwifery programs leading to registration and endorsement; and the providers of those programs.

AQF—the Australian Qualifications Framework is the national policy for regulated qualifications in Australian education and training. It incorporates the qualifications from each education and training sector into a single comprehensive national qualifications framework.

Assessment contexts—includes the professional practice context and simulated or laboratory context.[45]

Assessment tasks—includes, for instance, written papers, oral presentations or demonstrations of competence in midwifery practice.

Assessment types—includes formative assessment (intended to provide feedback for the purposes of future learning, development and improvement) and summative assessment (that indicates whether certain criteria have been met or certain outcomes have been achieved).[46]

Australian Health Practitioner Regulation Agency (AHPRA)—the organisation responsible for the implementation of the NRAS across Australia. Supports the National Health Practitioner Boards (such as the NMBA) in implementing the scheme.

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[44] ANMC, *Midwives Standards and Criteria for the Accreditation of Nursing and Midwifery Courses Leading to Registration, Enrolment, Endorsement and Authorisation in Australia with Evidence Guide*. Canberra, 2010.

[45] Ibid.

[46] Ibid.

Australian university—refers to a higher education provider registered with TEQSA in the 'Australian university' provider category.

Block credit—refers to the recognition of previously completed formal training and/or qualifications, such that credit is given for whole stages or components of a program.

Collaborative practice—where health professionals work as an effective team, optimising individual skills and talents and sharing case management to reach the highest of patient care standards.

Competence—the combination of skills, knowledge, attitudes, values and abilities underpinning effective and/or superior performance in a profession or occupational area.[47]

Competent—refers to the person who has competence across all the domains of competencies applicable to the midwife, at a standard judged to be appropriate for the level of midwife being assessed. [48]

Consumer—a term used generically to refer to a woman receiving care. Advising consumers of their right to make informed choices in relation to their care, and obtaining their consent, are key responsibilities of all health care personnel.[49]

Continuing competence—the ability of midwives to demonstrate they have maintained their competence in their current area and context of practice.[50]

Continuity of care experience—refers to the ongoing midwifery relationship between the student and the woman from initial contact in pregnancy through to the weeks immediately after the woman has given birth, across the interface between community and individual health care settings. The intention of this experience is to enable students to experience continuity with individual women through pregnancy, labour, birth and the postnatal period, irrespective of the carers chosen by the woman or the availability of midwifery continuity of care models.[51]

Criminal history—is defined in the National Law as:

- every conviction of the person for an offence, in a participating jurisdiction or elsewhere, and whether before or after the commencement of this Law
- every plea of guilty or finding of guilt by a court of the person for an offence, in a participating jurisdiction or elsewhere, and whether before or after the commencement of this Law and whether or not a conviction is recorded for the offence

[47] ANMC, *National Competency Standards for the Midwife*, 2006.

[48] Ibid.

[49] ANMC, *Midwives Standards and Criteria for the Accreditation of Nursing and Midwifery Courses Leading to Registration, Enrolment, Endorsement and Authorisation in Australia with Evidence Guide*. Canberra, 2010.

[50] ANMC, *Continuing Competence Framework*, February 2009.

[51] ANMC, *Standards and Criteria for the Accreditation of Nursing and Midwifery Courses Leading to Registration, Enrolment and Authorisation in Australia with Evidence Guide. Midwives, February 2009*

- every charge made against the person for an offence, in a participating jurisdiction or elsewhere, and whether before or after the commencement of this Law.

Under the National Law, spent convictions legislation does not apply to criminal history disclosure requirements.[52]

Criteria—refer to statements to support a standard on which a judgement or decision in relation to compliance can be based.

Cultural safety—the effective midwifery practice of a person or a family from another culture, as determined by that person or family. Culture includes, but is not restricted to: age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability. The midwife delivering the midwifery service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual.[53]

Curriculum—the educational and professional midwifery philosophies underpinning the curriculum, including: program philosophy; program structure and delivery modes; subject outlines; links between subject objectives, learning outcomes and their assessment, and National Competency Standards for the Midwife; teaching and learning strategies; workplace experience plan.

Deep versus surface learning—surface learning is when students accept information at face value and focus on merely memorising it as a set of unlinked facts. This leads to superficial, short-term retention of material, such as for examination purposes. In contrast, deep learning involves the critical analysis of new ideas, linking them to already known concepts and principles. This leads to understanding and long-term retention of concepts so they can be used to solve problems in unfamiliar contexts. Deep learning promotes understanding and application for life.

Delivery mode—the means by which programs are made available to students: on‑campus or in mixed‑mode, by distance or by e-learning methods.[54]

Education provider—university, or other higher education provider, responsible for a program of study, the graduates of which are eligible to apply to the NMBA for nursing or midwifery registration or endorsement.

[52] NMBA, *Criminal history registration standard*. July 2010.

[53] Adapted from: Nursing Council of New Zealand, 'Guidelines for Cultural Safety, the Treaty of Waitangi and Maori Health in Nursing Education and Practice', last amended July 2011.

[54] ANMC, *Midwives Standards and Criteria for the Accreditation of Nursing and Midwifery Courses Leading to Registration, Enrolment, Endorsement and Authorisation in Australia with Evidence Guide*. Canberra, 2010.

Emotional intelligence—the ability to understand, identify in oneself and others, and manage emotions and includes the domains of self-monitoring, self-regulation, self-motivation, empathy and social skills.[55]

English language proficiency—where English language skills, including listening, reading writing and speaking are at a level enabling the provision of safe, competent practice. Demonstration of English language proficiency is a NMBA criterion for registration.[56]

Equivalent professional experience—refers to the successful completion of a qualification equivalent to that being taught and sufficient post-graduate professional experience[57] in the discipline being taught, to demonstrate competence in applying the discipline's principles and theory.

Fitness for practice—refers to being able to demonstrate no professional impediment, or physical or mental incapacity that would preclude a person from nursing or midwifery practice.[58]

Governance—framework, systems and processes supporting and guiding an organisation towards achieving its goals and the mechanisms by which it, and its people, are held to account. Ethics, risk management, compliance and administration are all elements.

Graduates—students who, having undertaken a program, are eligible to apply for midwifery registration.[59]

Higher education provider—tertiary education provider who meets the Higher Education Standards Framework (Threshold Standards) as prescribed by the *Tertiary Education Quality and Standards Agency Act 2011* and is registered with TEQSA.[60]

Head of school/Head of discipline—refers to the lead midwifery academic responsible for designing and delivering the midwifery program of study on behalf of the education provider.

Health informatics—refers to the appropriate and innovative application of the concepts and technologies of the information age to improve health care and health.[61]

Health Practitioner Regulation National Law Act 2009 (the National Law)—contained in the Schedule to the Act. This second stage legislation provides for the full operation of the National Registration and Accreditation Scheme for health professions from 1 July 2010 and covers the

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[55] Goleman, D. 2005. *Emotional Intelligence (Why it can matter more than IQ).* 10th anniversary edition. Bantam Books. London

[56] NMBA, *English language skills registration standard*. September 2011.

[57] To be read in the context of the *Recency of practice registration standards*, NMBA. Viewed at www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx on 15 May 2013.

[58] Adapted from: NMBA, *Framework for the assessment of internationally qualified nurses and midwives for registration*. July 2010.

[59] ANMC, *Midwives Standards and Criteria for the Accreditation of Nursing and Midwifery Courses Leading to Registration, Enrolment, Endorsement and Authorisation in Australia with Evidence Guide*. Canberra, 2010.

[60] TEQSA (2011), Higher Education (Threshold Standards) 2011 Legislative Instrument, Chapter 2. Viewed at www.teqsa.gov.au/higher-education-standards-framework on 2 October 2013.

[61] Standards Australia, *e-health: What is Health Informatics?* Viewed at www.e-health.standards.org.au/ ABOUTIT014 /WhatisHealthInformatics.aspx on 15 May 2013.

more substantial elements of the national scheme, including registration arrangements, accreditation arrangements, complaints, conduct, health and performance arrangements, and privacy and information-sharing arrangements. The purpose is to protect the public by establishing a national scheme for regulating health practitioners and students undertaking programs of study leading to registration as a health practitioner. The National Law is legislated in each state and territory. The *Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008* outlines the administrative arrangements established under the first stage of the National Registration and Accreditation Scheme for the Health Professions (Act A).

Health service providers—refers to health units or other appropriate service providers, where students undertake supervised professional experience as part of a program, the graduates of which are eligible to apply for midwifery registration (adapted from definition for 'clinical facilities' in the ANMC National Accreditation Framework).[62]

Health technology—includes: medicines; diagnostics, devices, equipment and supplies; medical and surgical procedures; support systems; and organisational and managerial systems used in prevention, screening, diagnosis, treatment and rehabilitation.

International definition of the midwife—a person who has successfully completed a midwifery education program that is duly recognised in the country where it is located and that is based on the International Confederation of Midwives Essential Competencies for Basic Midwifery Practice and the framework of the International Confederation of Midwives Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery.

Scope of practice

The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and infant. This care includes preventative measures, promotion of normal birth, detection of complications in mother and child, access of medical care or other appropriate assistance and carrying out of emergency measures.

The midwife has an important task in health counselling and education, not only for the woman, but also within the family and community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care.

A midwife may practise in any setting including the home, community, hospitals, clinics or health units.[63]

Interprofessional learning—occurs when two or more professions learn with, from and about

[62] ANMC, *Midwives Standards and Criteria for the Accreditation of Nursing and Midwifery Courses Leading to Registration, Enrolment, Endorsement and Authorisation in Australia with Evidence Guide*. Canberra, 2010.

[63] International Confederation of Midwives, *International Definition of the Midwife,* June 15, 2011.

each other to improve collaboration and the quality of care.

Learning outcomes—the skills, knowledge and attitudes identified as the requirements for satisfactory program completion including, but not limited to, the graduate competency outcomes.[64]

Life-long learning—includes learning firmly based in clinical practice situations, formal education, continuing professional development and informal learning experiences within the workplace. Also involves the learner taking responsibility for their own learning, investing time, money and effort in training or education on a continuous basis.[65]

Midwifery practice experience—any midwifery learning experience, including in simulated environments or professional experience placements, which assists students to put theoretical knowledge into practice. Must include but may not be limited to continuity of care experiences.[66]

Midwifery practice experience placement—the component of midwifery education that allows students to put theoretical knowledge into practice within the consumer care environment (adapted from the ANMC Standards for Registered Nurses). Must include, but may not be limited to, continuity of care experiences. Excludes simulation.

National Competency Standards for the Midwife—core competency standards by which performance and professional conduct is assessed to obtain and retain registration as a registered midwife.[67]

NMBA—the Nursing and Midwifery Board of Australia works under the auspices of the AHPRA to protect the public and guide the professions of nursing and midwifery. Its functions include: registering nursing and midwifery practitioners and students; developing standards, codes and guidelines for the nursing and midwifery professions; handling notifications, complaints, investigations and disciplinary hearings; assessing overseas trained practitioners who wish to practice in Australia; and approving accreditation standards and accredited programs of study.

Pharmacodynamics—study of the biochemical and physiological effects of drugs and the mechanisms of their action in the body.

Pharmacokinetics—study of the bodily absorption, distribution, metabolism, and excretion of

[64] ANMC, *Midwives Standards and Criteria for the Accreditation of Nursing and Midwifery Courses Leading to Registration, Enrolment, Endorsement and Authorisation in Australia with Evidence Guide*. Canberra, 2010.

[65] Adapted from: Homer CSE, Griffiths M, Ellwood D, Kildea S, Brodie PM. & Curtin A. (2010). *Core Competencies and Educational Framework for Primary Maternity Services in Australia: Final Report*. Centre for Midwifery Child and Family Health, University of Technology Sydney, Sydney.

[66] Adapted from: ANMC, *Midwives Standards and Criteria for the Accreditation of Nursing and Midwifery Courses Leading to Registration, Enrolment, Endorsement and Authorisation in Australia with Evidence Guide*. Canberra, 2010.

[67] Australian Nursing and Midwifery Council, *Midwives Standards and Criteria for the Accreditation of Nursing and Midwifery Courses Leading to Registration, Enrolment, Endorsement and Authorisation in Australia with Evidence Guide*. Canberra, 2010.

drugs.

Primary health care principles[68]—

- reflect and evolve from the economic conditions and sociocultural and political characteristics of the country and its communities and are based on the application of the relevant results of social, biomedical and health services research and public health experience
- address the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly
- include at least education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunisation against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs
- involve, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors
- require and promote maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate.
- should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need
- rely, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

Program—refers to the full program of study and experiences that must be completed before a qualification recognised under the AQF, such as a Bachelor or Masters of Midwifery, can be awarded.

Program provider—refers to the school or faculty responsible for designing and delivering a program of study in midwifery leading to the award of a Bachelor Degree in Midwifery as a minimum.

Recognition of prior learning—refers to an assessment process for the students formal and

[68] WHO; UNICEF (1978). Declaration of Alma-Ata: report on the International Conference on Primary Health Care, 6 to 12 September, Alma-Ata, USSR. Viewed at www.who.int/publications/almaata_declaration_en.pdf on 15 May.

informal learning to determine the extent to which that they have achieved required learning outcomes, competency outcomes or standards for entry to and/or partial or total completion of a qualification.

Registered midwife—a person with appropriate educational preparation and competence for practice, who is registered by the NMBA to practise midwifery in Australia.

Registered nurse—a person with appropriate educational preparation and competence for practice, who is registered by the NMBA to practise nursing in Australia.

Research—according to the Department of Industry, Innovation, Climate Change, Science, Research and Tertiary Education specifications for the Higher Education Research Data Collection, research comprises:

- creative work undertaken on a systematic basis to increase the stock of knowledge, including knowledge of man, culture and society, and the use of this stock of knowledge to devise new applications
- any activity classified as research which is characterised by originality; should have investigation as a primary objective and the potential to produce results that are sufficiently general for humanity's stock of knowledge (theoretical and/or practical) to be recognisably increased—most higher education research work would qualify as research
- pure basic research, strategic basic research, applied research and experimental development.

Scholarship—refers to application of a systematic approach to acquiring knowledge through intellectual inquiry. Includes disseminating this knowledge through various means such as publications, presentations (verbal and audio-visual) and professional practice. Also includes applying this new knowledge to the enrichment of the life of society.

School—refers to an organisational entity of an education provider responsible for designing and delivering a program of study in nursing or midwifery. Where the school of midwifery is part of a larger faculty, the school is regarded as the program provider for the purposes of these standards.

Simulation—any educational method or experience evoking or replicating aspects of the real world in an interactive manner.

Spontaneous vaginal birth—when a woman gives birth vaginally, unassisted by forceps or vacuum extractor. The labour may or may not be spontaneous.

Standard—a level of quality or attainment.

Student—any person enrolled in a program leading to midwifery registration.

Student assessment—process to determine a student's achievement of expected learning outcomes. May include written and oral methods and practice or demonstration.

Subject—unit of study taught within a program of study.

Supervision and/or support—where, for instance, an academic staff member or midwife supports and/or supervises a student undertaking a program for entry to the midwifery profession on a professional experience placement. Includes supervision and/or support provided for the student's participation in continuity of care experiences.

Tertiary Education Quality and Standards Agency (TEQSA)— an organisation established in July 2011 to regulate and assure the quality of Australia's large, diverse and complex higher education sector. From January 2012, TEQSA will register and evaluate the performance of higher education providers against the new Higher Education Standards Framework. TEQSA will undertake compliance and quality assessments.

University/universities—institution/s listed as Australian universities on the AQF Register. Being listed on the register indicates that the Ministerial Council of Education, Employment, Training and Youth Affairs vouches for the quality of the institution; and which meet the requirements of protocols A and D of the National Protocols for Higher Education Processes (2006), are established by an Australian legislative instrument, as defined in Part 3 of the National Protocols, and may include institutions operating with a 'university college' title or with a specialised university title, where they meet these protocols.

Woman—a term including the woman, her baby (born and unborn), and, as negotiated with the woman, her partner, significant others and the community.[69]

Woman-centred midwifery—principles of woman-centred midwifery are identified in the ACM Philosophy Statement: Midwife means 'with woman'. This meaning shapes midwifery's philosophy, work and relationships. Midwifery is founded on respect for women and on a strong belief in the value of women's work of bearing and rearing each generation. Midwifery considers women in pregnancy, during childbirth and early parenting to be undertaking healthy processes that are profound and precious events in each woman's life. These events are also seen as inherently important to society as a whole. Midwifery is emancipatory because it protects and enhances the health and social status of women which, in turn, protects and enhances the health and wellbeing of society.

Midwifery is a woman-centred, political, primary health care discipline founded on the relationships between women and their midwives.

Midwifery:

- focuses on a woman's health needs, her expectations and aspirations
- encompasses the needs of the woman's baby, and includes the woman's family, her other important relationships and community, as identified and negotiated by the woman herself
- is holistic in its approach and recognises each woman's social, emotional, physical,

[69] ANMC, *Midwives Standards and Criteria for the Accreditation of Nursing and Midwifery Courses Leading to Registration, Enrolment, Endorsement and Authorisation in Australia with Evidence Guide*. Canberra, 2010.

spiritual and cultural needs, expectations and context as defined by the woman herself

- recognises every woman's right to self-determination in attaining choice, control and continuity of care from one or more known caregivers
- recognises every woman's responsibility to make informed decisions for herself, her baby and her family with assistance, when requested, from health professionals
- is informed by scientific evidence, by collective and individual experience and by intuition
- aims to follow each woman across the interface between institutions and the community, through pregnancy, labour and birth and the postnatal period so all women remain connected to their social support systems
- focusses on the woman, not on the institutions or the professionals involved
- includes collaboration and consultation between health professionals.[70]

[70] Australian College of Midwives (ACM), Philosophy of Midwifery based on work from: New Zealand College of Midwives; Nursing Council of New Zealand; Nursing and Midwifery Council (United Kingdom); Royal College of Midwives; College of Midwives of British Columbia; College of Midwives Ontario, former ACM Incorporated; Nurses Board of Victoria; Nursing Council of Queensland; WHO; Guilland and Pairman (1995) and Leap (2004). Viewed at www.midwives.org.au/scripts/cgiip.exe/WService=MIDW/ccms.r?pageid=10019 on 2 October 2013.