Australian Nursing & Midwifery Accreditation Council

Review of the Midwife Accreditation Standards

Synthesis of responses to Consultation Paper 1

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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.

One hundred and thirty-seven stakeholders responded to the online survey and/or provided written responses. 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. 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 (feedback).

Responses from the Strengthening the quality of midwifery education survey identified key issues to be considered in Consultation Paper 1. Stakeholders were asked to respond to the following questions.

Question 1

Please indicate your agreement/disagreement (strongly agree, agree, unsure/don't know, disagree, strongly disagree) with the following statement.

The accreditation standards should continue to specify that students complete a minimum of supervised midwifery practice experiences.

Question 2

How can the standards ensure that students in pre-registration programs are educated to meet the full scope of midwifery practice?

Question 3

How can the accreditation standards best support inter-professional learning?

Question 4

What additional issues should be addressed in the revision of the standards that have not been considered in this consultation paper?

The data were analysed using NVivo. First, responses were grouped according to the specific question being answered. Second, issues raised in Question 4 were grouped and coded into categories. There was considerable overlap in some coding areas. For example, in Question 1, the rationales of some respondents referred to the number and requirements of Continuity of Care experiences (CoCE). Some addressed these issues in Question 4. Question 2 related to scope of practice. Some respondents listed specific skills that they considered should be included in the scope of practice in the Australian context while other respondents addressed specific skills in their responses to Question 4. To ensure a logical flow, all responses coded to CoCE are covered in the Question 1 summary and all responses coded to skill and skill development are covered in the Question 2 summary.

Five-standards framework

The consultation paper identified that ANMAC has moved from a nine-standard format for accreditation standards to a five-standard format. Two stakeholders responded to this move. One supported the move in the interests of consistency and reducing duplication within the standards. The second stakeholder stated that stakeholders had not been consulted on the move. The remaining respondents to the consultation paper did not comment on the move.

Question 1

The accreditation standards should continue to specify that students complete a minimum of supervised midwifery practice experiences.

One hundred and twenty-eight responses were recorded for this question. One hundred and fourteen responses indicated strong agreement (n=77)/agreement (n=37) with the statement. Eight responses indicated disagreement (n=7) /strong disagreement (n=1) with the statement. The remaining six responses were in the unsure/don't know category.

Rationale

The rationales provided for the choice were wide ranging. A number of responses stated there was a need for a standard minimum number of experiences to ensure that newly-qualified midwives had sufficient practice experience to work across a variety of midwifery settings. This was despite some responses supportive of maintaining minimum practice requirements articulating that the current practice requirements were overly prescriptive and focused on numbers rather than on the quality of the experience.

Responses indicating disagreement with the statement considered there was little or no evidence for the numbers, they were burdensome for students, especially those in rural and remote areas, and focussed on quantity rather than quality. Other responses articulated that ensuring students completed a minimum number of hours of clinical practice was considered preferable to completing numbers of experiences (more information in hours of practice below).

Change in numbers (excluding CoCE)

Some responses advocated a reduction or a realigning of required numbers:

- Ensure a minimum of 30 antenatal episodes exclusive of continuity of care experiences
- Reduce spontaneous birth requirement (8.11c) to 15 - 20 women
- Increase direct and active care from an additional 10 women (8.11d) to 20 women
- Extend the focus in 8.11e to reproductive health (to align with ICM) to shift away from just birth and reduce the requirement to caring for 30 women
- Include a set number of water immersion/water births as a requirement
- Reduce the number of full (discharge) baby examinations to 10 plus a minimum number (10) of initial (birth) and ongoing (postnatal) neonatal assessments
- Provide experience in stabilisation for neonates prior to transfer to a tertiary centre (rural & remote)
- Increase hours spent on caring for neonate with special needs

Hours of practice - % practice – theory

Twenty-eight responses were coded to this node. Some responses indicated a preference for requiring a minimum number of hours of clinical practice instead of experiences with a range of hours proposed (800 to 1000 hours). Some responses supported the current 50-50 split while others questioned the usefulness of percentages as a benchmark. They argued that universities calculate hours of theory and practice differently across the sector therefore the stated hours were open to interpretation. Some responses suggested that aligning with ICM standards (40% theory -50%. practice) could be an option.

Continuity of care experiences

Thirty-nine responses were coded to this node. Of these, eight responses called for a reduction in the number of experiences, 10 advocated an increase to experiences and 11 responses reflected satisfaction with the current number. The other ten responses related to other elements of CoCE outside of the numbers.

Reduce the numbers (and requirements)

Rationales for reducing the number of experiences included the difficulty in recruiting women, the burden of the experiences for students (impact on personal lives, ability to undertake part-time work, impact on attendance at university and compulsory practice commitments) and costs associated with traveling to appointments and births (petrol, phone). There was specific reference to the impact of the requirements on rural and remote students.

Proponents of reducing the numbers made a distinction between the number of experiences and reduced quality of the experiences for students and women. Reducing the number of required experiences was thought to result in an increase in quality. The proposed number of experiences ranged from a total of five or six across the program to undertaking one for each year of the program being undertaken (for example BN/BM, 4; 1- year postgraduate diploma, 1; 3-year BM, 3). Other responses recommended that the Standards should be revised to be consistent with UK standards which state *'all students experience continuity of carer and follow a number of women throughout the continuum of care'.*

In addition to reducing the number of CoCE, a number of responses argued that requiring students to be at a majority of the births was onerous, unfair and impacted on the safety of rural students traveling long distances. They proposed the removal of the birth attendance requirement.

Increase the numbers (and requirements)

Proponents of increasing the numbers argued that the experiences are highly valued by students, CoCE transitioned students to caseload midwifery, and were reflective of best practice for birthing women.

> *'Relationship based care makes you less nervous to practice new skills, and it develops the interpersonal skills we need as midwives to a much higher level. Continuity is the way of the future for our profession - it is what the consumer wants and it should be considered part and parcel of becoming a midwife'.*

Proposed increases ranged from 12 to 20. There was also a proposal to increase the requirements to four antenatal episodes of care, three to four postnatal episodes of care and attendance at 80% of the births.

Keep the numbers (and requirements) the same

Responses in favour of keeping the present number of CoCE included the importance of not placing further pressure on clinical partners to provide student placements in the current workforce climate and a perception that the quality of the experience is impacted when the number of experiences increases.

Overall stakeholder response

A majority of respondents strongly agreed/agreed that the revised midwifery accreditation standards should continue to specify a minimum number of supervised midwifery practice experiences. Some respondents advocated for changes to the current number of minimum practice requirements.

Question 2

How can the standards ensure that students in pre-registration programs are educated to meet the full scope of midwifery practice?

There was strong support for ensuring graduates of pre-registration programs are educated to meet the full scope of midwifery practice as defined by the ICM.

> *'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 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 measures. The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the 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.' International Confederation of Midwives (2017).*

To meet the ICM definition, it was argued that undergraduate midwifery students needed to undertake (amongst a range of skill acquisitions) speculum examinations, assessment of a Bishops score on vaginal examination, venepuncture, intravenous cannulation, ordering and interpreting relevant pathology tests and prescribing and administering medications, perineal care and repair, full newborn examination at discharge, family planning and inserting long-acting contraceptives and abortion care, breastfeeding support and management of complex breastfeeding issues.

Support for including prescribing in the practice requirements was divided with some responses advocating its inclusion whilst others considered that prescribing was a skill that required further postgraduate education. There was consistent support for ensuring graduates were able to undertake perineal repair. Some responses indicated that theoretical preparation for this skill using simulation may be required where access to clinical experience was limited.

A number of responses indicated that additional time would be needed in pre-registration programs to achieve competence in the full scope of midwifery. Several responses suggested that it was timely to consider the need for a four-year bachelor degree. It was highlighted that some workplaces did not currently support the level of autonomy inherent in the ICM definition. One respondent argued,

> *'we need to educate midwives in accordance with the internationally recognised definition of a midwife and not outdated industrial restrictions. We are educating midwives for the future that will need all of these skills to provide care in midwifery led continuity of care models.'*

While a number of responses considered that it was important for all stakeholders to have a shared understanding of what should be included in the scope of practice, the following quote from a stakeholder argues for a less prescriptive approach.

> *'The accreditation standards do not necessarily need to contain a comprehensive list of specific skills that students must achieve as this carries the risk of limiting the scope of practice, rather the accreditation standards should be enabling graduates to provide safe and competent care in all midwifery contexts. This can be achieved by ensuring that the learning outcomes address the NMBA midwife standards for practice.'*

The role of the accreditation standards in sustaining the quality of midwifery pre-registrations education across Australia was highlighted in the following response.

> *'Of note, as the accreditation organisation, ANMAC is recognised as the governing body who safe guard against programs being watered down to save money at higher education institution levels. Having an organisation that stipulates the national standard for education providers to follow supports academics at university level.'*

Overall Stakeholder response

A majority of respondents agreed that the revised midwifery accreditation standards should ensure that students in pre-registration programs are educated to meet the full scope of midwifery practice.

Question 3

How can the accreditation standards best support inter-professional learning (IPL)?

All responses coded to this question supported the continued inclusion of IPL in the standards. Some responses advocated that IPL should be a mandated requirement in the Standards. It was thought to be important not to '*stipulate the how and when, but leave that to the flexibility and creativity of the education provider'*. Appropriate assessment of the learning by all those involved was considered essential and it was thought that the Evidence Guide accompanying the Standards could give examples of a range of best practice approaches for the benefit of program providers. Simulated experiences as well as practice-based experiences were thought to be appropriate.

Overall stakeholder response

Respondents provided feedback on how best to support IPL in the revised midwifery accreditation standards.

Question 4

What additional issues should be addressed in the revision of the standards that have not been considered in this consultation paper?

A number of issues were identified by stakeholders. They are listed below together with a brief summary of the responses.

Aboriginal and Torres Strait Islander Peoples

Seventeen responses were coded to this issue. A number of responses supported the use of CATSINaM publications Position statement: Embedding cultural safety across Australian nursing and midwifery (2017) and The Nursing and Midwifery Aboriginal and Torres Strait Islander Health Curriculum Framework (Version 1.0) (2017) in strengthening the standards to ensure a nationally consistent and adequately resourced approach to cultural safety training (students and academics) across midwifery programs in Australia. It was also argued that strengthening the affirmative action requirements in the standards was crucial to growing the First Peoples midwifery workforce.

One response considered that there was a need to strengthen the capabilities of midwifery students to care for Indigenous women and families. Another response was not supportive of the inclusion of the discrete unit on Aboriginal and Torres Strait Islander health and argued that the focus should be on a cultural safety and multicultural care for all cultures.

Social model of health

Three responses advocated the adoption of a social model of health rather than a biomedical model to underpin midwifery curricula. This approach was thought to strengthen midwives' ability as primary care providers.

Governance/midwifery leadership

A number of responses identified that revised standards should be strengthened with regard to leadership of pre-registration midwifery programs. Close alignment with the ICM standards was advocated. The preference across submissions was for the leader of program to be a midwife, with a PhD, appointed at the Associate Professor level, with a defined and visible role within the university.

One submission considered that it was essential to define some of the wording currently used in relation to midwifery leadership in the Standards. For example, 'contemporary' in 7.6 '… strong links with contemporary midwifery education and research' and 'active involvement' in 7.6 '…maintains active involvement in the midwifery profession'.

One submission stated:

> *'Findings from a recent Delphi study conducted with Australian and New Zealand academics found that lack of visible midwifery leadership was a key challenge facing midwifery education. This limits the opportunity to advocate for best practice and adequate resources in midwifery education within the university sector where midwifery is often a minority group- often consumed within nursing'.*

Respondents agreed that registered midwives who were teaching in midwifery programs should have acquired a masters or a PhD level of education. The question of whether or not midwifery academics should be undertaking clinical practice was raised. Also, with some University's currently moving towards teaching specialist roles, it was thought timely to discuss whether or not a minimum percentage of research active academics, and academics with contemporary clinical experience are required in the staffing profile of the program provider.

ICM Standards

A number of responses identified a need for the revised standards for midwifery programs to be consistent with the following ICM documents/definitions:

- global standards for midwifery education
- definition of the Scope of Midwifery Practice
- essential competencies for midwives
- in particular the following issues were highlighted:
- minimum length of three years for an undergraduate pre-registration midwifery program
- the minimum length of the pre-registration midwifery program for registered nurses should be at least 18 months full time
- curriculum should contain a minimum of 40% theory and 50% practice.
- Bachelor of Midwifery sole pathway to registration

Benchmarking

Ten responses cited the need to benchmark the following aspects of the Standards:

- standards should be commensurate with other similar OECD nations (United Kingdom [UK], New Zealand [NZ], Canada)
- there should be uniformity of the requirements for CoCE across program providers
- equity of clinical experiences for all midwifery students regardless of place of education (stated that not all pre-registration midwifery students had equal opportunity and access to all models of care)
- 4-year undergraduate program to align with current international programs (UK & NZ) where midwives' complete additional clinical placement to consolidate skills – such as an intern year

Content

There was considerable feedback in relation to the content that respondents believed should be included in the standards. The feedback identified there should be more emphasis on the following:

- postnatal care
- health informatics
- perinatal mental health
- stillbirth
- impact of the social determinants of health on maternal and infant well-being
- family violence
- self-care for the midwife
- women's sexual and reproductive health
- vaccination knowledge and practice

Some respondents argued that the revised standards should support the inclusion of practice experience in water birth, home birth and Indigenous birthing models of care. Reflection on how to address the higher than the OECD average rate of third and fourth-degree perineal lacerations experienced by birthing women was also considered important.

Quality of practice experiences

The need to ensure the quality of practice experiences was identified. The following issues were raised:

- access to diverse practice learning experiences (public, private, community, home birth, MGP, rural, remote, international)

- facilitated student exchange between metropolitan tertiary institutions and regional and remote areas
- program providers to ensure competent and effective supervisory staff
    - comprehensive training for midwives supervising learners
    - academics/midwives supervising learners have up-to-date clinical knowledge/practice experience
    - preceptors/mentors have postgraduate qualifications
- appropriate ratios of learners to supervisors to women receiving care
- clinical practice experiences sequenced to ensure learners have appropriate theoretical knowledge prior to commencing practice experience.
- use of a tool to measure the quality of the clinical learning environment from the student's perspective (e.g. MidSTEP)
- evidence of appropriate management of professional placements, particularly for CoCE due to its ad-hoc nature in comparison to structured placements

One respondent wrote this (information on management of professional placements)

> *'…needs to include evidence of appropriate student clinical facilitation, student feedback/assessment, availability of 24/7 student/venue support, measures for recruitment and support of women, and safety measures in place for students being called in for births in the middle of the night.'*

Rural and remote

Issues associated with undertaking midwifery education in a rural and/or remote area or educating midwives for practice in rural and/or remote areas have been discussed under the relevant coding categories.

Reference documents

CATSINaM (2017a) Position statement: Embedding cultural safety across Australian nursing and Midwifery.

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