Background

The Australian Nursing and Midwifery Accreditation Council (ANMAC) is the independent accrediting authority for nursing and midwifery programs of study with responsibility for maintaining and facilitating the development of accreditation standards leading to registration as a nurse and/or a midwife. To ensure standards remain current, contemporary and effective, ANMAC follows a five-year cyclical review. The current midwife accreditation standards were approved in 2014 and are now due to be revised.

Two hundred and fifty-four stakeholders responded to the online survey (n=229) and/or provided written responses (n= 25) to Consultation Paper 2. Table 1 shows survey respondents reflected the range of stakeholders including consumers, students of midwifery, early career midwives, midwives, midwife academics, national organisations, program providers and health service providers.

Table 1: Role identification of participants responding to the online survey

RESPONDENTS	ROLE % (N)*
Consumer	2.18 (5)
Midwife	12.66 (29)
Midwife educator/facilitator/lecturer/teacher	21.83 (50)
Endorsed midwife	3.93 (9)
Student midwife	28.38 (65)
Early career midwife	4.80 (11)
Midwife/Registered nurse	16.16 (37)
Health Service manager	1.75 (4)
Nominated organisational representative (specified from text box)	3.49 (8)
Midwife researcher	1.75 (4)
Other (specified from text box)	3.06 (7)
TOTAL	229

Written submissions (n=25) were received from a diverse range of stakeholders including program providers, regulators, health service providers, a peak body, quality and safety bodies, professional organisations, a union/professional organisation, a special interest group, a midwife and a consumer (Table 2).

Table 2: Role identification of participants providing a written response to Consultation Paper 2

RESPONDENTS	ROLE % (N)*
Program Provider	32 (8)
Regulator	8 (2)
Health Service	8 (2)
Peak body	8 (2)
Quality and Safety organisation	8 (2)
Professional organisation	20 (5)
Union/professional organisation	4 (1)

Midwife	4 (1)
Special interest group	4 (1)
Consumer	4 (1)
TOTAL	25

All states and territories were represented in the online survey feedback with stakeholders from metropolitan, regional and remote areas all responding to the questions raised in the consultation paper (Table 3).

Table 3: Participants responding to the online survey by State and Territory

LOCATION	% (N)*
Australian Capital Territory	2.62 (6)
New South Wales (metropolitan)	20.96 (48)
New South Wales (regional or remote)	11.35 (26)
Queensland (metropolitan)	16.59 (38)
Queensland (regional or remote)	11.79 (27)
South Australia (metropolitan)	3.49 (8)
South Australia (regional or remote)	0.87 (2)
Victoria (metropolitan)	11.79 (27)
Victoria (regional or remote)	10.92 (25)
Western Australia (metropolitan)	6.11 (14)
Western Australia (regional or remote)	0.44 (1)
Tasmania	1.31 (3)
Northern Territory	0.44 (1)
National	1.31 (3)
TOTAL	229

Written submissions to the consultation paper represented a range of stakeholders and stakeholder organisations located in states and territories across Australia.

Limitations

When assessing the contribution of stakeholders, the responses from national organisations, program providers and health service providers represent the feedback from large numbers of stakeholders and so the number of responses to individual questions is not a true reflection of the weight of stakeholder opinion. Additionally, not all participants (individual or organisational) answered every question so the number of responses to each question varies.

Responses from Consultation Paper 1 identified key issues to be considered in Consultation Paper 2. Additionally, feedback was sought in relation to the draft standards included in the consultation paper. Stakeholders were asked to respond to the following questions.

Question 1

Continuity of care experience (CoCE)

Please choose one of the following options for student engagement with women during CoCE's.

Option 1 –attend the labour and birth for a majority of women (present requirement) or

Option 2 –attend the labour and birth where possible

Please select one

1. Option 1
2. Option 2
3. Don't know/unsure

A total of 231 participants (individual & organisational) provided feedback to this question. One hundred and fifty-nine responses (68%) selected Option1, 68 responses (29%) chose Option 2 and 4 responses (2%) indicated uncertainty.

Rationales

Responses in agreement with continuing to require students to attend the labour and birth for a majority of women recognise the CoCE as "an important principle for midwifery practice in Australia." In particular, responses highlighted the following:

- adheres to the ACM midwifery philosophy
- supports the students to fulfil the ICM Definition of a Midwife
- embodies 'woman-centred' practice'
- embeds the ability to 'see' the woman as a person rather than a patient
- enable students to learn to manage multiple commitments
- supports the ability to work in partnership
- exposure/understanding of the core principles of the midwife's role
- prepares students for the reality of practice

Responses indicated that changing the requirement to "attend the labour and birth where possible" risks:

- students not attending the labour and birth of any of the women, therefore not experiencing the full involvement of the CoCE
- discouraging the student and sending the message that labour and birth are not an important component of the CoCE

Responses in favour of changing the requirement to "attend the labour and birth where possible" cited the burdens the attendance placed on students. In particular they highlighted the following issues:

- "midwifery education is discriminatory to women who are mothers, single parents, and [those who] need to work to support family"
- difficulty in recruiting women
- women not wanting to have student attend the labour and birth due to "student's inability to develop adequate rapport during brief antenatal appointments"
- having to travel long distances (rural & remote students)
- heath service factors
    - unable to be released from rostered midwifery or nursing placement to attend
    - another (rostered) student is present and caring for the woman
    - support personnel restricted to two people which can exclude student (woman choses partner, mother)
    - private obstetrician not allowing student to attend birth (commonly at caesarean section)
- university required attendance at lectures, tutorials, clinical assessment and exams

- unacceptable working hours
    - attending the labour and birth of the woman after completing, or prior to commencing, a rostered shift
    - hours associated with CoCE are in addition to the required practice hours
- "not a lot that the student gets out of the CoCE other than observation"
- "being on-call for births brings unnecessary stress and anxiety"

Overall, the consensus from stakeholders was that students should continue to be required to attend the labour and birth for a majority of women with whom they engage in a CoCE.

Question 2

Labour and birth care

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

Yes/No/Unsure

Please provide a rationale for your choice.

A total of 212 participants (individual & organisational) responded to this question. One hundred and fifty-seven responses (74%) agreed that the number of spontaneous vaginal births (SVD) for whom the student is the primary birth attendant should remain at 30 women. Forty-eight responses (23%) recommended a reduction in the requirements (20 instead of 30) and seven responses (3%) indicated they were unsure if a change would be beneficial. One response advocated an increase to 40 births.

Rationales

Responses in agreement with continuing to require students to be the primary birth attendant for 30 women highlighted the following:

- ensures students gain vital experience in supporting women during physiological birth
- enables students to gain substantial experience in 'normal' birth
- supports increasing student confidence in their competence
- wide variation in 'normal' labour and birth experiences therefore students require sufficient experience across the range to support the transition to practice

Responses advocating a reduction highlight the following:

- "a concerning emphasis on the birth itself to the detriment of labour care"
- "students regularly being sent in to births for second stage having never met the woman, nor provided any care – just to meet the numbers"
- health services finding increasing difficulty for students undertaking Midwifery Practice Experience (MPE) to achieve 30 SVB
- no evidence to support the increase to 30 SVD's (increase from 20 required in the 2009 Midwife Accreditation Standards), no evidence of improved student competence therefore 20 sufficient
- negative impact on graduate midwife competence because almost all SVD's are conducted by students
- possible mismatch between the number of students undertaking MPE at a hospital and hospital birth rates
    - hospital with1000 births a year has 40 students assigned to undertake MPE. "A third of the cohort are so behind through no fault of our own"

    - impact of high minimum practice requirements on regional and rural students who are placed at facilities with smaller birthing numbers
- "should move to competency-based and student-led learning requirements" instead of a reliance on numbers to demonstrate competence
- focus of the standards is weighted in favour of being the primary birth attendant – undermines the student's perception of the value given to caring for women in labour
- "higher required number of births promotes fragmented care where the student is 'called in for a catch' "

Overall, the consensus from stakeholders was that students should continue to be required to be the primary birth attendant for 30 women experiencing an SVB.

Question 3

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

Yes/No/Unsure

Overall, 247 participants (individual & organisational) responded to this question. One hundred and thirty-six responses (55%) were in favour of including educational preparation for prescribing in entry-to-practice midwifery programs. Seventy-one responses (29%) were against the inclusion and 40 responses (16%) indicated they were unsure for a variety of reasons outlined below.

Responses in agreement with adding education for prescribing highlighted the following:

- ensuring greater autonomy for the midwife
- congruent with other countries (Canada, New Zealand)
- supports the full scope of practice
- improves the quality of care for women
- faster safer access to medications especially in rural and remote communities
- "given that midwives have been able to apply to the NMBA for an endorsement to prescribe scheduled medicines since 2010, ……it is an appropriate time to include the preparation to prescribe in the entry-to-practice programs"
- promote workforce mobility
- "……..more effective use of midwifery workforce……importance consideration in progressing continuity of care models for women in a variety of settings"

The following issues were also highlighted:

- would require regulatory changes
- need agreement on curriculum content to ensure appropriate level of knowledge
- need to extend the duration of programs to accommodate content

Many responses disagreeing with adding education for prescribing considered that prescribing was an advanced skill that should be undertaken as a postgraduate qualification. They also argued that the inclusion of this content would necessitate lengthening the course and queried whether or not the duration of Bachelor of Midwifery programs should be extended to 4 years.

There were some references to the level of autonomy that 'education to prescribe' would imply. They asked whether or not there would be a further period of consolidation after graduation before full autonomy to prescribe to the scope of practice was recognised. Other responses indicated uncertainty regarding the process of registration. They appeared to consider that graduates would still need to apply

for endorsement to prescribe medications separately and queried how soon after graduation that could occur.

The following issues were also highlighted:

- unsure how many midwifery academics would have the knowledge and skills to teach prescribing
- newly registered midwives are beginning practitioners and require time to consolidate midwifery practice before prescribing medications
- many will work in hospital setting where midwife prescribing isn't recognised
- not all midwives need or desire the ability to prescribe therefore unnecessary

Responses indicating uncertainty about the proposal included the following:

- time considerations of including the content
- unsure of the content needed
- unsure of the additional demands it would place on already over stretched tertiary education environment

Overall, 136 respondents were in favour of including education for prescribing while 111 respondents were either against or uncertain regarding the inclusion.

Question 4

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

The responses to this question highlighted the following implications:

- duration of course
- changes to legislation
- need for national consistency in course content
- existing barriers to prescribing by midwives in health facilities
- implications for nursing education
- how to manage role ambiguity for students enrolled in BN/BM (RM could prescribe, RN could not)
- need to upskill the current midwifery workforce
- including the content could distract from foundations of midwifery practice (support, relationship building, advocacy, facilitating physiological birth)
- lack of experienced midwifery mentoring for prescribing practice

Question 5

Do the draft accreditation standards cover the required knowledge, skills and attitudes to ensure that the graduate meets the NMBA Midwife standards for practice?

Two hundred and seven participants (individual & organisational) responded to this question. One hundred and sixty-four responses (79%) agreed the draft accreditation standards covered the required knowledge, skills and attitudes to ensure that the graduate meets the NMBA Midwife standards for practice, 18 responses (9%) indicated disagreement and 25 (12%) responses were uncertain.

Of the responses indicating agreement there was some evidence of a caveat on that perspective. Some stated they agreed only if the Minimum Practice Requirements (MPR) did not reduce. Other 'yes but' comments are reflected in the following:

- all new midwives should have access to a graduate program/transition
- too much content to complete in a postgraduate year (Graduate Diploma)
- too much emphasis on 'catches'
- use of AMSAT tool for assessment of students in the clinical area should be used to standardise assessment across the country

The responses indicating disagreement identified the following issues:

- insufficient MPE
- more exposure to Midwifery Group Practice and midwife-led continuity of care models (several responses)
- inadequate cover of the knowledge and skills required to provide appropriate care in the antenatal setting (2 responses)
- more emphasis on labour care

Responses indicating uncertainty whether or not the accreditation standards covered the required knowledge, skills and attitudes to ensure that the graduate meets the NMBA Midwife standards for practice identified the following:

- need to strengthen the criteria relating to prescribing competencies
- need to include criteria related to environmental health
- strengthen knowledge and skills and provide students with supervised practice (where possible) in caring for women experiencing stillbirth
- need more focus on quality of MPE and less on quantity

Question 6

Are there any additional criteria that should be included?

One respondent requested additional mapping of specific criteria be undertaken and others made detailed suggested changes to criteria. The remaining responses indicated additional criteria that should be included and these responses were grouped into the following categories (curriculum content, philosophy, MPE).

Curriculum Content

- standards do not adequately cover required knowledge and skills for outpatient antenatal setting
- more breastfeeding education
- include professional ethics and legislation
- more content on biophysics, biochemistry, radiology, bacteriology, virology and parasitology – immigrant population with different regional backgrounds
- more emphasis on co-morbidities (cardiac, obesity)
- mandate inclusion of content on supporting women/partners/midwives in respect to the impact of traumatic birth; especially working antenatally with women and partners on how to cope if the birth experience does not match expectations/assumptions
- greater understanding of the midwife's role in protecting the child (child protection requirements)
- more emphasis on multicultural care and care of first peoples' women and babies
- further emphasis on receiving and assessing the baby after birth
- education to manage stillbirth before encountering it in practice

- content related to emerging digital initiatives
- self-care (managing personal health and well-being)
- inclusion of change management

Philosophy

- "Reinstatement and explicit reference to woman centred care throughout the standards to ensure alignment with Woman-centred care: Strategic directions for Australian maternity services (2019)"
- "Provision to assist students and educators to focus on providing woman-centred care during labour and birth ……less emphasis on 'catches'"
- newly graduated midwives able to work within continuity of care models, all risk, any setting
- promoting and protecting physiological birth
- formal feedback from the woman should be part of the CoCE requirement

MPE

- more MPE
- initiatives to manage extenuating circumstance where student has provided care during labour but is unable to experience the birth and/or third and fourth stage support
- more emphasis on supporting women in the postnatal period up to four to six weeks after birth
- all graduates capable in the skill of perineal suturing, cannulation
- MPE in community setting/birth centre/homebirth/
- more experience in outpatient antenatal setting (several responses)
- opportunities for midwifery experience with privately practising midwives
- additional focus on 'direct and active care of women during the first stage of labour' - increase requirements from 10 to 25
- national approach to assessment of clinical competency and professional portfolio requirements that "reflect the tenets of woman-centredness alongside clinical aspects of care"
- mandated rural and remote placement

Question 7

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

Some respondents suggested deletions to criteria as well as instances where criteria should be amalgamated. These suggestions have been considered in the revision of the draft standards.

Question 8

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

Four respondents commented that, while they fully supported the specific criteria relating to social and emotional wellbeing, complex family health, domestic violence, stillbirth and family bereavement care and perinatal mental health, they queried why other aspects had not been specifically described.

There were numerous comments regarding the number of required MPE with some respondents advocating increases (particularly in CoCE) while others wanted reductions (CoCE & birthing numbers) with the following rationales:

- stress and burden on students

- inability of students to achieve the required numbers due reduction in women giving birth spontaneously
- requirement for spontaneous birthing numbers detrimental to qualified junior midwives (less consolidation in the first year of practice)
- less overall minimum practice requirements for Graduate Diploma students

Question 9

Are there further issues that should be addressed in the revision of the Midwife Accreditation Standards that have not been discussed so far in the consultation process?

The issues ranged from a continued emphasis on aspects of MPE already discussed including increasing/reducing the number of MPR, benefits of continuity of care for women and babies, the importance of educating students to work in midwifery-led models of care, and the burdens and the stress faced by students in completing the MPR.

Other program/content/practice experience issues raised in this question included the following:

- perceived disparity in the practice hours required for completion of the program across the country (960 to 2000). This was linked to equal access to learning opportunities.
- documentation of practice experiences should be standardised across universities
- allocation of students to clinical setting/hospitals should reflect the percentage of births available to support the quantum of required MPE
- ensure students assigned to private facilities also have experience in public facilities
- need to address student's knowledge/understanding of underlying (non-pregnancy) conditions
- prepare midwives to practise in the digital age
- consider implementing a national curriculum
- specify a minimum number of experiences in care of the neonate with special needs

One respondent highlighted the need to take into consideration international registration and regulatory requirements to support the ability of Australian midwives to transition to practice in other countries without the need to complete additional education requirements.

Summary

This summary presented feedback received to the second round of consultation for the revision of the Midwife Accreditation Standards. The feedback will contribute to the development of Consultation Paper 3.