

Editorial: Reflection on the importance of safe practice



Enjoy reading the views of one of our Council Members, Midwife Kate Cheney, who shares with us her views on collaboration, engagement and understanding professional capabilities.

After a background in high risk antenatal care, in 2008 I moved to work as a Clinical Midwifery Consultant in early pregnancy and this year was appointed as a member of the Nursing and Midwifery Council of New South Wales (Council) to represent Midwifery. The purpose of the Council is to protect the public by ensuring that midwives (and registered nurses) are fit to practice and adhere to professional standards.

My belief is that a registered midwife needs to understand how the profession is regulated and be aware of their professional responsibilities. While, midwifery regulation exists to protect the public in receipt of midwifery care, public safety is the shared responsibility of all health practitioners.

It is a shared responsibility to adhere to professional values and at all times identify and minimise harm to the public, while engaging in and influencing the health system.

Performing below the expected standards of a midwife has ramifications for women, their families and for midwives professionally; and probably personally. Therefore, at the clinical level, being 'accountable' as a midwife is paramount.

Midwives may at times feel like they face challenges in balancing women's personal choices with safe care delivery. The choice of women to have a homebirth is the example often cited. The evidence informs us that there is a small but increasing demand for homebirths and I would like the choice women make about maternity care to be a safe and supported one. Indeed, De Jonge and colleagues, (BJOG 2009), found no major difference between planned home and planned hospital birth; "providing the maternity care system facilitates this choice." In my view, midwives need to be women-centred and use evidence-based practice to provide midwifery expertise.

Midwives work in a variety of settings. These include tertiary hospitals, rural community hospitals, universities, in the community, in the bush and independently. On occasion, we work with good support and sometimes with little or no support. Some environments are combative, while others are nurturing. Guidance for safe practice comes from

the [Standards of Practice established by the Nursing and Midwifery of Australia \(National Competency standards for the midwife\), Code of professional conduct, Code of ethics and Code of professional boundaries for midwives](#). By familiarising ourselves with these guidelines, we can use them to steer our practice in the variety of maternity situations in which we work.

The starting point of how we can ensure our care giving is always safe and professional is:

- Greater collaboration and support of each other
- Using our evidence-based knowledge and skills to the utmost; and
- Ensuring we are aware of the standards expected by the women and their families and by the profession generally.

My message to you, therefore, is to not be daunted by your role as a midwife but rather become fully engaged in the provision of supportive, evidence-based and professional midwifery care.

References:

de Jonge, A., van der Goes, B. Y., Ravelli, A. C., Amelink-Verburg, M. P., Mol, B. W., Nijhuis, J. G., & Buitendijk, S. E. (2009). Perinatal mortality and morbidity in a nationwide cohort of 529 688 low-risk planned home and hospital births. *BJOG: An International Journal of Obstetrics & Gynaecology*, 116(9), 1177-1184.

Why working in a group is safe - not just for women but for midwives too

Hannah Dahlen, Professor of Midwifery at the University of Western Sydney shares her experience of working as a midwife in group practice and the benefits this provides for women and midwives.



I have been a midwife for 25 years and I have always worked in collaboration with other midwives, doctors and allied health workers. In 2010 when midwives, in Australia, gained access to Medicare, the Pharmaceutical Benefits Scheme and insurance; I set up in private practice with four other midwives alongside my role as Professor of Midwifery at Western Sydney University.

Our group practice is called Midwives at Sydney and Beyond, and we are now, five years later, a strong group of six. I would not work any other way. Working in a group is not only fun, but also I think it increases safety, not only for women, but also for us personally as midwives. Midwives who work privately and provide homebirth services in particular, walk a tightrope between women, regulation, and health service bureaucracy. Private midwives are also finding themselves increasingly being reported to the Australian Health Practitioner Regulation Agency (AHPRA). This makes the job of being a private midwife at times exhausting, fearful and conflicted. In order to survive this modern day reality, midwives need to protect themselves in ways that have not previously been required. I wrote an article for the *British Journal of Midwifery* in 2012 called *Homebirth: Ten Tips for Safety and Survival* (Dahlen HG, 2012). Many of these tips were about working together, and here is a summary of what I said.

Many private midwives in Australia work in solo practices. It has been one aspect of our Australian culture. The term 'independent midwife' was commonly used during the 1970s, 80s and 90s; a time when midwives were desperate to shake free of a highly medicalised system and provide another option for women. However, today we realise that none of us are truly independent and I would question the safety of this aim.

When you work alone it leaves you with no respite, no backup and little opportunity for support and peer review. When a labour turns into a marathon of 24 hours or more you cannot give your best to a woman and you will find it much harder to make competent decisions. When you do not have a colleague to turn to or ring to discuss your concerns, it is hard to maintain perspective.

Working in a group provides support, clinical reflection and an opportunity for conversation about care. Meeting regularly with a group of midwives, as we do monthly, helps you to raise issues that may need to be dealt with, to review cases and update clinical skills and knowledge.

We talk frequently to the midwives we are grouped with, in between these monthly meetings and update each other on anything significant after visiting with a client. 'Relationships are the glue' that hold everything together when it comes to sustaining midwifery models of care (Leap, Dahlen, Brodie, Tracy, & Thorpe, 2011). These relationships are vital to the care we provide our clients and facilitate enjoyment and sustainability in our work. We engage with mainstream health services as well, booking all our women into a hospital in case of transfer, if we need advice and additional expertise.

As I look back on 25 years of a wonderful career, being with women has been the best part of it but working together with others is what has made it really fun; whilst providing the elements of quality assurance, reflection and a place to consider safety for both the women, their families and for us as professional midwives.

References:

- Dahlen HG. (2012). Homebirth: ten tips for safety and survival *British Journal of Midwifery*, 20(12), 774-778.
- Leap, N., Dahlen, H., Brodie, P., Tracy, S., & Thorpe, J. (2011). 'Relationships-the glue that holds it together': midwifery continuity of care and sustainability. In L. Davis, R. Daellenbach & M. Kensington (Eds.), *Sustainability, Midwifery and Birth*. New York: Routledge.

The role and scope of the midwife in Australia

Caroline Homer, President of the Australian College of Midwives reflects on the scope of practice of midwives and the significant role midwives play in maternity services across the country.



It is an exciting time to be a midwife in Australia. The profession has experienced a number of years of reform and change, although there is clearly more to come. It is essential that midwives have quality education, both initially and then as a life-long process, are appropriately regulated to ensure safety of the public and are supported in their practice.

On registration, a midwife in Australia is authorised to provide maternity care without medical supervision to women without complications throughout pregnancy, birth and the postnatal period for up to six weeks after their baby is born.

The scope of practice for midwives in Australia is based on the International Confederation of Midwives' (ICM) [definition](#) of a midwife and scope of practice which is endorsed by the Australian College of Midwives (ACM).

ACM's view states that a midwife in Australia, may practise in any setting including the home, in birth centres or free-standing birth units or hospitals, in urban, rural and remote geographical locations. However, regardless of setting, the midwife works in partnership with women and their families to provide woman-centered care and promote normal, physiological pregnancy and birth, with subsequent care for the newborn and infant. The midwife provides care that is culturally safe, respectful and compassionate, providing information based on best practice evidence to support the woman's decision making. This support may extend to the woman's general health, sexual and reproductive health, and parenting practices. The midwife works in collaboration with other midwives and health professionals when needing to access medical care or other assistance, and to facilitate consultation and referral. The midwife carries out relevant emergency measures as appropriate.

The midwife has a role which complies with Australian federal and jurisdictional legislation, regulatory registration standards and requirements, professional guidelines and policies. These include:

- Australian federal and jurisdictional legislation including the [Health Practitioner Regulation National Law Act 2009](#) and subsequent amendments;
- [Nursing and Midwifery Board of Australia \(NMBA\) regulatory documents](#); [Australian College of Midwives' policies and guidelines](#) including the [National Midwifery Guidelines for Consultation and Referral](#);
- Other relevant national and local area professional policies and guidelines.

An individual midwife's scope of practice is dynamic; changing as we gain experience or take on different roles or activities. When deciding if a role, function, responsibility or activity is within the scope of practice, the midwife must comply with the NMBA's

“Decision-Making Framework”. A role, function, responsibility or activity must not be carried out without appropriate education or supervision until such a time that the midwife is deemed to be competent. The midwife ensures the role, function, responsibility and activity is based on best-practice principles, considered to be contemporaneous midwifery practice by the profession, and able to be defended to peers and regulators.

While in many ways, the scope of practice of a midwife is limited, as it is focussed on the childbearing period of women’s lives. However, used to their full capacity, midwives can, will and do play a significant role in providing maternity services across the country. Utilising midwives to the full scope is the challenge facing all health service providers, policy makers and regulators. Equally, it is the responsibility of the midwife to ensure that quality care is provided to women and babies within all the regulations, codes and frameworks. It is indeed an exciting and opportune time to be a midwife in Australia.

Midwifery services in rural and remote areas from an indigenous perspective

Nicole Ramsamy works for the Cape York Health Service District Office in Queensland and shares with us her insight into midwifery services in rural and remote areas from the client’s point of view. Understanding both the client’s experience and some of the challenges faced by midwives in different settings helps the midwifery profession work through barriers to provide quality care and maintain a supportive environment for clients and midwives alike.

While all women in Australia have the right to safe midwifery care, accessing such care close to their own community poses challenges for women in rural and remote communities. This has a significant impact on the women’s experience and role of midwives.



Midwifery services available

There are a small number of government and non-government midwifery service providers that offer antenatal and postnatal midwifery care in rural and remote communities. Some women may have access to private procedural general practitioners (with obstetrics) and midwives who fly in and out of their community. However, because of the lack of access to 24 hour cover from doctors with anaesthetic and obstetric qualifications, the full range of maternity and child services is not available to women in these communities.

Due to the lack of locally accessible services, women have few options available to them other than leaving their communities prior to 36 weeks gestation and travelling to metropolitan areas to await the arrival of their baby. Indeed, those at high risk, for example due to twin pregnancies, are required to leave their communities much earlier than 36 weeks gestation.

This can be an anxious and lonely time for the mother-to-be. The majority of women from remote communities leave their children and partners behind because they cannot afford accommodation and airfares for the family. Women may not be able to afford the upfront costs to stay in apartments and are only entitled to airfares and hostel-type accommodation.

Safety risks

When women travel out of their community for confinement, accessing childbirth education is difficult as antenatal, childbirth and postnatal education can be fragmented and classes are often full. Without access to education, women may experience fear and anxiety as they go into labour with no family support in an unfamiliar environment.

An additional safety risk in rural and remote communities is the challenge of transferring information between service providers. While each service provider has their own health records (medical charts, pathology and sonography services), limited access to health records can be potentially dangerous if there is no communication. Communication may also be challenging when caring for a transient Indigenous population, who move from one community to another and have received very few antenatal examinations.

Midwives therefore play an important role in education, inter-professional collaboration and communication. There may be some continuity of care by midwives' case management. Midwives can also ensure mothers know to keep their own pregnancy health records and ensure these are completed by each health care provider. Antenatal, childbirth and postnatal education can help women to understand their condition, any risk of complications to herself or baby and guide birthing choices.

Maintaining quality care

Midwives are therefore critical to women in rural and remote communities. However, limited maternity services reduce the opportunities for midwives to train and professionally develop their competencies. Increasing professional development leave entitlements for rural and remote midwives to attend conferences, workshops or birth centres could help midwives develop their competencies and stem workforce shortages. This in turn could increase women's access to quality maternity health care and help minimise risks for women and their babies in rural and remote communities.

Case Study One: Safe practice for independent midwives

This case study reflects on safe practice in homebirths and the importance of putting plans in place where complications arise.

Issue: Inappropriate patient treatment and delayed referral to hospital, resulting in the death of a baby.

The Nursing and Midwifery Council of New South Wales (Council) received a complaint about a registered midwife (RM) from a Local Health District raising concerns about a RM's practice.

A second complaint about the RM was also received from the Coroner's Court of New South Wales, who had investigated the death of a baby who had passed away during a home birth procedure. The baby was found to have suffered foetal stress and covered in a large amount of meconium at birth.

The inquest identified a lack of professional advice given by the RM to the mother during the antenatal period about the risks involved in delivering a breech birth at home. The inquest also identified that clinical guidelines on back-up or partnership agreements for home births had not been followed and complications were not referred as



soon as possible to an obstetrician.

The Coroner found that the RM's ideologically dislike of mainstream obstetric care interfered with ensuring that both the mother and baby were appropriately cared for. The mother had been in labour for almost two days before being transferred to hospital for an emergency caesarean, jeopardizing the health of the baby and mother by failing to prepare for an urgent transfer to hospital.

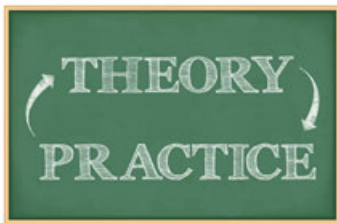
While the complaints are being assessed, the Council placed restrictions on the RM's registration for the safety of the public.

Case Study Two: Is your practice current?

In this case study, failure to maintaining recency of practice meant avoidable mistakes were made with serious consequences.

Issue: Clinical Care - Inappropriate discharge or transfer

The complainant presented at hospital in labour and notified the registered midwife (RM) that she had tested positive for Group B Streptococcus (GBS) positive in her third trimester and handed over her 'yellow card', indicating her positive results from the GBS swab.



The RM put on a trace, took a swab and urine sample to check that membranes had not broken. The RM advised the woman that she was in the early stages of labour, which could last for days and indicated that an internal examination was not necessary at this stage. Although the woman was experiencing intense pain, she was sent home without a vaginal assessment to determine cervical dilation.

Within 15 minutes of arriving home the woman felt the urge to push. Her partner phoned emergency services at 4am and the baby was born half an hour later. The mother and baby were taken to hospital by ambulance. At hospital, the RM failed to discuss with the woman the risks of not receiving IV antibiotics prior to delivery and the possibility of illness after birth.

At three weeks the baby tested positive for late onset of GBS and developed an infection resulting in osteomyelitis and septic arthritis. The baby was put on a course of antibiotic and required extensive treatment over a month.

The matter was referred to the Nursing and Midwifery Council of New South Wales (Council) and the RM attended a Performance Interview at the Council.

The Performance Interview Committee (Committee) discussed that at the time of the complaint, the RM had been a casual midwife at the hospital for a few months, mostly allocated to the antenatal and postnatal units. Although the RM had practised in birthing units in 2011, the RM had only worked two shifts since then due to an extended study break.

The RM was asked by the Committee to reflect on the incident and identify how the RM's responses and level of knowledge could be improved and implemented in practice. The Committee noted that the RM's workplace was providing ongoing support and education to improve performance. The Committee counselled the RM on specific competency standards

and codes of conduct for a midwife and the importance of recency of practice and continuing professional development to safely practice independently.

Case Study Three: Non-practising registration

If you cannot maintain recency of practice, should you move to a non-practising registration?

Issue: Clinical Care - Inadequate or inappropriate treatment and impairment

For 6 years the RM had worked as an independent midwife and as a community Health Education Co-ordinator, co-ordinating Maternal Health community programs in rural NSW.

The RM came to the attention of the Nursing and Midwifery Council of New South Wales (Council) due to a notification from the Health Care Complaints Commission about an investigation relating to the death of an infant. The investigation found that the RM failed to provide safe pre-natal care in relation to a high-risk pregnancy.

The Council sent the RM to an independent performance assessment, which highlighted the RM needed to be supervised in most competencies. The RM acknowledged that greater educational development and further professional development in a hospital setting would benefit their practice. The RM also noted that at times working as an independent midwife had felt isolated.

The RM entered into a mentoring scheme with a local hospital, which agreed to mentor the RM's practice as a midwife to ensure the safety of the RM's practice. However, after 5 months, the RM terminated the mentoring scheme and the hospital notified the Council, raising concerns that the RM:

- requires full supervision with clinical tasks
- has difficulty with medication administration and is unable to calculate doses and convert milligrams to grams.
- does not understand risk factors surrounding medication, possible side effects or complications.
- had set up intravenous fluids and tried to connect to the woman without first priming the line with fluid.
- was unable to safely interpret the trace or recognise when a foetal trace is suspicious or pathological, despite completing mandatory K2 Foetal Monitoring requirements.

Council Action

The Council took urgent interim action and imposed conditions on the RM's registration stating that the RM:

- must only practice under direct supervision
- must not engage with an agency to practise midwifery

The Council requested that the RM attend a Performance Interview to discuss the RM's current practice. The Performance Interview Committee noted that the RM had not recently practised birthing or worked in a hospital midwifery setting and raised concerns that the

RM's lack of recency of practice would result in clinical de-skilling.

The RM discussed their options with the Performance Interview and agreed to move to non-practising registration. The RM noted that under a non-practising registration the RM could continue to work in her current role and no longer needed:

- to be subject to continued monitoring by the Council.
- to meet registration requirements of continuing professional development
- Professional indemnity insurance
- Recency of practice

Non-practising registration

Non-practising registration is a type of registration, which is suitable for those who wish to retain a protected nursing and/or midwifery title but have stopped all nursing and/or midwifery practice. This may include nurses or midwives who:

- have retired from nursing or midwifery practice
- are experiencing an illness, or
- are intending to take a long period of absence from the profession.

Further details on non-practising registration can be found [here](#).