NMBA public consultation on the Registration standard endorsement for scheduled medicines for eligible midwives October 2014 – Australian College of Midwives' response 19/12/2014

Questions	Feedback
1. Is the content of the draft revised registration standard helpful, clear, relevant and more workable than the current standards?	The draft revised registration standard is generally clear and easy for the practitioner to follow. The Australian College of Midwives (ACM) supports the removal of the requirement for an additional 20 hours of CPD. However, the ACM does not support the amalgamation of the "Eligible midwife registration standard" and the "Registration standard for endorsement for scheduled medicines for midwives" as it then prevents all midwives from attaining an ability to prescribe through their employment in the public sector. This also prevents the possibility of inclusion of the education in pre-registration midwifery programs in the future. The ACM recommends further clarity as to the standard requirements being solely for initial endorsement as an eligible midwife, or ongoing requirements. The ACM questions in particular, is what would occur if midwives receive conditions on their practice once they are endorsed – will this mean automatic loss of endorsement as an eligible midwife regardless of the nature of the conditions?

	The other area of major concern has been the requirement for 3 years full time/5000 hours practice. The ACM questions whether this is a requirement for initial registration for as an eligible midwife or an ongoing requirement The ACM does not support 3 years full time/5000 hours as an ongoing requirement but rather would expect that eligible midwives meet the same requirement as the ongoing registration as all midwives, as per the Recency of Practice Registration Standard.
2. Should the registration standard require an eligible midwife to practice across the continuum of care or should eligible midwives be able to have a specified context of practice listed on their notation?	The ACM strongly supports the retention of practice across the continuum of care in the registration standard. The ACM believes that this registration standard needs to reflect the spirit of the Determination and the National Maternity Services Plan from which eligible midwifery emerged, that is, that consumers want continuity with the same provider/midwife, who they get to know in their antenatal period (build a relationship with), who care for them through labour and birth, through to a period of time (usually 6 weeks) after the baby is born. a. The scope of the practice of the midwife in Australia is the management and care of women with normal pregnancies, labour and birth and the postnatal period up to 6 weeks after the baby is born and where complexities exists for the women and/or baby, consultation and referral as appropriate. The ACM believes very strongly that the profession defines the midwifery scope of practice and not the regulatory requirements associated with access to MBS and PBS. b. Midwifery continuity of carer across the continuum is the gold standard as evidenced by the Cochrane Review on midwife-led care (Sandall et al, 2013).. This is the standard for the provision of maternity care as is evidenced by a number of major studies of which two are Australian (Tracey et al, McLachlan et al). Not only does midwifery continuity of care across the continuum provide the best clinical outcomes, it is cost effective. c. By allowing midwives to practice in certain areas of midwifery, maternity care will become increasingly fragmented for women and babies, and corporatised to enhance 'clinic' practice. This is not only putting the clock back, but it is flying in

	the face of research that clearly demonstrates the benefits of continuity of care and a known provider., as well as the potential risks to safety and quality of care caused by fragmentation. . d. The ACM acknowledges there is a significant interest in midwives having specified context of practice on their notation, in particular, midwives who are also lactation consultants who wish to provide specific postnatal care under Medicare. Nevertheless, the ACM believes it is appropriate for other care providers such as lactation consultants to have their own Medicare arrangements under their own endorsement standards, not through the eligible midwives' standard. e. The ACM has concerns about the impact of specified practice on women, as well as the logistics of monitoring midwife's practice. Is it realistic to expect consumers to go to the AHPRA website to check what an individual midwife can and cannot do? How confident in a midwife's care in general can women be if the midwife only has a notation against one element of practice? What will be the flow on effect, in both quality of care and the woman's confidence in the midwife, if a midwife is only deemed to be competent/knowledgeable in one specified area of care. For example, a large amount of the work a midwife does in the antenatal period is supporting and preparing the women for birth and after the baby is born. If the midwife is only be deemed to be competent with antenatal care, how can the woman (and the NMBA) be sure that the labour/birth, and postnatal preparation work is relevant, accurate and up to date? How easy will it be for midwives to move from one specified context to another? f. Specified context of practice will cause difficulties in relation to diagnostics and prescribing. Eligible midwives are currently able to prescribe from the Formulary so if midwives are only going to be working in one area such as the postnatal area for example, should they have a more limited formulary? For example, midwives who work as lactation consultants only will use approximately four of the 62 drugs on the formulary. The ACM would not support the ability of midwives to prescribe

	in areas in which they are not practising and remaining current. That being said, this raises the question of how midwives' prescribing practice will be tracked and monitored to ensure they do not prescribe outside their area of notation.
3. Is there any content that needs to be changed or deleted in the registration standard?	**Registration as a midwife constituting the equivalent of 3 years full time / 5000 hours within the past 6 years across the continuum of care or specified context of practice.** The ACM does not support the time frame of three year's full time or 5000 hours experience over six years as a prerequisite to endorsement as an eligible midwife. The only difference between a 'midwife' and an 'eligible midwife' is an ability to prescribe to a small formulary and order a limited scope of diagnostic tests for the normal scope of practice of a midwife. The ACM preference is for the three year time frame to be removed. However, the ACM also acknowledges the concerns in some quarters about the appropriateness of new graduates being able to register as eligible midwives. Therefore, the ACM recommends compromise, with regards to newly graduated midwives. The ACM recommends that midwives seeking to become 'eligible' should have a more flexible methodology of endorsement that includes: • Equivalence of two years full time practice before applying for endorsement; • Midwives given a provisional notation for two years, including new graduates, provided they are working in a supported model in the same way as a new GP. a. Midwives are deemed by the NMBA to be competent across the midwifery scope of practice as defined by the International Confederation of Midwives. Midwifery cannot be broken down into niche specialty areas as in some other disciplines, and midwives do not require advanced practice to practice across the full scope. b. There is no evidence demonstrated in this standard to support the notion that years of experience or a period of time is required to develop midwifery skills, especially in a private practice context. The Dreyfus model was developed in the early 1980s based on the study of air force pilots and army tank drivers, and adapted for nursing in 1984 by Benner. It is now dated, is context and discipline

	specific, and does not relate to contemporary midwifery or consider midwifery education and development in Australia. c. The development of competency, knowledge acquisition and application is a holistic process that is individual to each midwife, and cannot be applied or measured in relation to a period of time in practice. Hours of work do not necessarily equate to quality of midwifery care. d. Other documents and frameworks that will impact on the regulation of eligible midwives, such as the Safety and Quality Framework and the NMBA's proposed supervision for midwives model are currently unavailable. It is problematic to be looking at this standard in isolation. The ACM needs to see these documents before we can give informed feedback, as these documents will directly impact on this requirement. e. A model incorporating supported practice for midwives seeking a provisional notation may have the potential to achieve a higher quality of practice through the use of preceptors, structured mentorship program, fostering of professional relationships with complementary skill sets, and providing opportunities to acquire skills in the context of, and specific to, private practice. **Current registration as a midwife in Australia with no conditions on registration relating to unsatisfactory professional performance or unprofessional conduct.** The ACM does not accept the criteria "*Current registration as a midwife in Australia with no conditions on registration relating to unsatisfactory professional performance or unprofessional conduct*" and recommends that the criteria reflects that individual cases will be assessed accordingly. The ACM believes that conditions may not necessarily warrant the loss of notation/endorsement unless it is necessary for the protection of the public that the midwife does not practice. For example, a condition relating to improved record keeping may not prevent a midwife from becoming an Eligible Midwife. Considering the NMBA and APHRA has the ability to effect supervision for private midwives, conditions may not be a reason for the midwife to lose notation.

4. Is there anything missing that needs to be added to the registration standard?	The ACM supports the removal of the approved professional practice review program from the registration standard.. However, ACM still firmly believes that peer review is an important tool for midwives and recommends that this component is appropriately placed as a mandatory requirement elsewhere in the suite of standards/codes for all midwives. The requirement for peer review highlights to the community that there is a process for supporting and monitoring safety and quality of midwifery practice Furthermore, the peer review process in its current form involves consumer input which is important for the support of women-centred midwifery care in partnership with women.
5. Do you have any other comments on the registration standard and options presented?	This standard should be placed on hold until the Safety and Quality Framework, Supervision for Midwives, Standards for Midwifery Practice, Continuing Professional Development Registration Standard, and Recency of Practice Registration Standard are complete.