Australian Nursing & Midwifery Federation

australian nursing and midwifery federation

Submission to the Australian Nursing and Midwifery Accreditation Council (ANMAC) consultation on the Review of the Midwifery Accreditation Standards

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1. Introduction

Established in 1924, the Australian Nursing Federation (ANF) is the largest professional and industrial organisation in Australia for nurses and midwives, with Branches in each State and Territory of Australia. Reflecting membership from both the nursing and midwifery professions, the Federation has recently changed its name to the Australian Nursing and Midwifery Federation. The core business of the ANMF is the professional and industrial representation of our members and the professions of nursing and midwifery.

The union has membership of over 230,000 nurses, midwives and assistants in nursing. Members practice in a wide range of settings across urban, rural and remote locations, in both the public and private health and aged care sectors.

The ANMF takes a leadership role for the nursing and midwifery professions by participating in the development of policy relating to: nursing and midwifery practice, professionalism, regulation, education, training, workforce, and socio-economic welfare; health and aged care, community services, veterans' affairs, workplace health and safety, industrial relations, social justice, human rights, immigration, foreign affairs and law reform.

Safe and competent care for birthing women and their babies in Australia is of paramount importance. The ANMF supports the Five Year Vision set out in the National Maternity Services Plan 2011:

> *Maternity care will be woman centred, reflecting the needs of each woman within a safe and sustainable quality system.*[1]

It is imperative that the accreditation system ensures that midwifery education and subsequently registered midwives have the capability to provide all aspects of maternity care.

The ANMF has had a long standing interest in the preparation of midwives for practice. This has been demonstrated through the significant role we continue to play in the development and review of accreditation standards for nursing and midwifery programs. Given our keen interest in this area, the ANMF welcomes the opportunity to participate in the current review of the midwifery accreditation standards to ensure that all Australian women have available to them a competent and accessible midwifery workforce.

The ANMF applauds the Australian Nursing and Midwifery Accreditation Council's (ANMAC) endeavour to acknowledge and safe guard the discreteness of both the nursing and midwifery professions, whilst seeking consistency and commonality of accreditation standards wherever possible.

The commentary to follow is in response to the matters raised in the ANMAC *Review of the midwifery accreditation standards: First Consultation Paper.*

1 National Maternity Services Plan, Commonwealth of Australia, 2011. piii

2. General Response to the Consultation Paper

The following statement in the Consultation Paper is fully supported by the ANMF:

> *The objective of entry level programs is to ensure graduates are able to meet the NMBA approved competencies to practice safely and competently in the context of the current Australian health environment (p.3).*

The ANMF wishes to highlight and make commentary on points made in the Consultation Paper.

Points made on page 7:

- The increasing maternal age of women, and the increasing incidence of maternal obesity, and rates of chronic illness, referred to in the Paper are an important indicator of the requirement for the Australian midwifery workforce to be multi-skilled, with an ability to provide all levels of maternity care.

- The ANMF supports the ongoing development of continuity models of midwifery care. We consider access to a known midwife ought to be available for all pregnant and birthing women regardless of the presence of clinical risk factors.

- Health Workforce Australia has demonstrated that the midwifery workforce is in balance and predicts that it will remain so until 2025.

- ANMF members have advised that: single registration midwives have greater difficulty accessing employment than dual registration midwives; and single registration midwife graduates experience more difficulty accessing a "graduate year" transition to practice program.

- The Consultation Paper states that there are "increasing numbers of registered midwives without a nursing registration". Whilst this is correct, the percentage of registered midwives without nursing registration remains very low. It should be noted that currently in Australia the cohort of practicing midwives without nursing registration is approximately 7% of the midwifery workforce.[2]

Points made on page 10:

- This section of the Paper refers to alignment between the ANMAC *Midwifery Accreditation Standards* and the World Health Organisation (WHO) *Global Standards for the initial education of professional nurses and midwives*. The ANMF questions the need for this alignment and notes that this requirement is not made of the *Registered Nurse Accreditation Standards 2012*.

- In the absence of any evidence, it is noted that the development of the ANMAC draft *Midwifery Accreditation Standards* has relied on minimum practice requirements used by New Zealand and the United Kingdom (UK). The ANMF contends that Standards in existence and utilised for course accreditation prior to changes made in 2010, produced competent, safe midwives for the Australian context.

2 NMBA News for Nurses and Midwives Issue 5 – July 2013 p3

Point made on page 14:

Research from the UK in relation to continuity of care experiences is quoted here. It must be noted that population density in most parts of Australia is significantly different to the UK, making the achievement of continuity experiences in Australia subject to extensive travel.

Point made on page 19:

The UK, New Zealand and the International Council of Midwives (ICM) pre-registration midwifery program standards are used in this section as the baseline for discussion on the length of program and the ratio of practice to theory. The ANMF contends that there should be no ratio of theory to practice as there is no evidence to support this approach. There is risk, if the ratio is relied upon, of a reduction in theory hours to achieve equivalence with clinical hours, thereby reducing the overall hours in a program. Stipulating minimum practice requirements is enough of a safety net to ensure that adequate clinical preparation will be provided without compromising the potential theoretical component of the program.

Point made on page 26:

The paper states that Direct entry midwifery programs were, in part, developed with the aim to improve workforce flexibility. The ANMF maintains this has not occurred. Rather, workforce flexibility has been achieved through the continuing provision of the dual degree and postgraduate pathways for registered nurses to midwifery registration. The ANMF is not aware of evidence which indicates that Bachelor of Midwifery courses will experience significant growth in Australia during the next 10 years.

3. Specific Response to Consultation Paper Questions

Question 1:

Demographics of Australian Nursing Federation members

The ANMF holds the largest membership of registered midwives and student midwives in the country. Subsequently, as noted above, the Federation has recently taken the necessary steps to amend our name, to reflect this cohort of our membership, to the Australian Nursing and Midwifery Federation (ANMF).

In March 2013,[3] the total number of registered midwives in Australia was 35,808. Of these registrants, 2,629 hold midwife only registration. The remaining 33,179, hold dual registration as a nurse and midwife. The ANMF currently has over 19,000 members registered as midwives.

3 NMBA News for Nurses and Midwives Issue 5 – July 2013 p3

Question 2:

Version 1 DRAFT midwifery accreditation standards.

PROPOSED CRITERIA for enabling intraprofessional and interprofessional learning. (Criteria 2.4 (i) and (h); 3.5 and 8.4)

The program provider demonstrates:

- **Teaching and learning approaches that:**
  - **promote emotional intelligence, communication, collaboration, cultural safety, ethical practice and leadership skills expected of registered midwives**
  - **incorporate an understanding of, and engagement with, intraprofessional and interprofessional learning for collaborative practice.**
- **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.**
- **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.**

Q2: Are the above criteria collectively appropriate to enable intraprofessional and interprofessional learning?

ANMF Response:

a) Yes, these criteria are appropriate, but we suggest the following amended wording as enhancements:

The program provider demonstrates:

- Teaching and learning approaches that:
  - promote emotional intelligence, communication, collaboration, cultural safety, ethical practice and leadership skills expected of registered midwives **whilst maintaining maternal and foetal well-being (both physical and environmental)**
  - incorporate an understanding of, and engagement with, intraprofessional and interprofessional learning for collaborative practice.
- **That each student is provided with the opportunity for** interaction with other health professions to support understanding of the multi-professional health care environment and facilitate interprofessional learning for collaborative practice.
- **That each student is provided with the spectrum of midwifery practice experiences within all settings (including tertiary level maternity care) giving** opportunities for intraprofessional and interprofessional learning and the development of knowledge, skills and behaviours for collaborative practice.

The ANMF considers it is essential to maintain a midwifery and medical workforce who can work co-operatively in a seamless manner. The New Zealand experience has indicated a need for ongoing communication between midwives and medical officers, as seen in the following quote:

> *…there is extensive literature around the need for effective teamwork in order to provide safe and effective healthcare. Midwives and obstetricians are frequently required to work closely together in order to deliver safe and high quality maternity services for women.*[4]

Question 3:

Version 1 DRAFT midwifery accreditation standards.

PROPOSED CRITERIA to guide development of midwifery student competency across all-risk models of midwifery care. (Criteria 8.3, 8.4, 8.5 and 8.6)

The program provider demonstrates:

- **Midwifery practice experiences provide timely opportunities for experiential learning of curriculum content that is progressively linked to the attainment of the current National Competency Standards for the Midwife.**
- **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.**
- **Effective and ethical recruitment processes that enable women to participate freely in the continuity of care experiences for students, and enable students to engage readily with women who consent to participate.**
- **Clearly articulated models of supervision, support, facilitation and assessment are in place, including for continuity of care experiences, so students can achieve the required learning outcomes and current National Competency Standards for the Midwife.**

Q3: Do the above criteria 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?

ANMF Response:

The ANMF agrees these standards provide guidance to develop midwifery student competence across all-risk models of care but **only** if clarification and definitional changes are made as per the following commentary.

The ANMF is concerned that no definition exists for “all-risk models of midwifery care”. The ANMF suggests the following as a definition or alternative wording: “midwifery practice for all pregnant and birthing women, including those with complex pregnancy care needs”.

The words ‘continuity of care’ and ‘continuity of carer’ need to be defined. Our interpretation is that ‘continuity of care’ means care is ongoing, coordinated with the woman and the health professional providing the care at the time of presentation, as per the care plan. Whereas, ‘continuity of carer’ allows for the **same** person to provide the care, in collaboration with the woman.

4 Wellington Area Maternity Review Report for Ministry of Health – October 2008 p. 38.

To meet Standard 8.4, it is stated that "the student is to develop, knowledge and skills for collaborative practice." As it currently reads in the draft, there is an assumption that collaborative practice is the relationship between the primary carer and the woman. For inter-professional learning, there needs to be an acknowledgement of the relationship between the medical workforce (including General Practitioners and Obstetricians), the midwife and the woman. The curriculum should provide the midwifery student with the opportunity to participate in/observe the provision of care within a multidisciplinary framework.

We suggest including an additional dot point stating:

- Clearly articulated models of supervision, support, facilitation and assessment are in place, and provide for all-risk models of care, including continuity of care experiences, so students can achieve the required learning outcomes and current *National Competency Standards for the Midwife*.

If the above points are included the Standard will then be able to met with a 'yes'.

Question 4:

Q4: Should minimum requirements for what constitutes 'engagement' in a continuity of care (CoC) experience be stipulated within the midwifery accreditation standards?

ANMF Response:

a) No, minimum requirements for CoC experiences should not be stipulated.

The ANMF supports the implementation of continuity models of care to enable women access to a known midwife for her pregnancy birth and postnatal journey. However, it is our experience that the existing requirements for students of midwifery are unnecessarily onerous. This has resulted in negativity towards this model of care as an employment option. Whilst it is critical that students gain an understanding of the nature and benefits of continuity of care there are a variety of ways in which this experience can be gained. It would be appropriate for the standard to indicate the importance of CoC experience and the fact that it can be gained through a variety of situtations. It is the ANMF's position that it is unnecessary and deleterious to mandate the number and type of continuity experiences that a student of midwifery is required to undertake.

Question 5:

This question is about developing a shared understanding of what constitutes 'being with' a woman as she gives birth. The current midwifery accreditation standards describe this as:

> ***…where the midwifery student is directly and actively involved with the woman as she spontaneously gives birth to her baby vaginally and includes attending to third stage and initial mother and baby interaction.***

Q5: During midwifery students' practice experience, does this definition match what is being regarded as 'being with' a woman as she gives birth?

ANMF Response:

b) No, this definition does not match what is regarded as 'being with' a woman when giving birth.

The ANMF suggests removal of the words "directly and actively involved" as this terminology is subject to interpretation, and for clarity, replacement with the term "accoucheur".

In addition, the ANMF contends that "attending to …initial mother and baby interaction" is one element in the care a midwife provides after third stage, (formerly known as the "fourth stage of labour"). We suggest therefore that "being with woman" in this context stipulates the heightened observation of mother and baby. This is a critical midwifery action at this time to enable the identification and management of any signs of complication.

The suggested amended definition is as follows:

> ***…where the midwifery student is the accoucheur for the woman as she spontaneously gives birth to her baby vaginally and includes attending to delivery of the placenta, and the initial, heightened observation of the mother and baby to identify and manage any signs of complication and facilitating their interaction.***

Question 6:

Q6: 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?

ANMF Response:

b) Some minimum requirements should continue to be stipulated.

Question 6:

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

Please provide a reason for your response.

Type and number of minimum midwifery practice requirements

(i) ??* (currently 20) continuity of care (CoC) experiences. Specific requirements of these experiences include: (with a-g following)

ANMF Response:

Change - there should be no minimum number of Continuity of Care (CoC) experiences **prescribed**.

This does not mean that there should be no continuity of care experiences in the program, however, the number and detail can be determined by the program provider. The student outcome of an understanding of the benefits to women of this model of care is of more importance than prescribing a minimum number.

a)	**enabling students to experience continuity with individual women throughout pregnancy, labour and birth and the postnatal period, irrespective of the availability of midwifery continuity of care models**

ANMF Response:

Change - attendance at the birth is desirable but is not always possible. It is possible to experience the nature and benefits of continuity models of midwifery care as a student without the obligation to be present for 20 hours of the care per woman. The definition of CoC requires further discussion.

b)	**participation in CoC experiences involving contact with women throughout pregnancy and continuing after birth**

ANMF Response:

No change.

c)	**supervision by a midwife (or in particular circumstances a medical practitioner qualified in obstetrics)**

ANMF Response:

Change – with a significant reduction of the number of CoC experiences required, to a realistically attainable level, the need for supervision which is not provided by a midwife should be extremely limited.

d)	**consistent, regular and ongoing evaluation of each student's CoC experiences**

ANMF Response:

No change.

e)	**CoC experiences distributed across the program and with the student fully involved in providing midwifery care with appropriate supervision**

ANMF Response:

No change - with a significant reduction of the number of CoC experiences required to a realistically attainable level this should be achievable.

f)	**engagement with women during pregnancy and at antenatal visits, labour and birth as well as postnatal visits according to individual circumstances. Overall, it is recommended that students spend an average of ??* (currently 20) hours with each woman across her maternity care episode**

ANMF Response:

Change – It is the ANMF view that a minimum number CoC experiences should not be specified and that experience in continuity models should be redefined. The numbers of hours should not be defined but rather determined by the supervising midwifery team as part of the student's clinical plan.

However, should the existing model be maintained, 20 is an excessive number of hours therefore, suggest the number of hours should be halved to 10.

g)	**provision by the student of evidence of their engagement with each woman**

ANMF Response:

No change.

(ii) Attendance at ???* (currently 100) antenatal visits with women, which may include women being followed as part of CoC experiences.

ANMF Response:

There is an absence of evidence to guide specification of minimum clinical requirements. Rather than quantifying clinical practice, ideally we should focus on having an outcomes based approach. The ANMF contends that 100 antenatal visits is excessive and that there should be no such onerous requirement. Should this approach be perpetuated, however, we would recommend the requirement is at least halved to 50.

(iii) Attendance at ???* (currently 100) postnatal visits with women and their healthy newborn babies, which may include women being followed as part of CoC experiences.

ANMF Response:

There is an absence of evidence to guide specification of minimum clinical requirements. Rather than quantifying clinical practice, ideally we should focus on having an outcomes based approach. The ANMF contends that 100 postnatal visits is excessive and that there should be no such onerous requirement. Should this approach be perpetuated, however, we would recommend the requirement is at least halved to 50.

(iv) 'Being with' ??* (currently 40) women giving birth, this may include women being followed as part of CoC experiences.

ANMF Response:

There is an absence of evidence to guide specification of minimum clinical requirements. Rather than quantifying clinical practice, ideally we should focus on having an outcomes based approach. The ANMF contends that following 40 women through pregnancy, birth and the postnatal period is excessive. Should this approach be perpetuated, however, we would recommend this requirement is halved to 20.

The ANMF understands that a primary purpose of accreditation standards is to ensure that graduates are safe and competent for practice. Prior to implementation of the 2010 Accreditation Standards, student midwives undertaking postgraduate midwifery programs were required to be the accoucheur for 20 births and to observe a number of complicated births. Having met that requirement and passed their examinations, the midwives who graduated from these courses were deemed competent to practice. The ANMF believes that a requirement for students to "be with" 40 women giving birth is not necessary to ensure safe and competent midwifery practice.

(v) Experience of caring for ??* (currently 40) women with complex needs across pregnancy, labour and birth, and the postnatal period, which may include women the student is following through as part of their CoC experiences.

ANMF Response:

There is an absence of evidence to guide specification of minimum clinical requirements. Rather than quantifying clinical practice, ideally we should have an outcomes based approach. The ANMF contends that experience of caring for 40 women with complex needs is excessive. We recommend no prescription of quantity.

However, if minimum requirements are specified, we would support a requirement of caring for no more than an additional 20 women in labour and this would include women with complex pregnancies and/or labour and/or birth.

(vi) Experience in the care of babies with special needs (currently no minimum number specified).

ANMF Response:

No change. However, "babies with special needs" should be altered to babies whose clinical needs are greater than normal, for example, require admission to a special care nursery.

(vii) Experience in women's health and sexual health (currently no minimum number specified).

ANMF Response:

No change.

(viii) Experience in medical and surgical care for women (currently no minimum number specified).

ANMF Response:

No change.

(viii) Experience in medical and surgical care for women (currently no minimum number specified).

ANMF Response:

No change.

(ix) Experience in (a-i currently have no minimum numbers specified):

a) antenatal screening investigations and associated counselling

b) referring, requesting and interpreting results of relevant laboratory tests

c) administering and/or supplying medicines for midwifery practice (however authorised to do so in the jurisdiction of practice)

d) actual or simulated midwifery emergencies, including maternal and neonatal resuscitation

e) actual or simulated vaginal breech birth

f) actual or simulated episiotomy and perineal suturing

g) examination of the new born

h) provision of care in the postnatal period up to four to six weeks following birth, including breastfeeding support

i) perinatal mental health issues including recognition, response and referral.

ANMF Response:

Point b) should be removed, and point c) amended to remove reference to 'supplying' medicines as these are scope of practice issues for student midwives. Point h) should be amended to remove reference to breastfeeding support and an additional point (j) added as follows:

j) provision of breast feeding support from birth throughout postnatal period.

No specified minimum numbers is supported.

Question 8:

Version 1 DRAFT midwifery accreditation standards.

PROPOSED CRITERION for 'Standard 4. Program content' to facilitate development of midwifery students' understanding of woman-centred midwifery and the midwife's role in supporting women's right of informed choice.(Criterion 4.5)

The program provider demonstrates:

- **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 and support the woman's informed choices.**

Q 8: Is this standalone criterion required to facilitate development of a woman-centred approach in midwifery practice?

ANMF Response:

a) Yes, the addition of this new criterion is required to facilitate the development of a woman centred approach in midwifery practice.

Suggest inclusion of an addition to the statement as follows:

- 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 and support the woman's informed choices, **provided that the woman's choice is not opposed to either midwifery or medical evidence based advice.**

Please provide a reason for your response.

Facilitating midwifery students understanding of woman-centred care is consistent with the teaching and learning approach that should underpin the development of all midwifery curricula. This requirement should be expanded to state that information should not only be 'relevant' but should also be 'unbiased' and 'complete' to ensure that both risks and benefits are outlined to support the woman's informed choice/s.

Question 9:

Version 1 DRAFT midwifery accreditation standards.

PROPOSED CRITERIONto guide program development and structure.(Criterion 3.7)

The program provider demonstrates:

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

Q 9: What should the midwifery accreditation standards specify in regard to postgraduate program minimum length?

ANMF Response:

a) 12 months.

Please provide a reason for your response.

The ANMF is unaware of evidence indicating that the 12 month postgraduate midwifery program is of insufficient length or has produced unsafe and incompetent midwifery graduates. With a substantial reduction of the specified minimum midwifery practice requirements to a realistically attainable level there should be no need for the program length to be extended. Any extension of program length for registered nurses would only serve to negatively impact the available midwifery workforce, the effects of which would be greatest in regional and rural areas.

The 2010 Accreditation Standards significantly increased the specified minimum midwifery practice requirements to what has proven to be, in many instances, an unattainable level. There was, and is, no demonstrable need for the program length to be extended.

The length of the program should be 12 months full-time, utilising the entire year (not a university calendar) to achieve the learning outcomes for a competent novice.

Based on member feedback, the ANF believes that increasing the length of the postgraduate program will negatively impact the viability of many such programs. Adverse impacts will be felt most keenly in rural and regional areas.

Were an 18 month postgraduate program to be implemented, it is anticipated that student numbers would decline due to:

a) difficulties faced by small employers in releasing registered nurses for study purposes; and

b) work-life balance issues experienced by registered nurses required to spend additional time away from family and work.

Question 9:

Version 1 DRAFT midwifery accreditation standards.

PROPOSED CRITERION to guide program development and structure. (Criterion 3.8)

The program provider demonstrates:

- **Theory and practice must be integrated throughout midwifery programs in equal proportions (50% theory and 50% practice).**

Q10: Should the ratio of theory to practice in the curriculum be specified within the midwifery accreditation standards?

ANMF Response:

b) No, the ratio of theory to practice should not be specified.

Go to Question 12

Please provide a reason for your response.

The minimum number of midwifery practice requirements and experience specified will ensure that students will attain sufficient midwifery experience across the continuum of midwifery care. For consistency with the *Registered Nurse Accreditation Standards 2012*, no theory to practice ratio should be specified. The ANMF argues this is an artificial and outdated 'split' which does not fit with contemporaneous midwifery practice. This approach does not consider the practical components that are sustained during the clinical experience.

Question 12:

Version 1 DRAFT midwifery accreditation standards.

PROPOSED CRITERIONto guide program development and structure.(Criterion 3.9)

The program provider demonstrates:

- **A minimum of ????* hours of midwifery practice experience, not inclusive of simulation activities, incorporated into the program and providing exposure to a variety of health care settings.**

***To be determined**

Q12: Please consider in conjunction with your responses to Q9 and Q11. Is a criterion that specifies the minimum number of hours for midwifery practice (clinical) experience required in the midwifery accreditation standards?

ANMF Response:

a) No, a specified minimum number of midwifery practice experience hours is not required, as this does not equate with quality of experience.

Question 13:

Q13: 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?

ANMF Response:

b) Yes, it is necessary for the standards to be explicit regarding the use of simulation.

Please provide a reason for your response and if you answered 'yes', please also specify what you consider is required in the midwifery accreditation standards to make explicit the use of simulation in terms of the curriculum's clinical or theoretical hours.

The explicit use of simulation should be consistent with the requirements in the *Registered Nurse Accreditation Standards 2012.* As is the case for students of nursing, there are concerns that, without clarification, simulation could be used to replace clinical hours within midwifery curricula.

Question 14:

Version 1 DRAFT midwifery accreditation standards.

PROPOSED CRITERIA to develop competence in the midwifery care of Aboriginal and Torres Strait Islander women and their families. (Criteria 1.5, 3.1 and 4.7)

The program provider demonstrates:

- **Terms of reference for relevant school committees and advisory and / or consultative groups, including partnerships with Aboriginal and Torres Strait Islander health professionals and communities.**
- **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.**
- **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 into other subjects across the curriculum.**

Q14: Are these criteria collectively sufficient to support the development of culturally competent midwifery practice?

ANMF Response:

a) Yes, these criteria provide sufficient support for the development of culturally competent midwifery practice.

The ANF insists that this remain exclusively Aboriginal and Torres Strait Islander focused.

Question 15:

Version 1 DRAFT midwifery accreditation standards.

PROPOSED CRITERIA to support Aboriginal and Torres Strait Islander people entering the midwifery workforce.(Criteria 6.8 and 7.4)

The program provider demonstrates:

- **Aboriginal and Torres Strait Islander peoples are encouraged to enrol and a range of support needs are provided to those students.**
- **Staff recruitment strategies:**
  - **o are culturally inclusive and reflect population diversity,**
  - **o take affirmative action to encourage participation from Aboriginal and Torres Strait Islander peoples.**

Q15: Are these criteria collectively sufficient to support Aboriginal and Torres Strait Islander people entering the midwifery workforce?

ANMF Response:

a) Yes, these criteria provide sufficient support for entry to the midwifery workforce.

Question 16:

Version 1 DRAFT midwifery accreditation standards.

PROPOSED CRITERIA to support the development of competency in midwifery care for women experiencing high risk pregnancy and childbirth.(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).

The program provider demonstrates:

- **A map of subjects against the current National Competency Standards for the Midwife which clearly identifies the links between learning outcomes, assessments and required graduate competencies.**
- **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.**
- **A comprehensive curriculum document, based on the conceptual framework discussed in Standard 2, that includes:**
- **linkages between subject objectives, learning outcomes and their assessment and the national competencies,**
- **a midwifery practice experience plan across a variety of midwifery practice settings.**
- **The central focus of the program is on midwifery and contemporary midwifery practice; this comprises how woman-centred midwifery 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.**
- **Inclusion of subject matter that gives students an appreciation of the diversity of Australian culture and develops their knowledge of cultural respect and safety.**
- **Midwifery practice experiences provide timely opportunities for experiential learning of curriculum content that is progressively linked to the attainment of the current National Competency Standards for the Midwife.**
- **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.**
- **Minimum midwifery practice experience requirements**
- **Experience of caring for ?? (currently 40)women with complex needs across pregnancy, labour and birth, and the postnatal period, which may include women the student is following through as part of their continuity of care experiences.**
- **Experience in the care of babies with special needs.**
- **Experience in medical and surgical care for women.**

***To be determined**

Q16: Please consider in conjunction with your responses to Questions 6 and 7 (ie whether or not to stipulate the minimum midwifery practice experience requirements).

Do the above standards 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?

ANMF Response:

a) Yes, these criteria guide the development of student competency in the care of women and babies with complex needs.

The ANF suggests the inclusion of an additional point as follows:

- A midwifery practice experience plan across a variety of midwifery practice settings which involves a range of low and high risk pregnant women.

As noted in our responses to Q6 and Q7, some minimum requirements are supported and our rationales are detailed above.

As also mentioned earlier, the ANMF believes that midwives must be competent to effectively identify variance from normal and to collaborate with medical officers to manage unwell women.

The New Zealand Ministry of Health has recommended that all staff involved in the care of pregnant women should undertake regular training in the management of obstetric emergencies.[5] The ANMF believes that these priorities must be reflected in the Australian midwifery curriculum.

Question 17:

Q17: 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?

ANMF Response:

a) No, separate and specific guidance is not required as the same standards should apply to all entry to practice midwifery programs.

Question 18:

Q18: 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?

ANMF Response:

a) No, specific criteria for Dual Degrees is not required.

5 Perinatal and Maternity Morbidity in NZ in 2006. 2nd Report to the Minister for Health June 2007 – June 2008.

Question 19:

Version 1 DRAFT midwifery accreditation standards.

PROPOSED CRITERION to facilitate the midwifery student's transition to practice as a graduate midwife.(Criterion 3.12)

The program provider demonstrates:

- **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.

Q19: Within the context of accreditation standards for entry to practice midwifery programs: Is this criterion sufficient to facilitate the midwifery student's transition to practice as a graduate midwife?

ANMF Response:

a) Yes, this criterion facilitates transition to practice.

a) However, it should be acknowledged in the criterion that midwifery practice experience should be a continual learning experience which is integrated and consolidated throughout the program. Therefore, the journey through the midwifery program will provide a confident and competent novice which enables a smooth and successful transition to midwifery practice as a registered midwife.

Question 20:

Q20: Within the context of accreditation standards for entry to practice midwifery programs: Are there other areas where the draft midwifery accreditation standards – Version 1 require amendment or change to ensure they adequately prepare midwives for beginning practice in the context of contemporary Australian maternity services?

ANMF Response:

There is a need to strengthen reference throughout the draft midwifery accreditation standards – Version 1, to the issues of safety and quality. Focus on a wellness model in midwifery education must be balanced by education in aspects of illness including non-communicable diseases, and co-morbidities of women, particularly with the increase in maternal age, leading to increased complexity of care for women and/or their babies (especially premature babies). The Australian health system requires a midwifery workforce capable of providing safe, quality care, compliant with current National Safety and Quality Health Service Standards. Standard 9 of these national standards, for example, relates to "recognising and responding to clinical deterioration in Acute Health Care."

In a 2010 study, Pollock et al stated that severe maternal morbidity mainly occurs in young and previously healthy women. The occurrence is relatively frequent and the incidence is increasing. A UK prospective study found that 1.2% of all pregnant women (≥ 24 weeks gestation) experienced at least one of the following four serious complications: severe haemorrhage, severe pre-eclampsia, sepsis or uterine rupture. A Victorian record-linkage study found that in 2002, hysterectomy associated with post-partum haemorrhage occurred nearly three times more frequently than in 1999.[6]

6 Pollock, W, Sullivan, E, Nelson, S and King, J. Capacity to monitor severe maternal morbidity in Australia. Australian and New Zealand Journal of Obstetrics and Gynaecology 2008 Vol 48 pp. 17-25.

The ANMF welcomes the work currently being undertaken to improve the quality of maternal morbidity data in Australia and believes that the most up to date information should be considered by ANMAC when determining curriculum priorities for the education of midwives in Australia.

Further commentary relates to amendments required for specific Standards as follows:

Standard 2.1

The ANF recommends that the curriculum be underpinned by principles of safety and quality and risk management. In addition to those stated in Standard 2.1: woman centred philosophy, primary health care principles, and an education philosophy.

Standard 4.2

The ANF notes that in this Standard "international maternity care priorities, research, policy and reform" carries equal weight with "regional and national maternity care priorities, research policy and reform" in determining contemporary midwifery practice.

Whilst it is important for students to gain knowledge of international circumstances, the ANF contends that this should not be a core principle underpinning the curriculum. *The Registered Nurse Accreditation Standards 2012* do not give such weight to international circumstances.

The ANF maintains that the primary focus of the education of midwives in Australia is to provide a workforce for Australian circumstances. The Australian system of maternity care is unique in the world, and whilst some evidence based practices can be adapted to conditions in our country, many other practices are not suitable for the Australian environment.

Standard 4.5

This Standard relates to inclusion of content in the curriculum pertaining to the role of the midwife in the provision of relevant information and support to the woman to enable an informed choice.

The ANF is aware of a number of circumstances where the provision of information to women is inconsistent and this has led to episodes of inter- professional and intra-professional conflict. Two Coroners have found it necessary to make comment on the type of information that should be provided to women and their families as outlined below.

Victorian Coroner Kim Parkinson, in findings into the death of a baby, noted that "the professional obligation is to progress the discussion with the patient." She made a recommendation that "the Minister for Health give consideration to developing… an information resource to enable prospective parents to be fully informed of the issues associated with the various birthing options"[7]

South Australian Deputy State Coroner Schapel, in inquest findings into the death of three babies, recommended: "…education in the form of written advice distributed generally to the public be provided in respect of… matters concerning homebirth".[8]

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7 Finding into the death of Joseph Thurgood-Gates, Coroner's Court of Victoria 10 May, 2013. COR 2010 4851

8 Findings of Inquest into the deaths of Tate Spencer-Koch, Jahli Hobbs and Tully Kavanah 6 June, 2012

The ANF recommends that the curriculum provide greater emphasis on the nature of information provided to women. Information must be complete to enable a woman to make an informed choice. The relevant legislation relating to informed choice should be an integral part of the curriculum, including reference to current legal cases.

Standards 8.1, 8.2, 8.5, 8.6, 8.7 and 8.9

This Standard relates to the Management of Midwifery Practice Experience. Students and women have not been adequately protected by the current Standard. The ANF is aware of a significant number of cases where unethical recruitment of women and work health and safety risks to students have occurred. The research by McLachlan et al[9] supports the widespread anecdotal evidence available to the ANF. The ANF submits that any review of the Continuity of Care experience must also include a review of Standard 8

Glossary and Abbreviations

The ANF submits that this section of the Standards will require review. In particular the terms "being with woman", "continuity of care experience" "woman centred care" and "cultural safety" are currently the subject of consultation within the current Review. Additional terms should also be included following consultation and review: "all-risk models", and "midwifery practice".

9 McLachlan, H, Newton, M, Nightingale H, Morrow, J, and Kruger, G. Exploring the 'follow-through experience': A statewide survey of midwifery students and academics conducted in Victoria, Australia. Midwifer. 2013. Available at: http://dx.doi.org/10.1016/j.midw.2012.12.017

4. Conclusion

The ANMF welcomes the opportunity to contribute to the development of the ANMAC Midwifery Accreditation Standards. As the largest professional and industrial body for midwives within Australia, the ANMF has a significant interest in midwifery education. We consider it imperative that students of midwifery and registered midwives be providing safe and competent care to pregnant and birthing women in this country.

Our interest in this review is then to influence the development of standards for accrediting midwifery programs which will be attainable in their preparatory content, and, lead to the production of registered midwives capable of providing all aspects of maternity care.

The foregoing submission provides advice to the ANMAC for the development of the Midwifery Accreditation Standards. We look forward to further contributing to the review of these Standards through participation in the upcoming workshops. In particular, we will be reiterating our essential message that midwifery programs should prepare safe and competent registered midwives through attainable requirements which reflect contemporary practice within the context of the Australian community.