

Credentialling Midwives

What are the experiences of midwives working in
midwifery-led models of care in NSW who
undertake the credentialling process?

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(Hons) degree

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Certificate of Authorship/Originality

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

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Rachel Smith

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Contents

Certificate of Authorship/Originality	i
Acknowledgements.....	ii
List of tables and figures	ix
Abstract.....	x
Title	x
Background	x
Method	x
Findings.....	x
Implications for practice	xi
<i>Glossary of terms and concepts.....</i>	<i>xii</i>
<i>Chapter One – Introduction and Background.....</i>	<i>1</i>
Introduction	1
The research question and study objectives	2
Subjectivity of the researcher.....	2
Background.....	3
Credentialling.....	3
Introducing credentialling in NSW	3
Implementing credentialling	4
The four-step credentialling process	4
Credentialling midwives: a contentious issue	5
Thesis Outline	6
Chapter One – Introduction and background	6
Chapter Two – A review of the literature	7
Chapter Three – Methods.....	7
Chapter Four – The results	7
Chapter Five – The discussion	8
Conclusion.....	8

Chapter Two – The Literature Review	9
Review of the Literature	9
Introduction.....	9
Search Strategy.....	9
An overview of terms, definitions and meanings in relation to the study	10
Introduction.....	10
Background	10
Credentialling.....	11
Accreditation.....	12
Continuing (Ongoing) Professional Development	13
Summary of definitions	13
Professional Competency	14
Introduction.....	14
Professions.....	14
Competency	14
Professional competency: core concepts.....	16
Professional competency standards	16
Levels of competence	17
Continuing professional competence.....	18
Introduction.....	18
Determining and maintaining professional competency	18
Demonstrating or assessing continuing competency	18
Continuing competency in nursing and midwifery professions.....	23
Introduction.....	23
International context	23
Australian situation in nursing and midwifery	25
Competency standards for midwives	28
Consistent regulation	29
Summary	30
Assessing continuing competency in health care	30
Introduction.....	30

Continuing professional development	30
CPD in nursing and midwifery.....	32
Professional development frameworks	33
CPD in Australian midwifery	34
Midwifery practice review processes.....	35
Credentiailling	36
Credentiailling in Australia	36
Mandatory credentiailling.....	36
The use of reflective practice and practice portfolios.....	37
Summary	38
Conclusion	38
Chapter Three - Methods Chapter	40
Methodology and Methods.....	40
Introduction.....	40
Research approach, paradigm, framework, methodology and philosophical approach.....	40
Introduction.....	40
Qualitative research.....	40
Qualitative methodologies.....	41
Descriptive exploratory methodology	42
Reflection on methodology and method.....	43
Subjectivity and location of the researcher in the study.....	44
Ethical considerations.....	46
Method.....	46
Aim and objectives.....	46
Selection of research participants	47
Data collection	49
Data analysis	50
Reflexivity	52
Conclusion.....	54

Chapter Four - Results Chapter.....	55
The Findings of the Research.....	55
Introduction.....	55
Preparing for credentialling	55
Getting Started	55
Becoming clearer.....	57
Moving through.....	58
Getting there.....	59
Summary – Preparing for credentialling	61
Doing credentialling.....	61
The panel review was great.....	62
Nothing like I expected	63
Appreciating reviewing practice	64
Enjoying telling my story	66
Summary – Doing credentialling	67
Achieving credentialling.....	68
Experiencing immediate relief.....	68
Feeling personal achievement.....	69
Summary - Achieving credentialling.....	69
Valuing credentialling	70
Introduction.....	70
Is it just another piece of paper?.....	70
Assessing and affirming practice	72
Existing advanced level of practice	74
Developing a professional plan.....	76
Reflective Practice	77
Summary – Valuing credentialling.....	78
Improving credentialling	79
Introduction.....	79
Making it applicable to all.....	79

Making the process clearer	80
Strategies for completion	81
Summary – Improving credentialling	82
Conclusion	83
Chapter Five – Discussion	85
Exploring the meaning of credentialling for midwives	85
Introduction	85
Diagrammatic representation of the findings	85
Credentialling as part of a continuing competency framework	86
Overview of findings	87
Advanced level of practice or advancing practice?	87
A midwife is a midwife is a midwife	88
Levels of competency	89
Levels of practice	90
Full role and scope of midwifery practice	91
Working towards change	92
One level of practice	93
Maintaining scope of practice	93
Creating levels of practice in midwifery?	94
Professional Development	95
Increasing professionalism	96
Supporting continuing professional development	96
Promoting reflective practice	97
Summary	98
Limitations	98
Limitations of this study	98
Implications for practice and future research	100
Conclusion	102
Reference List	104
Appendices	112
Appendix I – Consent form	113

Appendix II – Information sheet	114
Appendix III – Credentiailling policy directive	115
Appendix IV – Participant characteristics	116

List of tables and figures

- Table 1:** The four-step credentialling process for midwives in NSW
- Table 2:** Summary of the continuing competence requirements by Australian Nursing and Midwifery Regulatory Authorities
- Figure 1:** Example of emerging concept informing the theme *achieving credentialling*
- Figure 2:** Diagrammatic representation of findings

Abstract

Title

Credentiailling Midwives: the experiences' of midwives working in midwifery-led models of care in NSW who undertook the credentiailling process.

Background

In 2004, NSW Health issued a Policy Directive that required midwives, who worked in midwifery-led models of care, to undergo a process known as credentiailling. Credentiailling for midwives in NSW involves a four-step process: self-assessment, panel review of midwifery practice, emergency management skills assessment and discussion of a case study from practise. The NSW Midwives Association (NSWMA), a state branch of the national midwifery professional body the Australian College of Midwives (ACM), administers the process. The introduction of credentiailling for midwives in NSW was contentious and there was much debate about the need for credentiailling and its introduction for a specific group of midwives.

Method

This descriptive exploratory study examined the experiences of the midwives who undertook the mandated credentiailling process in NSW. The study collected data through in-depth, semi-structured interviews with twelve midwives who had experienced the credentiailling process. Data were analysed using simple descriptive and thematic analysis.

Findings

The midwives' in the study had similar experiences of undertaking the credentiailling process. Preparation for the process was time-consuming, difficult and stressful. Much of this was because this was a new process introduced into midwifery in NSW and the midwives in the study were among the first midwives ever to undertake the process. The midwives were generous in their praise for the panel review, and were both proud and relieved when awarded the credential. The more contentious findings were that the midwives saw themselves as an 'elite' group who practised at an 'advanced' level and therefore were probably less likely to need their practice reviewed. This led to a general feeling that credentiailling was just 'ticking the box', 'jumping through the hoop' or merely

completing what was required of them rather than something they, or the women they cared for, would benefit from.

Implications for practice

The introduction of credentialling within midwifery was contentious. This was particularly so as it was introduced for one specific group of midwives. The midwives offered several suggestions that they felt would improve the process. These included improving the clarity of information available and providing more practical assistance around preparing for the process. They also felt the experience would mean more if the process was standardised across midwifery.

Standardising the process and applying the process to all midwives would work toward addressing the perceived 'advanced practice' notions that have evolved through targeting only one group of midwives. Although, standardising the process to be applicable to all may be difficult. This is because many midwives currently do not work in a system that provides for ensuring that they all practise in the full role and scope of practise of the midwife.

Glossary of terms and concepts

Competence/competency - the combination of skills, knowledge, attitudes, values and abilities that underpin effective professional performance in the individual's area and context of practice (Australian Nursing and Midwifery Council, 2009)

Continuing competency framework – a structure that exists to assist professionals to systematically evaluate their practise against the relevant professional competency standards in order to identify learning needs and demonstrate continued competence to practise (Australian Nursing and Midwifery Council, 2009)

Continuing professional development (CPD) - post qualification education that aims to actively engage professionals in lifelong learning with the ultimate goal of improving delivery of health care (Griscti & Jacono, 2006).

Continuing professional development framework – a structure that exists to allow professionals to identify, plan, participate in and reflect on relevant professional development activities (Australian College of Midwives, 2007a)

Credentialling - a process that can be used by health care organisations to verify and evaluate qualifications and the experience of health care professionals. Credentialling can be attended to prior to appointment, reappointment or at other times. Its purpose is to assist the organisation in forming an opinion about the professional's training, skills, experience and competence (Australian Council for Safety and Quality in Health Care, 2004).

Peer review – a process by which a professional's practise is examined, discussed or critiqued by one or more peers, for the purpose of identifying excellent practise and areas for improvement (Australian Nursing and Midwifery Council, 2009)

Quality and safety in healthcare – a strategic framework based on patient centred healthcare, systemisation of evidence-based practice and a culture of safety (Australian Institute of Health and Welfare, 2009)

Chapter One – Introduction and Background

Introduction

Within Australia, both nationally and at state and territory level, there is increasing recognition of the need for all health professionals to demonstrate ongoing or continuing professional competence. Currently, there exists an inter-governmental agreement between all states and territories to establish a single national health professional registration and accreditation board (Council of Australian Governments (COAG), 2008). This Board will be established and in operation by July 2010. One of the planned legislated objectives of this national board will be to provide protection of the public by ensuring only those health professionals who are suitably qualified and competent to practise within a profession will be able to be registered to do so (Council of Australian Governments (COAG), 2008).

At present, regulation of the nursing and midwifery professions in Australia is the domain of state and territory regulatory authorities referred to as the Australian Nursing and Midwifery Regulatory Authorities (NMRAs). The NMRAs are legislated to accept the responsibility to ensure that nurses and midwives registered by them are competent to practise. Each state and territory NMRA has a different process and often differing standards and requirements to address this responsibility (Australian Nursing and Midwifery Council, 2008). With the advent of the national registration board for nursing and midwifery, these requirements and processes will be standardised across Australia. In preparation for this, the peak Australian national body for the regulation of nursing and midwifery, the Australian Nursing and Midwifery Council (ANMC), developed a national framework for continuing competence. The national framework provides both the regulatory authorities and health professionals with a standard national approach to demonstrating continuing competence. It is hoped that this framework will be adopted at a national level with the commencement of national registration in 2010 (Australian Nursing and Midwifery Council, 2009).

In general, continuing competence frameworks incorporate several requirements. They often include components such as providing proof of recency of practice; undertaking self- assessment of practice; demonstrating continuing professional development (CPD); and, some form of declaration of competence. Often, these

requirements or components are collected and presented in a professional portfolio.

In 2005, the New South Wales Department of Health introduced a continuing competence framework for a specific group of midwives. The framework is known as credentialling. The introduction of credentialling for midwives in NSW provided the impetus for this Master of Midwifery (Hons) research. As the process was newly introduced and may be expanded to include all midwives in the future, it was important to examine the effect it has on the midwives required to undertake it.

The research question and study objectives

The research question was:

What are the experiences of midwives working in midwifery led models of care in New South Wales (NSW) who undertake the credentialling process?

The objectives of the study were to:

1. Describe and explore the experiences of midwives who are required to undertake credentialling in NSW.
2. Describe the credentialling process and examine the effect it had on the professional development of the midwives.
3. Examine the possible relationship between credentialling and professional development in relation to the experience of the midwife undertaking the process of credentialling.

Subjectivity of the researcher

This will be discussed in more depth later in the thesis, but it does need to be declared up-front that I was involved in the introduction and the implementation of credentialling for midwives in NSW. I am a member of the New South Wales Midwives Association's (NSWMA) Professional Development Committee, which oversaw the implementation of credentialling. In addition, I am a credentialling reviewer and I was one of the first midwives in NSW to be credentialled. During the planning and conduct of this research project, I purposefully was not involved in any of the credentialling processes. In addition to withdrawing my involvement

in the reviews, I also did not volunteer to be a member of the credentialling sub-committee¹.

Background

Credentialling

Credentialling has been defined as a process that can be used by health care organisations to verify and evaluate qualifications and the experience of health care professionals. Credentialling can be attended to prior to appointment, reappointment or at other times. Its purpose is to assist the organisation in forming an opinion about the professional's training, skills, experience and competence (Australian Council for Safety and Quality in Health Care, 2004). There exists an implied link between credentialling, competent practice, ongoing professional education/development and improvements in the provision of safe and high quality health care (Australian Council for Safety and Quality in Health Care, 2004). Although this link is firmly believed and often cited when promoting credentialling and similar processes used to demonstrate professional competence, it is not, as yet, well supported with evidence.

Introducing credentialling in NSW

Currently, in Australia there is no nationally recognised formal framework or structure to ensure that all health professionals demonstrate that their practice and knowledge remain current. In August 2005, the New South Wales Department of Health (NSW Health), through the Nursing and Midwifery Office (NaMO), introduced a credentialling framework for midwives working in midwifery-led models of care² (New South Wales Department of Health, 2004a). This framework was introduced through a mandated policy directive³ (New South Wales Department of Health, 2005b). NSW Health developed the credentialling framework in consultation with the midwifery professional body at both national and state level. A credentialling working party was established which included representatives from NSW Health, the Australian College of Midwives (ACM), the

¹ A sub-committee of the NSWMA Professional Development Committee (PDC). The aim of the PDC is to provide and co-ordinate formal education activities and research relevant to the development of midwifery practice. The credentialling sub-committee was formed to administer the credentialling process.

² Defined by NSW Health as models where midwives are working as primary care providers through the antenatal, intrapartum and postpartum period.

³ A policy directive is any document that contains material that must be understood by, complied with and implemented across NSW Health. All policy directives must include a policy statement outlining the purpose, mandatory requirements and implementation responsibilities associated with the policy position taken by NSW Health.

New South Wales Midwives Association (NSWMA) a state branch of ACM, selected Area Health Service (AHS) representatives and midwifery academics (New South Wales Department of Health, 2004b). The framework was developed as a risk management strategy, with the intention to protect consumers, midwives and the models of midwifery-led care (New South Wales Department of Health, 2005b) and was endorsed by the NSW Ministerial Maternity and Perinatal Committee⁴ prior to being issued (New South Wales Department of Health, 2004b).

Implementing credentialling

The credentialling midwives policy directive drove the need to implement the credentialling process in NSW and was the catalyst for the development of this research. The midwifery professional body in NSW, the NSWMA, implemented the credentialling process. A sub-committee of the NSWMA Executive committee led the implementation of the process. A project midwife was employed and the process was designed in accordance with the policy directive. The credentialling sub-committee included midwives, consumers and a representative from the NSW Health Department.

The four-step credentialling process

The policy directive, credentialling for midwives in NSW, involves a four-step process; self-assessment, panel review, workstation assessment and discussion of a case study (Table 1). The credential is valid for three years. The credentialling process was designed to allow midwives to assess their individual needs and practice standards. It was expected that by working through the process, the midwives would be able to identify and address areas of their practise that required improvement.

Table 1: The four-step credentialling process for midwives in NSW

Four-step credentialling process	Description
1. Self-assessment	The midwife undertakes self-assessment of practice using the ANMC Midwifery Competency Standards for the Midwife (Australian Nursing and Midwifery Council,

⁴ The NSW Ministerial Maternal and Perinatal Committee is a quality committee responsible for reviewing maternal and perinatal mortality and morbidity, making recommendations arising from lessons learned that improve the care of mothers and babies in NSW

	2006a) and the ACM Practice Development Resource (Australian College of Midwives, 2006c) The assessment indicates where development of practice is required and identifies if the midwife meets the requirements of credentialling
2. Panel Review	The midwife presents evidence in the form of a portfolio and case management discussion to the panel The panel consists of a midwife and a consumer of midwifery care The panel needs to satisfy itself that the midwife meets the credentialling requirements
3. Scenario-based assessment	The midwife discusses a case study (tells a story) from their practise that demonstrates how they meet the midwifery competencies and the Australian midwifery guidelines for consultation and referral (Australian College of Midwives, 2008)
4. Workstation assessment	The midwife being credentialled then demonstrates and discusses their management of a simulated maternity emergency such as shoulder dystocia or post-partum haemorrhage

Credentialling midwives: a contentious issue

In NSW presently, credentialling is mandated only for midwives working in midwifery-led models of care (New South Wales Department of Health, 2004a). The introduction of credentialling for midwives working in midwifery-led models of care in NSW was contentious. There was much debate about the need for

credentialling and its introduction for this one group of midwives. Whilst the ACM supported the notion of credentialling, they expressed concern over the possible misinterpretation of the title. This was due to the existing link between credentialling and clinical privileges for medical officers (New South Wales Department of Health, 2004b). In addition, there was also concern from members of the NSWMA that in the future, credentialling may be used as a means for this state to somehow exert control over midwifery practice (New South Wales Department of Health, 2004b). The debate around credentialling threatened to divide the national midwifery college (ACM), as at least one state in particular was vehemently opposed to the introduction of credentialling (Brodie, 2007). The contentious issues included the possible misuse of credentialling to 'police the profession' or its use by employers as a disciplinary management strategy (Kinnear, 2009). In part, due to these concerns, there was recognition that the process needed to be introduced in a non-threatening manner, and that it should be considered a support strategy for the midwives and the new models of care, rather than just an examination of practice (New South Wales Department of Health, 2004b). NSW Health claims that introducing a process of credentialling has the capacity to improve maternity care through the provision of a skilled and competent workforce (New South Wales Department of Health, 2004a). The introduction of this credentialling process for midwives in NSW was contentious and this research set out to examine the experience of the midwives who were required to undertake the process.

Thesis Outline

The thesis aims to explore the experiences of midwives who undertook credentialling in NSW. The thesis is arranged in five chapters.

Chapter One – Introduction and background

This chapter introduces the research question and objectives and sets the scene for the research. This includes a brief introduction to the context of demonstrating continuing professional competence in Australia as this concept provides the framework for the research. The background to the introduction and implementation of credentialling is provided. This background gives an overview of the context in which the research was conducted. The key terms in relation to the study are introduced and explained. This includes an explanation of the mandated policy directive that was the impetus for this study. In addition, a

description of the actual process of credentialling and definitions of note within the policy directive are provided. Much of the information provided in this chapter is discussed in detail in the coming chapters.

Chapter Two – A review of the literature

Chapter two examines the body of literature relevant to the research. An overview of terms, definitions and meanings in relation to the study are provided. Literature relating to professional competence is examined. The notion of continuing competence in general and specifically in nursing and midwifery, both internationally and within Australia is presented. Comparison and discussion on the most common methods used when attempting to assess a professional's continuing competence is included as this is a common area of contention. Claims, debates and opposing views within the body of literature are identified and argued. Gaps in the current body of literature are highlighted. In particular, the lack of rigorous research available to either support or refute claims concerning provision of proof and assessing continuing competence of health care professionals is examined.

Chapter Three – Methods

Within this chapter, both the methodology of, and the method for, the research is presented. Descriptive exploratory methodology, which was used in this research is explained, justified and discussed. A reflection on the use of this evolving methodology is included. Subjectivity and location of the researcher in the study is declared, the possible effects this may have had on the research and strategies to minimise the effects are provided. Ethical considerations of the research are also addressed. The research method, including participant selection and data collection and analysis, is discussed. In addition, an audit trail is provided to justify the development of the themes from the data.

Chapter Four – The results

The findings of the study are presented in this chapter. The five major themes that emerged during the analysis of the data are presented. Each of the themes and the development of concepts that informed the themes are discussed separately. The words of the midwives are used to present the results. Using the midwives' words demonstrates and supports the results.

Chapter Five – The discussion

This chapter presents and explores the midwives' experiences of the credentialling process based on the findings of the study. The results are examined and compared to the current body of literature. This provides a deeper exploration of the midwives' experiences and includes possible theoretical explanation of the experiences. Commonalities and differences between the findings and the body of literature are discussed. The more contentious findings of the midwives' experiences of credentialling are discussed. Much of this discussion concentrates on the notions of advanced practice and professional development, which were key findings from the study. This chapter also includes a summary of the findings, limitations of the research and implications for practice.

Conclusion

Despite the debate and contention in introducing credentialling, the process is now well underway. The first group of midwives were credentialled in May 2006. To date, more than 100 midwives have undertaken the credentialling process in NSW. A new national process called Midwifery Practice Review (MPR)⁵ which was informed, by the process of credentialling, has been developed and introduced by the midwifery profession's national body, the Australian College of Midwives.

As the credentialling process is newly introduced and may well be expanded to include all midwives in the future, it is important to examine the effect it has on the midwives required to undertake it. For this reason, this study was conducted to examine, explore and describe the effect of the credentialling process on the midwives mandated to undertake it.

This chapter has introduced the research question, the aims for the study and provided background to, and explanation of, the context in which the study took place. The next chapter provides an in-depth review of the body of literature relevant to this research.

⁵ Midwifery Practice Review (MPR), a professional development program designed to assist midwives through self-assessment and peer and consumer review to reflect on practice and plan continuing professional development.

Chapter Two – The Literature Review

Review of the Literature

Introduction

This chapter examines the literature relevant to credentialling, ongoing professional development and related topics in health care. Several themes have been identified. The themes include: definitions; professional competence; continuing competence; demonstrating or assessing continuing competence; and, continuing professional development. The themes identify, support or discuss the major issues in relation to the credentialling process. Each of these themes will be discussed in detail. Many have interrelating concepts and further discussion reappears throughout the literature review.

The review of the literature was undertaken primarily to identify gaps in relation to the research on credentialling, practice review and ongoing professional development. The literature review informed the development and conduct of this study. Reviewing related literature also assisted in discussing, supporting and exploring the midwives' experiences of the credentialling process.

Much of the body of literature purports a connection between credentialling, ongoing professional development, proof of competence and improvements in patient safety. Although the literature regularly states or implies this connection, there is a paucity of research to provide this evidence. In fact, there is a general lack of research on this topic and most of the papers identified and reviewed were discussion or opinion papers. The lack of evidence supporting the effects of credentialling and/or ongoing professional development on practise will be critically discussed in this chapter.

Search Strategy

A search of the literature was conducted using the databases of Medline (OVID), CINAHL (EBSCO), MIDIRS (Maternity and Infant Care Database) and Journals @ Ovid. The search covered the period from 1990 – 2009. Credentialling and credentialing (both spelling options) were combined and used as the key term initially, but later required broadening by incorporating the terms midwives, midwifery or health professionals. Additional publications of relevance were found using key terms such as, ongoing professional development, continuing

professional development, competence assessment, accreditation, professional development and midwifery standards review.

Limitations of the search included the lack of available rigorous research evaluating credentialling or similar processes. In addition to the lack of research on the topic, the confusion that exists around the terms used to describe the process made it difficult to examine and compare opinions. There is also a lack of midwifery-specific literature related to credentialling. Due to the limited research articles available on credentialling, the review of the literature includes descriptive, discussion and opinion papers. Initially, the search aimed to find midwifery-specific literature, but due to the lack of this, it also includes papers from nursing and other health-related professions.

An overview of terms, definitions and meanings in relation to the study

Introduction

Within Australia and internationally, the process of determining a health care professional's competency is described by the use of many different terms and concepts. Some of these include competency assessment, accreditation, quality assurance, fitness to practise, professional development, registration, proof of continuing education and credentialling. There is a recognised interaction between these concepts and there is often misunderstanding between professionals around the meanings of the concepts (Cioffi, Lichtveld, Thielen, & Miner, 2003). This next section describes and defines some of the commonly used terms.

Background

Historically and up to the current day, there exists much confusion regarding definitions and understanding of the terms used to describe processes such as credentialling and accreditation (Gibson & Lawson, 1996), with these terms often being used interchangeably. Cioffi et al (2003) suggest that the concept of competency is often included in the misunderstanding and confusion when discussing credentialling and accreditation. They assert that there exists interplay between all three concepts and this interplay contributes to the misunderstanding of the concepts for both professional practitioners and academics alike.

Misunderstandings often occur due to the multiple definitions used when discussing competency, credentialling and accreditation (Cioffi et al., 2003). In practice, this confusion is common. For example, the Council of Australian Governments (COAG) in their agreement on the formation of a national registration and accreditation scheme state that the scheme will be responsible for reviewing 'profession-specific registration, practice, competency and accreditation standards' (p.3). Early in the document, accreditation refers to education and training programs, yet further on in the document accreditation refers to the health professional (Council of Australian Governments (COAG), 2008). Within NSW, hospitals and institutions are generally accredited and health professionals may be accredited, deemed competent, certified and/or credentialled.

Recognition of the differing interpretations of these concepts is important when determining the meaning ascribed to the terms. Depending on the context, the meaning of competency may be interpreted differently, but in general, competencies link content to a level of performance (Cioffi et al., 2003). It is well recognised by a large number of bodies that professionals commonly evaluate their performance by measuring performance against the professional standards or competencies (Australian Nursing and Midwifery Council, 2006a; Cioffi et al., 2003; Hravnak, 2009; Magdic, Hravnak, & McCartney, 2005; Minarik, 2005; New South Wales Department of Health, 2004a). Meeting professional standards or competencies is often considered a measure of a profession. The ANMC (2005) assert that the midwifery competencies provide the detail of how a midwife is expected to practise and what a midwife should be capable of doing. This concept of a professional being required to meet standards or competencies directly relates to this study, as a component of the credentialling process in NSW required the midwives to assess their current practice in relation to the midwifery competencies.

Credentialling

According to Gibson and Lawson (1996) credentialling is the evaluation of performance in relation to identified standards. Credentialling has also been defined as a process to verify qualifications, experience and professional attributes (Australian Council for Safety and Quality in Health Care, 2004). The Australian College of Midwives (2006) argues that credentialling is a term that is widely used and its meaning and definition depends on the context in which it is

used. For instance, credentialling can apply to an individual practitioner, to awarding of clinical privileges or when measuring the safety of an organisation. In terms of credentialling for midwives, evaluation of performance is measured against the ANMC competencies for the midwife (Australian Nursing and Midwifery Council, 2006a). Yet, when credentialling is discussed in the medical profession, it is often used in the context of a single practitioner being credentialled to undertake a specific skill or procedure. For example, gynaecologists need to be credentialled to undertake advanced laparoscopic surgery. The credential refers to a level of practise rather than to professional competency in general.

In this study, credentialling is utilised as a process, where-by the midwives undertaking it, demonstrate their ability to meet the midwifery competency standards. In NSW, credentialling was originally introduced as a mechanism to allow for the assessment and demonstration of competency and capabilities of midwives working in midwifery-led models of care (New South Wales Department of Health, 2004a).

Accreditation

Accreditation, a term commonly used in the body of literature reviewed, also has differences in definitions. Gibson and Lawson (1996) suggest that it is a term used in relation to validating quality of courses or institutions, whereas the Australian Council for Safety and Quality in Health Care (2004) define accreditation as a status conferred on an organisation or an individual. Again, accreditation refers to how the individual or organisation 'measure up' or evaluate their performance against professional competencies and/or recognised and widely accepted standards. Currently within midwifery, accreditation more commonly refers to the status of an organisation or facility, as opposed to an award for an individual practitioner. One example of this is, if a health facility meets specific requirements around promoting and supporting breastfeeding, they may be awarded the international Baby Friendly Health Initiative (BFHI) accreditation status. Yet, if a midwife completes the requirements of the International Board of Lactation Consultants (IBLC) so that they may better promote and support breastfeeding they are certified individually as a lactation consultant. Furthermore, to demonstrate the interchangeable nature of the terms used in the literature, the Australian College of Midwives (ACM) used to administer a program referred to as Accreditation of Independently Practising

Midwives (IPM) that allowed independently practising midwives to undertake an accreditation process with the college, and to advertise their accreditation status. These examples demonstrate the interchangeable nature and the confusion regarding some of the key terms of this research.

Continuing (Ongoing) Professional Development

Continuing professional development (CPD) in health care professions, or continuing professional education (CPE) as CPD was previously known, refers to post qualification education that aims to engage professionals actively in lifelong learning with the ultimate goal of improving delivery of health care (Griscti & Jacono, 2006). There is, again, considerable variation and interpretation of the terms CPD and CPE (Lawton & Wimpenny, 2003). A commonly cited definition that emerged from the professions of architecture and construction, describes CPD is a process whereby the professional systematically maintains, improves and broadens their knowledge and skills and continually develops the personal attributes necessary to undertake professional and technical duties in the profession that they belong to (Lawton & Wimpenny, 2003). Similarly, the ANMC defines continuing professional development as a systematic process that reviews practice, maintains competency and enhances both professional and personal skills and knowledge (Australian Nursing and Midwifery Council, 2007).

Although, sometimes confused as an overarching concept, most often CPD programs form only one part of a continuing competency framework. For example, The ACM has developed and encourages their members to participate in a CPD program called MidPLUS (Monaghan & Shorten, 2008). This program provides midwives with a structured approach that allows them to identify their learning needs, plan their ongoing education and take responsibility for their continuing professional development. This CPD program will form part of a continuing competency framework for the profession of midwifery. The CPD program is not a continuing competency framework in itself. The contribution of CPD to demonstrating continuing competency is argued later in this review.

Summary of definitions

As demonstrated, the interchangeable use of the above terms creates confusion in the literature, thus making it somewhat difficult to interpret. All terms will be discussed in the review, although terms directly related to the research question will be discussed in more depth.

Professional Competency

Introduction

When reviewing the literature related to credentialling and professional development there is much reference to ensuring competency of professionals. This section defines and discusses the term competency and professional competency. The general characteristics of a profession are described, as many of the arguments for and against demonstration of continuing competency centre on the concepts of a profession.

Professions

A profession can be defined as “ an occupation that needs special education and training” (Oxford University Press, 2003, p. 310). Characteristics of a profession include, undertaking education and training; completing skills that are underpinned with theoretical knowledge; having a code of ethics; having a recognised organisation and being involved in service provision (Miller, Adams, & Beck, 1993). When discussing essential elements of professionalism, the UK Department of Health (2003) support the above characteristics by listing the following central principles:

- Motivation for service delivery;
- Adhering to a moral/ethical code of conduct;
- Striving for excellence whilst recognising limitations and scope of practice; and,
- The ability to empower individuals and teams.

(Department of Health (UK), 2003)

It is recognised that professional capacity and scope of practice of each profession should be determined by the members of the profession (Miller et al., 1993; Wuest, 1994). Furthermore, it has been recommended that professions should develop and evaluate valid standards, thus allowing members to benchmark professional practice and demonstrate ongoing competency in their profession (Miller et al., 1993).

Competency

Competency is an often used, but not clearly defined, term (Axley, 2008; Eraut, 1998). It is argued that there is difference in the theoretical understanding and the practical understanding of the term competency (Axley, 2008). These arguments will be considered in the next section where discussion on professional

competency is presented. The definition most commonly referred to in the Australian nursing and midwifery competency discussions is the one described by the ANMC. The ANMC defined competence as 'the combination of skills, knowledge, attitudes, value and abilities that underpin effective and/or superior performance in a profession or occupational area' (Australian Nursing and Midwifery Council, 2006a, p. 141). Two years later, the ANMC added 'and context of practice' to this definition (Australian Nursing and Midwifery Council, 2008). The inclusion of 'and context of practice' provides for those nurses and midwives who practise in areas other than the traditional clinical areas. These areas include education, management and government or advisory roles. There continues to be debate in this area.

Where the regulatory authority utilises a recency of practice or proof of hours component in their continuing competency framework, context of practice is not particularly relevant as the health professional must be clinically current. If the regulatory authority deems influencing patient care, such as managing a service, sufficient (Goodridge, 2007) or using their registerable skills, as in teaching, (Nursing & Midwifery Council, 2004) then context of practice is taken into consideration. In New Zealand, where practice refers to direct clinical care, there is provision for a non-practising certificate for health professionals (Department of Health (NZ), 2003). This is where the health professional has the ability to register within their profession but they have restrictions that limit them to non-clinical roles such as education, management or research.

In midwifery in Australia, the context of practice should be relevant but is often overlooked. Homer et.al. (2005) in their description and discussion on the scope of practice of a midwife, state that there is an assumption that all midwives should be able to demonstrate that they are able to practise within the full role and scope of a midwife. However, they recognised that this is not always the case due to the fragmented nature of midwifery care provision in some areas of Australia. In my experience, I know some midwives who have spent their entire midwifery career in one area of midwifery, for instance the postnatal ward or the antenatal clinic. Although deemed competent as a midwife on registration, due to lack of exposure and experience in all areas since initial registration, many could not demonstrate competency across the full scope of practice of the midwife. These midwives could meet a recency of practice or proof of hours component, but their context of practice would be limited to one area of midwifery.

Professional competency: core concepts

There are a number of key terms or core concepts in relation to professional competency (Lysaght & Altschuld, 2000). These include knowledge, skill, attitude, standards and ability (Australian Nursing and Midwifery Council, 2007; Chiarella, Thoms, Lau, & McInnes, 2008; Hogston, 1993; Minarik, 2005). It is recognised that professional competency has many dimensions and is therefore difficult to assess or evaluate by any single means (Lysaght & Altschuld, 2000). Due to the difficulties in assessing professional competency, most competency assessment frameworks utilise a variety of assessment measures. These are discussed at length later in this chapter.

Much argument exists around the concept of competency. Competency has been described as an 'umbrella' concept (Butler, Fraser, & Murphy, 2008) as it relates to the individual, the context, performance and capacity or potential (Butler et al., 2008; Eraut, 1998). Another common argument revolves around seeing competence as being the ability to perform tasks and roles (Benner, 1982). This could be because nursing and midwifery professions are generally considered practise-based professions. Nursing and midwifery knowledge was traditionally considered technical rather than theory based (Benner, 1984; Walker & Holmes, 2008). Since the move from the apprentice-style approach of a hospital-based system of training for the nursing and midwifery professions to a tertiary education approach, there is increasing recognition of the importance of supporting technical practise with theoretical understanding (McKinley, Aitken, Doig, & Lui, 2002). If competency is seen as skills, knowledge, attitude and ability, then this narrow view of competency as merely task completion and role attainment should be defunct.

Professional competency standards

Benchmarking, or comparing professional practice against a set of agreed-upon standards is considered a necessary requirement of a profession (Axley, 2008; Pearson, Fitzgerald, Walsh, & Borbasi, 2002). Most professional bodies develop a set of standards or competencies for their profession to allow for benchmarking (Australian Nursing and Midwifery Council, 2008; Axley, 2008; Cashin, Chiarella, Waters, & Potter, 2008; Chiarella et al., 2008; Eraut, 1998; Gonczi, 1994; Hogston, 1993; van der Vleuten & Schuwirth, 2005). Professional competency standards should provide details of how the professional is expected to practise

(Gonczi, 1994). Furthermore, they should provide a guide for the professional that allows them to compare or measure their practise so that they may meet the expected professional standard (Australian Nursing and Midwifery Council, 2008). In addition to various health-related professions, non-health professions who currently use competency standards to measure or benchmark performance include, law, accountancy, education and engineering (Pearson et al., 2002).

Levels of competence

In terms of utilising competency standards to measure or benchmark performance, debate centres around the suggestion that competencies are standards in which to guide practice and not necessarily standards that must be fully attained (Eraut, 1998). In midwifery, a student midwife must meet the required competency standards prior to being eligible for registration into the profession (Nurses and Midwives Board of New South Wales (NMB), 2008). These are the competency standards that a midwife of considerable post registration experience demonstrates they meet, when undertaking the process of credentialling. It could be argued that the newly registered midwife is indeed competent as they meet the competencies at a beginning level, and the midwife with considerable experience is 'more competent' as their practice has developed and improved over time. For example, one of the competencies requires the midwife to assume responsibility for professional leadership functions. Although a newly qualified midwife would aspire to do this, they may not have fully attained this particular competency. This view is similar to those that suggest there are levels of competence, as discussed in the novice to expert view of Benner (1984).

The concept of levels of competency within a profession will not be easily agreed upon. Supporters of the novice to expert view and the levels of competence view utilise terms such as beginning competency or minimum competency, whereas there are those that firmly believe that competence is an end point in itself. There continues to be robust debate around this issue in particular, and a lack of consensus as to whether it is potential or actual ability that being deemed competent equates to (Eraut, 1998; Hogston, 1993; van der Vleuten & Schuwirth, 2005; Watson, Stimpson, Topping, & Porock, 2002). There is agreement that the concept of competency is difficult, if not impossible to define. In addition, due to this recognised difficulty, around the concept of professional competency, it is important to consider the context in which competency is viewed (Australian Nursing and Midwifery Council, 2008; Axley, 2008; Eraut, 1998).

Continuing professional competence

Introduction

The next section discusses the idea of, and the processes for, determining and maintaining continuing professional competency. Demonstrating competency or continuing competency relates directly to credentialling as this is often what credentialling aims to do, and claims it does (Cioffi et al., 2003; Hravnak, 2009; Kendrick et al., 2000; New South Wales Department of Health, 2004a; New South Wales Department of Health, 2005b; Redman & O'Hara, 2003). In addition, the argument for and against the need for continuing competency in health professions and in midwifery will be presented. A discussion on the challenges of assessing continuing competency will also be provided.

Determining and maintaining professional competency

In general, most professions have some way of determining competency prior to admission into the discipline (Hogston, 1993; Lysaght & Altschuld, 2000; Minarik, 2005). Many professions such as engineering, social work, psychology and accountancy do not regulate ongoing competency (Lysaght & Altschuld, 2000; Pearson et al., 2002). These professions claim to be self-regulating and expect members to maintain competency as part of their professional status. It is possible in some professions, and indeed in midwifery and nursing in some states of Australia, to register into a profession and maintain a licence to practise by only paying an annual fee (Australian Nursing and Midwifery Council, 2008). In general, most professions, regulatory authorities and consumers alike, expect practitioners to value the concept of maintaining competency and to ensure competency of practice is regulated (Hogston, 1993; Lysaght & Altschuld, 2000; Minarik, 2005). This expectation is based on the belief that professional competency is linked to safe and high quality care. This belief is discussed at length in the next section.

Demonstrating or assessing continuing competency

There has been an increasing recognition both in Australia and internationally that professional registration or licensure cannot be continually granted without some assessment of ongoing competency (Australian Nursing and Midwifery Council, 2008). This is in part due to increases in regulation and changes in legislation designed to protect the public (Productivity Commission, 2005). It may also be due to the increasing complexity of care provided by health professionals,

the rapid changes in use of technology in health care and the significant changes in the scope of practice and the practice environment of some health professionals (McAdams & Montgomery, 2003). There is increasing consumer awareness of the right to the best care by the most appropriately qualified professional. This rapidly changing health care environment puts added pressure to ensure the professionals are up-to-date with current best practice.

Although there is increasing recognition of the need for health professionals to demonstrate ongoing competency it is acknowledged that professional competency is difficult to measure or prove (Gonczi, 1994; Lysaght & Altschuld, 2000; McAdams & Montgomery, 2003; van der Vleuten & Schuwirth, 2005; Watson et al., 2002). As discussed previously, a definition for competency cannot be agreed upon. There is also lack of consensus on what exactly is being assessed when competency assessments are undertaken (Eraut, 1998). One of the oft stated reasons for this is the complexity or multi-dimensionality of competency (Cashin et al., 2008; Hogston, 1993; Lysaght & Altschuld, 2000) as multiple areas of practice need to be assessed. For example, to be considered competent in midwifery practice, assessment includes the following domains, as set out in the competency standards for the midwife; legal and professional practice; midwifery knowledge and practice; midwifery as primary health care; and reflective and ethical practice (Australian Nursing and Midwifery Council, 2006a). The credentialling process for midwives in NSW assesses many of these components but to adequately assess all components is somewhat challenging (McAdams & Montgomery, 2003; van der Vleuten & Schuwirth, 2005).

Due to the recognised challenges, the ANMC has provided guidance on how competency may be assessed in nursing and midwifery. This guidance includes six identified principles of competency assessment: accountability, contextual relevance, performance-based assessment, evidenced-based assessment and reliability and validity in the areas of assessment, participation and collaboration (Australian Nursing and Midwifery Council, 2008). Although this guidance identifies the principles underpinning competency assessment, it still does not identify the 'how to' of assessment.

Due to the challenging nature of assessing all components of competency, most competency assessment frameworks include several methods (Cashin et al.,

2008; Gonczi, 1994; Hravnak, 2009; Ireland et al., 2007; Lysaght & Altschuld, 2000; McAdams & Montgomery, 2003; Minarik, 2005; van der Vleuten & Schuwirth, 2005; Watson et al., 2002). Cashin et al. (2008) states that most available competency assessment methods or tools are aimed at students of the profession and not intended for use by qualified professionals. Nevertheless, it could be argued that as students are required to meet the competencies on registration, the same tool should be appropriate for those demonstrating continuing competency as the competency standards are the same. McAdams and Montgomery (2003) assert that, typically, large facilities that employ professional groups such as nurses and midwives will often develop their own competency assessment tools. This has led to a plethora of tools utilised to assess the same components of a profession, yet no standardised approach has been utilised. A non-standardised approach could lead to over-assessment in certain areas of practice and a lack of assessment in others. In addition, there are some aspects of competency that are seen as relatively easy to assess, such as knowledge base, and others such as attitudes and values that are considerably more difficult to assess.

Despite assessment difficulties, there remains a push towards assessing continuing competency in health professionals. Multiple methods of assessment have been introduced to assess the differing components. Common methods include collation of a professional portfolio that provides evidence of ongoing development and reflection, peer review of professional practice (Midwifery Council of New Zealand, 2005a; New South Wales Department of Health, 2005b) and evidence of recency of practice (Australian Nursing and Midwifery Council, 2008; Hogston, 1993; Nursing & Midwifery Council, 2004). All these methods were utilised in the credentialling process that was examined in this research. Although there are a number of reports on the different methods for assessing both initial and ongoing competency of professionals, there is very little research evidence on which method is superior and indeed if demonstrating continuing competency has a measurable effect on health care outcomes (Pearson et al., 2002).

Many of the discussions and opinions concerning competency assessment claim that the demonstration of ongoing competency will improve the quality and safety of health care provision (Australian Council for Safety and Quality in Health Care,

2004; Axley, 2008; College of Midwives of Ontario, 2006; Gonczi, 1994; McAdams & Montgomery, 2003; Minarik, 2005; Pearson et al., 2002). McAdams and Montgomery (2003) claim that assessing competency improves performance and it is the improved performance of health professionals that improves the care provided. They do not however, discuss *how* improved care equates to improvements in quality and safety. Pearson et al. (2002) concur, stating that assessing and assuring continued competency of professionals protects the public by ensuring safety of health professionals practice, but, again, they fail to discuss exactly *how* they have come to this conclusion. NSW Health, in their Credentialling Framework for midwives asserted that credentialling has the capacity to optimise quality and safety of care provision. They suggest that credentialling will ensure practitioners are skilled and competent and this will optimise the safety and quality of care (New South Wales Department of Health, 2004a). Although, they do not claim this with certainty as they use the phrase 'has the capacity to' they do provide justification by equating 'skilled and competent' practitioners may 'optimise' safety and quality.

There is a paucity of research to support the claims that demonstrating continuing competency will increase the quality and safety of care. I feel that this is not necessarily due to the claims being false, but because of the difficulties in examining such claims. The complexity of health care provision makes it difficult, or nearly impossible, to accurately measure the effect that an individual practitioner may have on patient outcomes (Pronovost, Miller, & Wachter, 2006). It is recognised that most measurements of patient safety relate to the process of care and not the effect of the caregiver (Pronovost et al., 2006). Those who believe in assessing ongoing competency, assert that this is vital in assuring safe and high quality health care provision (Australian Council for Safety and Quality in Health Care, 2004; Axley, 2008; College of Midwives of Ontario, 2006; Gonczi, 1994; McAdams & Montgomery, 2003; Minarik, 2005; Pearson et al., 2002). This assertion seems reasonable. In my experience, those that are committed to lifelong learning, those that believe they have a professional responsibility to maintaining and improving knowledge and skills and those who continually challenge their beliefs and values are most likely to provide best practice and quality care.

In addition to the acknowledged difficulties with measuring safety and quality in health care, there exists confusion as to whether it is even possible to measure, assess or demonstrate competency. Watson's (2002) systematic review on clinical competency argues that, even when there is agreement on a definition of competence, it is not clear whether performance is a necessary component. Furthermore, there is no consensus on whether competency can be measured. If competency is measurable, there is no agreement as to what the most appropriate way of measuring it would be (Watson et al., 2002). There is general consensus that no one method of demonstrating competency is reliable and that most professions use a variety of methods (Axley, 2008; Cashin et al., 2008; Herringer, 2002; van der Vleuten & Schuwirth, 2005). The midwifery profession in Australia, through credentialling and Midwifery Practice Review (MPR), have taken the approach of utilising various methods of assessment. This may optimise the effectiveness of any assessment process.

Adding to the debate around the ability to measure both competency and its effect on patient safety, philosophically, there are arguments around the actual need for continuing proof of competency within professions. The arguments centre on the concept of a profession. They refer to the fact that, as professions are guided by standards and codes of practice and ethics, and these are agreed upon when admitted to the profession, then it is argued that, competency maintenance should be a basic requirement of continuing professionalism and should not need monitoring (Lysaght & Altschuld, 2000).

Others argue that increasing consumer expectation, advancing technology and continual generation of new knowledge within professions underpins the need for professionals to maintain and continually provide evidence of competency within the scope of practice (Australian Nursing and Midwifery Council, 2007; Hogston, 1993; Lysaght & Altschuld, 2000). Lysaght and Altschuld (2000) assert that most often, those that are most in need of up-skilling or improving knowledge are those least likely to attend to it. In my experience with midwifery professional development, this would be a reasonable assertion. I have worked with many midwives, who completed their midwifery education years, or sometimes decades ago. Many of these midwives do not actively engage in life-long learning. They often only attend the compulsory education sessions provided by their workplace.

Despite the ongoing debates, there is consensus within health professions, including midwifery, of the need for some form of framework to assist the health care practitioner to regularly benchmark practice against the accepted standards of the profession (Australian Council for Safety and Quality in Health Care, 2005; Australian Nursing and Midwifery Council, 2007; Department of Health (UK), 2003). It is this consensus that was the force behind midwifery support for the introduction of credentialling in NSW and later, the national process of Midwifery Practice Review (Griffiths & Homer, 2008).

Continuing competency in nursing and midwifery professions

Introduction

The next section provides an overview of the issues pertaining to the requirements of continuing competency assessment in the professions of nursing and midwifery. The current Australian situation in midwifery is discussed in reference to regulation and legislation.

International context

Internationally, in similarly developed countries to Australia, continuing professional development and competency assessment frameworks for nurses and midwives are both in use and/or legislated. In the United Kingdom and New Zealand, where the midwifery scope of practice and context are in some ways similar to the Australian context, the regulatory authorities require proof of competency prior to the issue of an annual practising certificate (Midwifery Council of New Zealand, 2005a; Nursing & Midwifery Council, 2008).

In the United Kingdom, the professional development framework is known as post-registration education and practice (PREP) (Nursing & Midwifery Council, 2008). The Nursing and Midwifery Council as the registering authority for nurses, midwives and health visitors administers the process. PREP supports nurses, midwives and health visitors in keeping up to date with practice developments; reflecting on practice; demonstrating practice development; and, providing the best possible care (Nursing & Midwifery Council, 2008). The Nursing and Midwifery Council's (2008) framework supports professional development but it does not guarantee competency. The PREP framework is a key component of

clinical governance and the ultimate aim of PREP is “protecting the public through professional standards” (p5). To meet the PREP standards, midwives and nurses must have practised in the capacity of a midwife or nurse for a minimum of 450hrs in the three years prior to renewing registration or have completed an approved return to practice course. In addition to the practice requirements, the practitioner must have documented evidence of continuing professional development (Nursing & Midwifery Council, 2008; Robinson, 1994).

Midwives and nurses in New Zealand are required by legislation to demonstrate competency to practise prior to being issued with an annual practising certificate (Department of Health, 2003). The Health Practitioners Competence Assurance Act (2003) requires that the regulatory authority, (in the case of midwives, this is the Midwifery Council of New Zealand, and for nurses, the Nursing Council of New Zealand), set standards for midwifery and nursing practice and ensure all midwives and nurses meet those standards (Midwifery Council of New Zealand, 2004; Midwifery Council of New Zealand, 2005a; Midwifery Council of New Zealand, 2005b). The Midwifery Council of New Zealand has a recertification program that all midwives must participate in to demonstrate competency in midwifery practice. This involves the midwife declaring and proving competency to practise midwifery on an annual basis (Midwifery Council of New Zealand, 2005b). Midwives are also required to attend a Standards Review Process (Midwifery Council of New Zealand, 2005b) on an annual or three-yearly basis depending on their context of practice. The process is comparable for nurses. These processes are similar to the credentialling process in NSW and involve a panel review and presentation of a practice portfolio. Information within the portfolio demonstrates competency and provides proof that the midwife or nurse meets the standards set by the regulatory authority. Prior to the introduction of the Health Practitioners Competence Assurance Act (2003), this process was voluntary. It is now mandatory (New Zealand College of Midwives, 2009).

In the United Kingdom and New Zealand, regulation and legislation for the professions of nursing and midwifery are the same. Whereas in Canada, nursing is recognised as a profession nationally, midwifery is only recognised as a legal and regulated profession in some provinces and territories. The Canadian Midwifery Regulators Consortium (CMRC) is working toward harmonising the standards and regulatory requirements of midwives in Canada nationally

(Canadian Midwifery Regulators Consortium, 2009). In the provinces and territories where midwifery is legal and regulated, there are varying requirements of re-certification. These include recency of practice, for example, in the preceding five years midwives had to have practised for a minimum of 1125 hours (British Columbia) or have attended 15 women as primary midwife (Manitoba) or 10 births (Ontario); self assessment and review of practice to identify learning needs (British Columbia and Manitoba); peer review (Manitoba and Ontario); evaluation of previous years learning (British Columbia); and, documentation review (Ontario) (Australian Nursing and Midwifery Council, 2008; Canadian Midwifery Regulators Consortium, 2009; Goodridge, 2007). Credentialling in NSW includes variations of these requirements in some form (New South Wales Department of Health, 2004a; New South Wales Department of Health, 2005b).

In many countries, and within many disciplines, it is legislated that professionals need to provide proof of ongoing competency and professional development prior to gaining and maintaining a licence to practise (Australian College of Midwives, 2006a; Australian Council for Safety and Quality in Health Care, 2004; Canadian Midwifery Regulators Consortium, 2009; College of Midwives of Ontario, 2006; Lysaght & Altschuld, 2000; Midwifery Council of New Zealand, 2005a; Midwifery Council of New Zealand, 2005b; Nursing & Midwifery Council, 2008; Productivity Commission, 2005). The arguments for this legislation centre on the idea that proof of competency in the health professions equates to improvements in safety and quality of health care (Australian Council for Safety and Quality in Health Care, 2004; Axley, 2008; College of Midwives of Ontario, 2006; Gonczi, 1994; McAdams & Montgomery, 2003; Minarik, 2005; Pearson et al., 2002). Although, as previously noted, there exists little evidence to support this claim (Pronovost et al., 2006). Although the lack of evidence is more likely due to the difficulties in examining these claims, common sense would suggest that the more current and up-to-date the practitioner is, the more likely it is that they would provide best practice care.

Australian situation in nursing and midwifery

Currently, in Australia, each state and territory has a separate regulatory authority (Nursing and Midwifery Regulatory Authorities (NMRA)). Intended as a means to protect the public, each authority must recognise and utilise a consistent approach to assessing and proving competency of the health professions they

regulate (Australian Nursing and Midwifery Council, 2007; Productivity Commission, 2005). Presently this is a challenge due to the different legislation governing, and the practices of, the regulatory authorities across the states and territories. In addressing these challenges, recommendations from the Productivity Commission Report (2005) included establishing a single national registration board for health professionals. This national registration board would adopt national profession specific registration standards (Council of Australian Governments (COAG), 2008; Productivity Commission, 2005).

Although many of the health professions support the move to a national registration process, there is some concern as to the function of this board. Some health professions are concerned that the national registration board could be used to determine the function of a profession rather than to determine or ensure professional competency (Abbott, 2007; Productivity Commission, 2005). The Commonwealth Government has asserted that the primary function of this board is to guarantee safety of the public and it is not about altering professional demarcations (Abbott, 2007). This national registration system was due to commence operation in 2008, but due to a change in Federal Government, it is now expected to commence in 2010 (Council of Australian Governments (COAG), 2008).

With regard to Australian midwifery regulation, there have been challenges due to the differing standards and practices of the NMRAs across the different states and territories (Australian Nursing and Midwifery Council, 2007; Barclay et al., 2003; Brodie & Barclay, 2001; Productivity Commission, 2005). Some states and territories require a demonstration of 'recency of practice'⁶ whilst others require a declaration of competence⁷. Some states, namely NSW, do not require any proof of practice or professional development, nor do they require a declaration competence⁸ (Australian Nursing and Midwifery Council, 2008; Brodie & Barclay, 2001; Nurses and Midwives Board of New South Wales, 2009).

⁶ Provide satisfactory evidence of relevant nursing or midwifery practice during the five years preceding the date of the application.

⁷ Applications for renewal of registration must sign a declaration that they are competent to practise as a nurse or midwife

⁸ Personal experience as this is the state I am registered in.

Table 3: Summary of the continuing competency requirements by Australian Nursing and Midwifery Regulatory Authorities

State or Territory	Annual renewal of registration requirements	Audit requirements
Australian Capital Territory	• Declaration of competence • CPD requirements • Adherence to codes of practice and ethics	• Evidence of 30 hrs of CPD over 3 years One of the following types of evidence: • Professional development plan - signed by manager • Workplace competency assessment – signed by manager • Assessment against relevant competencies – by employer or manager • Professional portfolio
New South Wales	• Nil	N/A
Northern Territory	• Practice requirements within last 5 years • Written reference from employer • Declaration of adherence to codes of practice and ethics	Not currently audited
Queensland	• Practice requirements within last 5 years • Declaration of competence	• Completed Response to Notice of Audit – signed by the director of the employment facility Or • Certified copies of documents relating to competence and licensure
South Australia	• Practice requirements within last 5 years • Declaration of adherence to codes of practice and ethics	Nil

State or Territory	Annual renewal of registration requirements	Audit requirements
	Declaration of competence	
Tasmania	- Declaration of competence - Evidence of practice within last 5 years - Declaration of current practice including details of employment - Details of last employment	- Performance appraisal demonstrating ability to meet ANMC competencies: or - Declaration of competence by employer; or - Professional portfolio
Victoria	- Declaration of competence - Practice requirements within last 2 years - Evidence of CPD	May be required to provide proof of CPD
Western Australia	Nil requirements but may be audited and need to provide: - Evidence of CPD - Evidence of peer review - Professional portfolio - Recent satisfactory performance appraisal (if employed)	- Evidence of completion of CPD - Satisfactory performance appraisal - Evidence of peer review - Professional portfolio

(Australian Nursing and Midwifery Council, 2007)

Competency standards for midwives

Prior to 2006 in Australia, there were no recognised national competency standards specifically for midwives. Historically, in Australia, midwifery has been viewed as a specialty of nursing, therefore not an autonomous profession in its own right (Brodie, 2002; Fahy, 2007). Legislation in some of the states and territories is assisting the recognition of midwifery as a distinct profession from nursing, but the long held beliefs of midwifery as a sub-specialty of nursing, both publicly and professionally are slow to change (Brodie & Barclay, 2001; Fahy, 2007). Although slow, there is a steadily increasing recognition that nursing and midwifery are two separate and distinct professions. With this premise in mind, national competency standards were specifically developed for midwives in 2006 (Australian Nursing and Midwifery Council, 2008; Homer et al., 2005). These

standards were developed and endorsed by the ANMC with the purpose of providing common national standards for use by regulatory authorities (Australian Nursing and Midwifery Council, 2006a). The ANMC state that the standards should be used to assess competency in order to obtain and retain a license to practise as a midwife. The National Competency Standards for the Midwife were developed in consultation with midwives across Australia (Homer et al., 2005). The development and introduction of the competencies for the midwife was timely in relation to this research. These midwifery specific competencies provided the midwives undertaking credentialling with appropriate standards against which to judge their practice and demonstrate they meet. The standards state that the midwife should be able to demonstrate competency within four overarching domains in midwifery practice:

- Legal and professional practice
- Midwifery knowledge and practice
- Midwifery as primary health care
- Reflective and ethical practice

(Australian Nursing and Midwifery Council, 2006a)

Consistent regulation

The ANMC state that the regulatory authorities for nursing and midwifery in Australia are required to ensure that nurses and midwives registered in all states and territories are competent to practise, although they recognise that there is currently little consistency in this regard between the different states and territories (Australian Nursing and Midwifery Council, 2007). To date, all of the midwifery regulatory authorities in Australia have endorsed the competency standards (Australian Nursing and Midwifery Council, 2006b). Although the regulatory authorities have endorsed them, not all require midwives to demonstrate that they meet the recognised competency standards on an ongoing basis (eg. NSW).

With the introduction of national registration for health professions, standardisation of midwifery registration and ongoing regulation requirements should occur (Australian Nursing and Midwifery Council, 2008; Cashin et al., 2008; Chiarella et al., 2008; Nurses and Midwives Board of New South Wales, 2009). All nurses and midwives will need to demonstrate continuing competency, and the methods they each use to achieve this will be the same. It is possible that

the methods used to assess the nurse or midwife will be similar to strategies used in the credentialling process.

Summary

This section examined and discussed competency, professional competency and continuing competency. Confusion around the terms and definitions were highlighted, as was the perceived need for demonstrating continuing competency within professions. The relationship between competency and improvements in quality and safety was discussed. In addition, the continuing competency issues in relation to midwifery and nursing were presented.

It is strongly believed, but not necessarily well supported, that requiring and regulating health care professionals to demonstrate continuing competency is beneficial in terms of ensuring safe and professional practice. The most accepted ways for a health care professional to demonstrate continuing competency is to benchmark practice against the accepted standards of the profession. Although it is not clear how to assess this, there is general consensus that using a variety of methods would be most suitable.

Assessing continuing competency in health care

Introduction

As noted previously, assessment of the professionals' practice against competency standards of the profession is the most commonly agreed way of demonstrating continuing competency. This section compares and discusses the most common methods currently used to assess continuing competency. Discussion and critique will include literature from the following topic areas: Continuing (ongoing) professional development (CPD) or continuing (ongoing) professional education (CPE); credentialling and practice review; reflective practice and professional portfolios.

Continuing professional development

The concepts of competency and CPD are related (Gosling, 1999; Griscti & Jacono, 2006; Monaghan & Shorten, 2008; Munro, 2008). Engaging in CPD contributes to building knowledge and skills, which in turn maintains competency. A practitioner's engagement in CPD is arguably the most common method used to (attempt to) assess and demonstrate competency of health professionals (Australian Nursing and Midwifery Council, 2008; Midwifery Council of New

Zealand, 2005b; Monaghan & Shorten, 2008; Nursing & Midwifery Council, 2008; The Royal Australian College of Obstetricians and Gynaecologists (RANZCOG), 2006). Despite this, there is debate in the literature around whether CPD has the ability achieve this aim. The UK Nursing and Midwifery Council, when discussing their post registration education and practice (PREP) continuing professional development framework assert that, while CPD is a key component of clinical governance, undertaking CPD does not guarantee competency. Critics of mandatory CPD (agree and) argue that, as there is no evidence-based link to improving practice or competency, it should not be a re-certification requirement (Andersson, 2001; Lysaght & Altschuld, 2000). Lysaght and Altschuld (2000) are stronger in their views and state that CPD could be considered 'a weak proxy for competency' (p.99).

Despite the arguments for and against CPD in relation to its use in assessment of competency, many health professional groups recognise the value of ongoing or continuing professional development (Australian Council for Safety and Quality in Health Care, 2004; Cioffi et al., 2003; Department of Health, 2003; Driscoll & Teh, 2001; Gould, Berridge, & Kelly, 2007; Levett-Jones, 2005; Midwifery Council of New Zealand, 2005b; Nursing & Midwifery Council, 2008; Productivity Commission, 2005; Schon, 1983; The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), 2006). In Australia, many medical professions require formal demonstration of proof of continuing professional development. For example, general practitioners, obstetricians and gynaecologists, surgeons and physicians and most specialist practitioners are required to demonstrate continuing professional development as a requirement of fellowship of their respective colleges (The Royal Australian College of Obstetricians and Gynaecologists (RANZCOG), 2006). Allied health professions, such as physiotherapy, psychology and social work also expect their members to undertake CPD (Pearson et al., 2002).

Similarly, non-healthcare professions in Australia encourage and often require their members to engage in CPD. For example, lawyers in NSW must partake in their professional bodies' mandatory continuing legal education (MCLE) scheme (The Law Society of New South Wales, 2009). The situation is slightly different in accountancy. Whereas the scheme for lawyers in NSW is mandatory, accountancy is considered a self-regulating profession so their requirements are not mandated, unless the accountant is a member of CPA (Certified Practising

Accountants) Australia, then they must participate in a quality review by an auditor. They must also attend 120hrs of CPD every three years (Pearson et al., 2002).

CPD in nursing and midwifery

The midwifery profession, both internationally and within Australia, recognises the perceived benefits of ongoing professional development (Australian College of Midwives, 2006a; Mead, 2003; Midwifery Council of New Zealand, 2005a; Monaghan & Shorten, 2008; Nursing & Midwifery Council, 2008; Turnbull, Reid, McGinley, & Shields, 1995). Some of the perceived benefits include; increasing professionalism; increasing public safety; improving retention of staff and improving competency (Andersson, 2001; Fahey & Monaghan, 2005; Smith & Topping, 2001). There is a plethora of literature that expounds the benefits of CPD, but an absence of evidence to confirm the suggested benefits (Smith & Topping, 2001). Many agree that CPD needs to be more than merely attending an education session. CPD should be planned on an individual basis, it should be based on the principles of adult education, formal reflection on learning should be encouraged and these aspects should be monitored either through self-assessment or more formally as is the case when CPD is utilised as part of a continuing competency framework (Andersson, 2001; Fahey & Monaghan, 2005; Smith & Topping, 2001).

Much of the research around CPD in nursing and midwifery concentrates on nursing, or includes both nursing and midwifery as one (Driscoll & Teh, 2001; Harper, 2000; Levett-Jones, 2005; Nursing & Midwifery Council, 2008; Smith & Topping, 2001). There is however some midwifery-specific literature around ongoing professional development. For example, Fahey and Monaghan (2005) used a qualitative approach to explore rural midwives' experience and perceptions on CPD and concluded that CPD could be considered an important strategy for retention of midwives in the rural areas. They claimed that CPD improves professionalism in midwifery (Fahey & Monaghan, 2005). Due to different regulation, legislation, education and both geographical and clinical environments, one cannot presume the results could be generalisable across Australia. A longitudinal study of United Kingdom midwives' attitudes to CPD, reported that providing opportunities for CPD was important in retaining midwives in the profession (Robinson, 1994). Mitchell (1997) explored the CPD needs of midwives in the UK. This study was conducted during the introduction of PREP,

the post registration education and practice framework discussed earlier. The findings indicate the importance of assessing needs and providing part-time and distance CPD programs (Mitchell, 1997). A further study sampled 120 midwives using a survey that examined midwives' motivation for CPD and concluded that the major motivators were to improve professional competency and fulfil a desire to learn (Laszlo & Strettle, 1996). Much of this evidence is not recent and only one paper examined the views of Australian midwives.

More recently, Monaghan and Shorten (2008) conducted a review of a range of health professionals CPD programs in Australia, New Zealand and the United Kingdom. The purpose of the review was to examine the underlying principles of developing CPD programs. The review informed the development of the Australian midwifery CPD program known as 'MidPLUS' (Monaghan & Shorten, 2008).

Much of the evidence about ongoing professional development in health care professions are discussion papers rather than empirical research. Many discuss the perceived benefits, issues surrounding or barriers to ongoing professional development for midwives, nurses or other health professionals (Australian College of Midwives, 2006a; Cioffi et al., 2003; Harper, 2000; Levett-Jones, 2005; Minarik, 2005; Smith & Topping, 2001; Worth-Butler, Fraser, & Murphy, 1996). All examined ongoing professional development in a climate where it was a voluntary undertaking. When professional development is considered voluntary, the perceived benefits and issues could be expected to be quite different to when legislation or regulation require it. All imply a link between ongoing professional development and quality and safety in health care, but do not discuss this in depth or provide evidence of improved outcomes following ongoing professional development. Most agree that ongoing professional development has significant benefits. These include, but are not limited to, increasing analytical ability; improving critical thinking; promoting effective communication; improving teamwork; increasing adaptability; and, improving quality and safety (Australian College of Midwives, 2006a; Cioffi et al., 2003; Harper, 2000; Levett-Jones, 2005; Minarik, 2005; Smith & Topping, 2001; Worth-Butler et al., 1996).

Professional development frameworks

In Australia, both midwifery and other health professionals' regulatory bodies have recognised the need to develop and introduce some form of CPD

framework. Some professions have highlighted the need for CPD frameworks to be designed to incorporate a wide range of professions and practice settings (The Royal Australian College of Obstetricians and Gynaecologists (RANZCOG), 2006). Others go on to say that such frameworks should provide a structured system to support professionals to identify and address development needs (Australian College of Midwives, 2006b; Monaghan & Shorten, 2008; The Royal Australian College of Obstetricians and Gynaecologists (RANZCOG), 2006). Furthermore, such a framework should address learning processes, professional roles and educational activities (Australian College of Midwives, 2006b; Monaghan & Shorten, 2008). An example of a relevant professional development framework is the Learning, Education and Professionalism (LEAP) framework (The Royal Australian College of Obstetricians and Gynaecologists (RANZCOG), 2006). This framework was originally developed by RANZCOG in association with the Australian Commonwealth Department of Health and Ageing, it was then trialled for use with all medical practitioners who are Fellows of Australian specialist medical colleges. The Australian College of Midwives (ACM) developed a national continuing development framework specifically for midwives. This CPD framework is known as MidPLUS (Monaghan & Shorten, 2008).

CPD in Australian midwifery

Historically, ongoing or continuing professional development in Australian midwifery has been self-regulating and often not pursued by all (Australian College of Midwives, 2006a). It has been assumed that midwives take responsibility to ensure that their practice is current. Unfortunately, this is often not the case. The recent introduction of MidPLUS, the ACM professional development program, seeks to change this. MidPLUS provides a national approach for midwives so that they may keep their practice current, competent and capable (Monaghan & Shorten, 2008). As discussed, prior to the development of the MidPLUS program, a review of similar CPD programs was undertaken (Monaghan & Shorten, 2008) to ensure the development of the midwifery CPD program included key operational elements of existing CPD programs. MidPLUS takes a learning cycle approach to CPD and recognises the importance of planning and reflecting on CPD activities (Monaghan & Shorten, 2008). MidPLUS encourages participants to utilise a wide range of CPD which includes formal and informal education/development.

Midwifery practice review processes

The Australian midwifery CPD framework incorporates a practice review component known as Midwifery Practice Review (MPR). MPR utilises a process that is similar to the NSW credentialling framework and the New Zealand College of Midwives' Midwifery Standards Review process. The credentialling process in NSW was utilised as a pilot site, informing the development of MPR. The development of the credentialling process in NSW was informed by the Midwifery Standards Review process for midwives in New Zealand. All three processes entail some form of self-assessment, practice portfolio requirement and peer and consumer panel review (Australian College of Midwives, 2006a; Griffiths & Homer, 2008; Midwifery Council of New Zealand, 2005b; New South Wales Department of Health, 2004a; New South Wales Department of Health, 2005b). It is envisioned that in time, and with legislative support from new regulation systems, this process of MPR or a similar such process, may be accepted as a demonstration of continuing competency linked to gaining an annual practising certificate.

There is a paucity of research investigating the process of credentialling in NSW, MPR in Australia and the Midwifery Standards Review Process in New Zealand and the effect of these on midwives. Only two research papers were identified in this area and both of these came from New Zealand. The first paper reported on an in-depth analysis of the effect of the Midwifery Standards Review process on midwives (Skinner, 1998). Skinner (1998) found that the midwives thought the preparation for the review was difficult and they were nervous going into it. Afterwards they felt it was better than they expected and pleased they had completed it. The second paper used a case study design to evaluate and analyse responses from midwives and consumers who were involved in the Midwifery Standards Review process (Barlow, 2001). Although this latter study included the experiences' of midwives undertaking the review process, the ultimate aim was to evaluate the educational aspects of the review process. Both studies were undertaken and completed prior to the standards review process becoming mandatory in New Zealand. Therefore, the results do not necessarily represent the current climate. The experience and acceptance is often very different when a process is voluntary. When credentialling was introduced for midwives in midwifery-led models of care in NSW, there was much concern regarding the process. Anecdotally, the midwives felt it was unfair that one

particular group were mandated to undertake it. As the process was unknown, there was also fear and anxiety among the midwives, as will be explored in this thesis.

Credentialling

Credentialling in Australia

Credentialling in Australia is not specific to midwifery. Other professions that utilise credentialling include radiologists, medical practitioners, critical care nurses, mental health nurses and ambulance officers (Productivity Commission, 2005, p. 149; Robertson & Chiarella, 1995). Within these professions, there exist opposing views on its value. The Royal Australian and New Zealand College of Radiologists suggest that credentialling should be 'an integral aspect of a modern health workforce' (Productivity Commission, 2005). In contrast, The Medical Training and Education Council of NSW are concerned about the difficulty some doctors have in accessing formal training which may be a requirement of being credentialled (Productivity Commission, 2005). Some professional bodies have particular concerns around who is responsible for administering a credential (Robertson & Chiarella, 1995), and argue that it is inappropriate for employers to be the credentialling authority (Productivity Commission, 2005).

The New South Wales Midwives Association (NSWMA), the state branch of the Australian College of Midwives (ACM), administers the process of credentialling midwives in NSW. When developing the credentialling framework, it was recognised by both the NSW Department of Health (who issued the policy directive) and the NSWMA (who is administering the process) that it was inappropriate to have employers of midwives responsible for the process. As discussed in the Introduction Chapter, a major area of concern was the need to ensure credentialling was seen as a professional development process, not a performance management strategy (Brodie, 2007).

Mandatory credentialling

Support for mandated credentialling of health professionals exists in the literature (Australian Council for Safety and Quality in Health Care, 2004; Cioffi et al., 2003; Magdic et al., 2005; Minarik, 2005). Consumer (public) protection and quality of care provision feature strongly as justification for credentialling of health care professionals (Minarik, 2005). Despite this support, many professional

organisations in health, have concerns regarding mandatory credentialling requirements (Productivity Commission, 2005; Robertson & Chiarella, 1995).

The credentialling process for midwives in NSW was mandated by the Department of Health (New South Wales Department of Health, 2004a; New South Wales Health, 2005). Midwives working in midwifery-led models of care are required to undertake credentialling. As discussed previously, there has been much debate about the introduction of credentialling (Brodie, 2007) as it is only mandated for one group of midwives. Whilst consensus on the need for a mandated process in relation to the concept of credentialling is lacking, this should not prevent trialling such a process (Cioffi et al., 2003). It is, however, important that the introduction of these processes is closely monitored to ensure they are not overly arduous for the practitioners who have to undertake them. In addition to ensuring the process is reasonable and to provide evidence to support the processes, the experiences of those who undertake them should be explored. Currently, there is a perception that the actual process of credentialling is a long and arduous one (Levett-Jones, 2005; Magdic et al., 2005). The experience in NSW supports this view. In particular, those required to undertake the process were anxious and worried about the perceived amount of time and work that would be required to collate a professional portfolio.

The use of reflective practice and practice portfolios

One of the most common aspects of credentialling or practice review processes is the use of a practice or professional portfolio to provide evidence of reflection on, and development of, practice. Professional portfolios are increasing in popularity and considered important in encouraging and documenting lifelong learning (Goodridge, 2007). It is acknowledged in the literature that a professional portfolio should not merely be a repository for evidence of CPD attendance. Attending CPD sessions does not necessarily equate to learning or practice development (Australian Nursing and Midwifery Council, 2008; Endacott et al., 2004; Jasper, 1999; Levett-Jones, 2005; Levett-Jones, 2007; Spence & El-Ansari, 2004). A professional portfolio should contain evidence of the professional's practice, learning and development including reflection on learning, reflection on practice, and a documented development plan (Goodridge, 2007). Maintaining a professional portfolio is time consuming, particularly initially (Australian Nursing and Midwifery Council, 2008; Endacott et al., 2004; Scholes

et al., 2004). However, when utilised to their full potential, reflection on learning and practice is enhanced (McCready, 2007; Scholes et al., 2004).

There is also an increased recognition of the importance of reflective practice in health care professions (Goodridge, 2007). Reflective practice can assist practitioners to recall and critically analyse their experience and is a process that promotes development of the practitioner and their practice (Ralston, 2005). Again, there is acknowledgment that the process of formally reflecting on practice is time consuming (Heath, 1998; Ralston, 2005) but a necessary aspect of developing practice (Taylor, 2005). There is also some discussion regarding the need for guidance in regard to undertaking meaningful reflection. Reflection on practice should be a deliberate, structured and orderly activity (Levett-Jones, 2007) Provision of guidance encourages deeper reflection and analysis (Heath, 1998; Ralston, 2005). My experience in working with both students and midwives around reflecting on practice would suggest that reflective practice is not easy, but if supported and encouraged it provides opportunity for professional growth.

Summary

This section discussed the methods used to demonstrate or assess continuing competency in health care. Despite a lack of empirical evidence to support the perceived link between CPD and improvements in health care, the most common method used is the expectation and/or requirement that a health care practitioner undertakes CPD. CPD is supported as part of a continuing competency framework. Continuing competency frameworks utilise a multi method approach to demonstrate and assess competency of health care professionals. Some form of practice review or credentialling is usually included, but again under researched.

Conclusion

This review of the literature demonstrates that there is recognition of the potential for credentialling in general, and highlights the lack of rigorous research available to endorse or examine the actual process or the outcomes of credentialling or a similar process. The support for credentialling tends to focus on the perceived benefits of an improvement in the quality and safety aspects of care provision. There is also a lack of evidence analysing the experiences of those who are required to undertake credentialling or similar processes. This research is not intended to prove or provide support for the claims of increasing quality and

safety through credentialling health care professionals. It will however, contribute to understanding how the process of credentialling affects those who undertake it.

Mandated credentialling of midwives working in midwifery-led models of care in NSW is now underway. In addition, a similar but at present voluntary process, Midwifery Practice Review, is being introduced on a wider scale to the midwifery profession across Australia. As with any new process it is vital that the both the process and the effect it has on those who are required to undertake it, is examined. Therefore, it is timely that this research is conducted.

This chapter examined the literature pertinent to the study. Evidence supporting the use of credentialling is available, but there is scant evidence that examines the effect of credentialling or similar review processes on those that undertake them. The next chapter explains the methodological approach and the methods used to answer the research question of 'What are the experiences of midwives working in midwifery-led models of care in NSW who undertake the credentialling process'?

Chapter Three - Methods Chapter

Methodology and Methods

Introduction

This is a qualitative study for a Master of Midwifery (Hons) degree using a descriptive exploratory design. This design was chosen, as credentialling is a new process within midwifery. Qualitative descriptive studies are particularly useful when seeking to describe people's responses to a new event (Burns & Grove, 2005).

This chapter describes the methodological approach to the study and the methods used. Descriptive exploratory methodology is discussed and justification of the methodology is provided.

This chapter also includes a personal reflection on the difficulties and challenges involved in ensuring an appropriate methodology was chosen for the study.

Research approach, paradigm, framework, methodology and philosophical approach

Introduction

In general, research can be divided into two paradigms, quantitative or qualitative. Each paradigm has specific or guiding frameworks, methodologies and theories (Burns & Grove, 2005; Schneider, Whitehead, Elliott, Lobindo-Wood, & Haber, 2007). This study took a qualitative approach as will be discussed in the next section.

Qualitative research

Qualitative research seeks to gain insight and make meaning of a phenomenon (Burns & Grove, 2005). A qualitative design is concerned with how an individual reacts within their world and how they make meaning of these reactions (Lavender, Edwards, & Alfievic, 2004). A common characteristic of all qualitative research is that the researcher has a close relationship to the research participant (Schneider et al., 2007). Using a qualitative approach in this study enabled a description and exploration of the midwives' experiences of credentialling.

Qualitative methodologies and methods are constantly evolving. The term method refers to the steps undertaken by the researcher to collect the data for the study (Borbasi, Jackson, & Langford, 2008), whereas methodology refers to the approach that the researcher uses to guide the conduct of the study (Borbasi et al., 2008).

Qualitative methodologies

There are three well-recognised methodologies: Grounded Theory; Phenomenology; and Ethnography (Schneider et al., 2007). There is also, an evolving approach that is referred to as descriptive exploratory methodology (Annells, 2007). Descriptive exploratory methodology has also been referred to as mixed methodology or free-form methodology (Annells, 2007; Burns & Grove, 2005; Schneider et al., 2007). Method mixing is where the researcher has combined different aspects of the recognised methodologies or paradigms. Traditionally, mixed method or methodology has referred to combining both quantitative and qualitative methods. Thorne (1991) explores methodological orthodoxy in qualitative research in nursing and concludes that rigid conformity to one or other of the well-recognised methodologies often restricts enquiry. In saying this, she does not support indiscriminate enquiry or 'sloppy research', but proposes that carefully adapting the existing methodologies may provide more clinically practical theories (Thorne, 1991).

There is growing support and recognition that utilising a mixed methodological approach within the qualitative paradigm is both practical and accepted (Annells, 2007; Cresswell, 1994; Sandelowski, 2000). Annells (2007) suggests that the mixed methodology referred to as descriptive exploratory methodology is taking over as the most common approach in nursing and midwifery research. There are, however, some concerns with utilising a mixed methodological approach (Annells, 2007; Burns & Grove, 2005). The well-recognised methodologies such as Grounded Theory, Phenomenology and Ethnography are all informed by explicit philosophical approaches. A mixed methodological approach often has no explicit philosophical underpinning.

Quantitative researchers differ in opinion on the importance of having an explicit philosophical stance that informs the research. Some argue that, the underlying philosophical approach of the methodology directs the interpretation of the data, therefore the philosophical approach needs to be explicit (Lavender et al., 2004). The philosophical approach indicates the underlying belief systems that direct

and inform the research. Without an explicit philosophical approach the research is seen by some as less theoretical (Lavender et al., 2004; Sandelowski, 2000). Others suggest that having a philosophical approach is not of paramount importance, particularly when the study is concerned with description as opposed to analysis of experiences (Burns & Grove, 2005; Sandelowski, 2000). Although opinions on philosophical underpinnings differ, there is acknowledgment that although the philosophical approach guiding the research may not be named, it is often evident. Burns & Grove (2005) suggest that 'the philosophical base can be extracted from the text' (p.536). Through careful description of method and exploration of methodology used, the philosophical approach to the research can be identified.

Descriptive exploratory methodology

Descriptive exploratory methodology is particularly useful to answer research questions about people's response to something or how they feel about a particular event (Sandelowski, 2000). As this research examined the experiences of midwives who undertook the credentialling process, this methodology was appropriate.

A major criticism of descriptive exploratory methodology is the lack of a recognised or explicit philosophical base (Sandelowski, 2000). Sandelowski (2000) argues that this should not always be considered a flaw of the methodology. The lack of philosophical underpinning allows the researcher to remain 'close' to the data, and is useful when description of the experience is of utmost importance. Descriptive exploratory methodology allows for description of the data in terms of what 'is there', as opposed to what the researcher interprets as 'being there'. It allows the researcher to analyse data, without having to analyse them using pre-existing theoretical or philosophical views. The method is ideal for research that focuses on the who, what, why, and where of events (Sandelowski, 2000). The main disadvantage of using descriptive exploratory methodology is the criticism on the lack of a theoretical or philosophical underpinning; therefore, this approach is often considered the least 'theoretical' of qualitative approaches (Annells, 2007; Sandelowski, 2000). This need not be a disadvantage and is dependant on the purpose of the research.

Descriptive analysis is useful when investigating previously unexamined experiences (Sandelowski, 2000). The aim of descriptive exploratory studies is

generally to present a comprehensive summary of events as experienced by the participants in the event (Sandelowski, 2000).

Reflection on methodology and method

It was after much deliberation and investigation that I chose descriptive exploratory methodology. In the early stages of developing and designing, firstly the research question and then the study design, I felt that the best way to answer the research question would be by utilising a Grounded Theory approach. Grounded Theory is based on the well-recognised theory of Symbolic Interactionism. Symbolic interactionism was first explained by George Herbert Mead in 1934 (Burns & Grove, 2005). Symbolic interactionism argues that people behave towards things or events they experience based on the meaning they have for them (Lavender et al., 2004). Symbolic interactionism is based on three premises: 'firstly, that human beings act on the basis of the meaning things have for them; secondly, that meaning arises out of social interaction with others; and, thirdly, that meaning is modified by the person's own interpretation process' (Bulmer, 1969, cited in Fenwick, Gamble & Hauck, 2006).

In this study, it is the individual's meaning that is central to understanding how the credentialling process affects them. This is why I felt a Grounded Theory approach would suit the study. From the beginning, I made it explicit that I would use a Grounded Theory approach, but the study would not generate a theory. It is well recognised that Grounded Theory is characterised by clearly specified steps for conduct of the research. I now recognise it was this well organised approach that was appealing, not Grounded Theory per se.

When explaining the purpose of the study and justifying the method and design to a senior researcher, I should have picked up on what I now see as a rather large clue. The researcher listened intently and then said 'OK, but you are not going to call it Grounded Theory, are you?' At the time, I thought this rather strange, what else was I supposed to call it? The method needed a name and I needed something to concentrate on and of course write about. On reflection and wide reading around methodologies and methods, I can now see what was meant.

As a beginning researcher, one of the major difficulties was developing an understanding of the terms used in qualitative research. The terms are often used inter-changeably. Methodology and method are often used in place of each other. As I understand it, method or methodology refers to a consistent and coherent

way of collecting, thinking about, analysing and interpreting data (Richards & Morse, 2007). This definition made it clear to me that methodology is a way of thinking and therefore affects the doing of the research and method is the steps undertaken to conduct the research. Richards and Morse (2007) maintain that each methodology has its own body of literature and rules around it use. They also recognise that some 'methods vary in their completeness' (Richards & Morse, 2007, p. 11). They discuss the concern that researchers feel the need to label all qualitative research using the traditional methodologies, when in fact; the research may use a mixture of, or an incomplete methodology. In addition, they recognise that much qualitative research is not conducted within traditional methods even when it is stated as so (Richards & Morse, 2007). These issues and debates are confusing and challenging for a beginning researcher.

Whilst most authors recognise that not all qualitative research can be labelled as one of the established major methodologies, few provide recognised, relevant or workable alternatives. This was extremely frustrating. I knew I was just using bits of Grounded Theory, but in reality, I needed a label to investigate, apply and write about in relation to my study.

It was during this time of thinking and reflecting on my study design that I discovered that there was a qualitative research approach that is emerging in its own right as a qualitative methodology. This was, descriptive exploratory methodology.

Subjectivity and location of the researcher in the study

As a midwife who has been involved in developing and introducing credentialling in NSW, I have an in-depth understanding of both the process and the reasons for its introduction. As a midwife, I have a deep commitment to ongoing professional development and the effect, I believe, it can have on improving the quality and the safety of the care provided to women. The development and introduction of a framework that enables midwives to demonstrate competency is long overdue. Furthermore, the current situation in maternity care, with the emphasis on clinical governance and risk management (New South Wales Department of Health, 2005a) supports the introduction of a process that should improve the quality and safety of health care (Australian Council for Safety and Quality in Health Care, 2004).

I wish to identify and clarify issues involving possible subjectivity. I am actively involved in the professional organisation that administers the credentialling process, the NSW Midwives Association. I have undertaken the credentialling process and assisted in preparing colleagues to undertake credentialling. I am a trained credentialling reviewer and have sat on a panel that reviewed a group of midwives. Midwifery in NSW is not a large profession and through employment in clinical facilities, employment in midwifery education and professional activities, some of the participants in the study knew me. I identified strategies to ensure that this did not affect the quality of the data i.e. using another researcher to collect data when the participant is well known to myself.

Identifying these issues up front allowed me to recognise possible problems and introduce strategies to overcome them. I have also realised that being so deeply involved in the process may also bring a richness of understanding and experience to the research.

Being involved in the introduction of the credentialling process and having been in the first group of midwives credentialled, has led to some assumptions on my behalf. I assume that all midwives would be committed to lifelong learning and professional development. However, as this requirement is currently not regulated nationally, in reality, this is not always of concern to some of my midwifery colleagues.

Having undertaken the process, I needed to ensure whilst conducting the research that I was involved as researcher and not as a credentialled midwife. I did this by not being involved in the process of credentialling for the duration of the study. In addition to distancing myself from the process, after each interview I critically reflected on my ability as a researcher and scrutinised my ability to respond as researcher and not fellow credentialled midwife.

Whilst recognising the possible negative effect my experience could have on the research it is important to acknowledge that, having knowledge and experience of the process may allow me to better understand the experiences and the issues of the participants.

Ethical considerations

A number of ethical considerations were considered for the study. The Human Research Ethic Committee at the University of Technology Sydney has granted ethical approval for this study [UTS HREC REF NO. 2006-291A].

When conducting research with human participants the key concern is informed consent. In this study, consent was gained from all participants. They were given an information sheet about the study and asked to sign a consent form. The information sheet provided explanation of the purpose of the research, the data collection methods and how confidentiality and data storage concerns were met. Participants were reminded that they could withdraw from the study at any time.

Confidentiality was maintained by using an identification number for the participants. Initially, participants were allocated a number for ease of identification. This number was the order in which the interviews occurred. The initial plan was then to allocate a pseudonym to replace the identification number. However, as discussed previously, midwifery in NSW is a small profession, and many of the midwives know each other. I felt I would need to avoid all credentialed midwives names being allocated as a pseudonym regardless of whether I had interviewed them. As there are over 100 credentialed midwives this became problematic. So, to avoid confusion, and ensure confidentiality I then used the last two digits of sequence number that the digital voice recorder allocated the recorded interview as the study identification number. The original names of the participants and identification numbers were kept separate from the identification numbers and digitally recorded sequence number. This ensured that all identities were protected. In addition, all identifying data was removed from the transcripts. Data is stored in a locked cabinet for seven years, as per the University of Technology Sydney protocol for research data management. All data is stored separately from information that contains participant identification.

Method

Aim and objectives

The study aimed to answer the following question and address the stated objectives:

What are the experiences of midwives working in midwifery led models of care in New South Wales (NSW) who undertake the credentialling process?

The objectives of the study were to:

1. Describe and explore the experiences of midwives who are required to undertake credentialling in NSW.
2. Describe the credentialling process and examine the effect it had on the professional development of the midwives.
3. Examine the possible relationship between credentialling and professional development in relation to the experience of the midwife undertaking the process of credentialling.

Selection of research participants

Purposive sampling was used for this research as the study was designed to elicit views from individuals who had experienced the event being studied (Burns & Grove, 2005). Purposive sampling has the ability to provide rich information on the event being researched (Schneider et al., 2007) as it allowed the researcher to select only those participants who had experience of being credentialled. All participants in the study had to have undertaken the credentialling process; therefore, purposive sampling was suitable. The total number of participants for this research was small in number, which reduced the ability to utilise other sampling methods. At the time the study was conducted there were no more than 70 midwives who had undertaken the credentialling process in NSW.

There was no predetermined sample size, and sampling ceased when theoretical data saturation occurred (Guest, Bunce, & Johnson, 2006). It is the richness of the data, rather than the number of participants that is of utmost importance in qualitative studies (Schneider et al., 2007). Literature on data saturation (Guest et al., 2006; Higginbottom, 2005; Schneider et al., 2007) suggests that approximately 10-15 participants is often sufficient to reach data saturation. Data saturation occurs when the interviews fail to reveal new information.

I felt that theoretical data saturation occurred after approximately nine or ten interviews (Guest et al., 2006; Higginbottom, 2005; Schneider et al., 2007). Two further interviews were conducted to ensure no further new data emerged. It was reassuring when no new data emerged from the final two interviews, as this demonstrated saturation has most likely occurred.

Participant recruitment

Several recruitment strategies were employed to ensure purposive sampling and rich data. Firstly, all midwives who had undertaken the credentialling process were invited to participate in the study. A letter was written to the Vice-President of the NSWMA requesting assistance to contact the midwives who had undertaken credentialling. At the time, the President of the NSWMA was the supervisor of this research and therefore had a conflict of interest. The NSWMA, through the vice-president, agreed to provide support with this request.

Recruitment occurred in the following way:

1. Secondary access to a database of all credentialled midwives was made available for the purpose of the study. I did not have access to the database, the NSWMA administrative staff accessed the database on my behalf.
2. I provided the NSWMA with the letters inviting the midwives to participate in the study.
3. The letters of invitation were sent out by NSWMA to each midwife who had undertaken credentialling.
4. An advertisement was created inviting credentialled midwives to contact the researcher and was to be posted to the midwifery managers of the workplaces where midwifery-led models of care are in operation with a request that they be displayed in common areas. Due to the overwhelming response to the mail out, this strategy was not required.

The response from the midwives was enthusiastic. Twenty-two midwives initially offered to be interviewed for the study. Then through word-of-mouth after each credentialling session, more midwives were willing to be involved. This could have been because credentialling was a new and somewhat controversial process and midwives wanted their stories heard.

Purposive sampling allowed me to recruit midwives from a variety of models of care midwifery care and from different Area Health Services. This strategy was used to ensure recruitment of midwives who were representative of the total group of potential participants. Purposive sampling from the group of midwives who volunteered continued until no new information was emerging from the later interviews. Only one of these midwives was a close colleague (who worked at the

same Birth Centre where I continue to practise). She was offered an alternate interviewer, but she declined this offer.

The midwives who contacted me and who were not required as participants were advised of this by phone. I spoke with them, thanked them for offering to be involved and advised them that I felt I have obtained enough information for the purpose of this Masters research.

Data collection

The interviews took place between mid May and early November 2007. In-depth interviews were used to collect data. The interviews were semi-structured to allow the participants to express their own interpretations of the experience of credentialling. The trigger questions for the semi-structured interview were developed in consultation with supervisors, and from feedback from examiners, and were designed to assist in gaining data that contributed to answering both the research question and the objectives. The broad trigger questions were as follows:

- How did you find the credentialling process?
- What was the most challenging aspect?
- How did you feel during the credentialling review?
- How do you think undertaking the credentialling process will impact on your practice?
- How did you feel before the credentialling process?
- How did you feel after the credentialling process?

Further to the broad trigger questions more probing questions were used when information that was more detailed was sought, examples of additional probing questions were:

- How and when did you start you prepare for the credentialling process?
How much of this would you have done if did not have to go through the credentialling process?
- Who or what helped you most in your preparation?
- What motivated you to become credentialled? Would you have undertaken it if it was not mandated?

- Were there disadvantages or dangers for you undergoing the credentialling process?
- Tell me what happened during the actual credentialling review? How did that make you feel?
- What do you believe was being assessed during the review? Do you think this is important?
- How has your practice changed due to the review?
- How have others reacted to you becoming credentialled?
- What would you advise other midwives who are considering becoming credentialled?
- When you repeat the process in three years time, what would you do differently?

The interviews took no more than one hour. All interviews were recorded using a digital voice recorder. The interviews were transcribed verbatim by a professional transcription service. This was made possible by a scholarship from the Australian College of Midwives. I listened to the interviews as soon as practical after the event and made notes on tone, voice inflection and emotion as these are lost with transcription (Burns & Grove, 2005). Repeated listening of the interviews allowed me to become familiar with the data before transcriptions were available. Becoming familiar with the data allowed me to slightly alter the trigger questions and employ the probing questions in subsequent interviews. This assisted in ensuring focussed data collection that ensured the objectives of the research were addressed.

All interviews were conducted face-to-face, in a location chosen by the participant. This encouraged the participant to feel in control of the interview process and reduced the level of inconvenience for them (Lavender et al., 2004). I conducted all interviews as none of the participants requested an alternate interviewer.

Data analysis

In accordance with the methods used in qualitative descriptive exploratory studies, thematic content analysis was utilised. Most qualitative analysis utilises some form of thematic content analysis and it is the philosophical underpinning that directs the data analysis (Burns & Grove, 2005; Byrne, 2001; Ezzy, 2002;

Hsieh & Shannon, 2005; Pope, Zeibland, & Mays, 2000; Richards & Morse, 2007; Sandelowski, 2000; Tere, 2006; Thorne, 2000). Some literature refers to this as seeing the data through a certain 'theoretical lens' (Schneider et al., 2007).

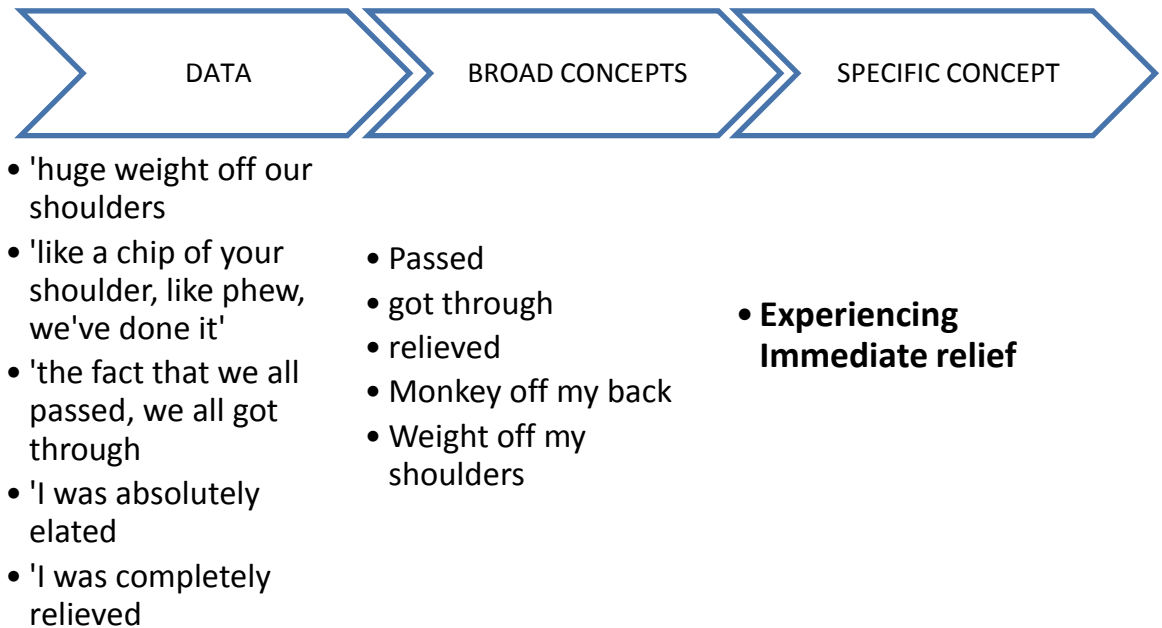
Descriptive exploratory methodology does not have an explicit theoretical underpinning when compared to a methodology such as Grounded Theory. Descriptive exploratory methodology seeks not to over-analyse, but to explore and describe the data. This therefore allows the data to be viewed as it presents. As previously mentioned this allows the researcher to remain 'close' or 'true' to the data (Annells, 2007; Sandelowski, 2000). Thematic content analysis in descriptive exploratory studies aims to describe, explore and summarise data (Sandelowski, 2000).

Data analysis commenced with listening to the recordings as soon as practical after the interviews. Thematic content analysis was used to identify major themes in the data. After the interviews were transcribed verbatim and stored as a Word document, I read all interviews from start to finish. I then proceeded to re-read each interview and identify common words or phrases, these were written in pencil in the margin. This form of analysis allowed the data to be grouped initially into broad concepts. The broad concepts were further explored and grouped into more specific concepts. The grouping of the common concepts allowed themes to emerge. Exploration of the concepts allowed in-depth description of the data. Using this form of data analysis through the descriptive exploratory methodology has allowed description and exploration of the experiences of midwives who have undertaken the credentialling process.

Using this process enabled an audit (decision) trail. The audit or decision trail demonstrates how the concepts and themes developed and how they relate back to the original data (Borbasi et al., 2008; Schneider et al., 2007).

Figure 1 below illustrates how, from the data, broad then specific concepts were identified. The exploration of the data used in this example ultimately related to how the midwives in the study experienced achieving the credential.

Figure 1: Example of emerging concept informing the theme *achieving credentialling*



Reflexivity

Reflexivity was required during data analysis. Reflexivity allows the researcher to examine the effect they have on the data. Reflexivity is a process that involves critical self scrutiny (Burns & Grove, 2005). Throughout data collection and analysis, I have considered and attempted to minimise the effect I had on the data and the analysis.

Identifying possible issues of subjectivity prior to data collection, allowed me to identify strategies to overcome the effect these issues may have had on the data. As previously discussed, I have undertaken the credentialling process myself. Through critical self-reflection, I have been able to address some of these issues. For example, because I was involved in developing and introducing the process, I realised that I initially attempted to defend the process. This may have had an effect on how open the midwives were in discussing their experience of credentialling as not only was I subtly defending the process, the midwives were aware that I assisted in the development and the introduction of credentialling. I was also a known supporter of the process as I had spoken at various seminars and in-services that some of the midwives had attended. The midwives may have not wanted to offend me. To try to minimise this effect I attempted to remain neutral during the interview, and often stopped myself from commenting on things the midwives said. Instead, I employed further probing questions. When I reflect

on this strategy, I note how the interviews changed as I became aware of this issue. In the initial interviews, I failed to explore some interesting comments. One of the midwives made quite a negative comment about the process. Instead of exploring this comment further, I chose to ignore it. I now realise the reason for this, that being, I did not want to hear criticism about a process I strongly believed in. After critically reflecting on the first couple of interviews, I realised what I was doing and made sure that I reassured the midwives that my role was researcher, not midwife or manager. When the midwives discussed the process, I used further questioning to encourage explanation and discussion. I also reminded the midwives that the interview was confidential and all information gained from it would be de-identified. In addition to this, I attended an interview with a colleague for practise purposes only. During this interview, I was able to try several strategies to help me overcome some of the more obvious researcher bias. I was able to transcribe this interview and listened to it repeatedly to critically analyse and reflect on my technique. In addition to this, time during supervision sessions was spent discussing how I might improve interviewing technique. My technique improved over the period of data collection. Due to this research being at Master's level, a decision was made not to return to the initial interviews, as similar comments were evident and explored fully in following interviews.

During my initial review of the body of literature around data collection and analysis there were frequent recommendations from various authors about the importance of keeping field notes (Cluett & Bluff, 2000; Rees, 2003; Richards & Morse, 2007). Although many well-versed researchers espoused the benefits of field notes, I had difficulty in understanding their purpose and exactly how to write them. I bought a special notebook for my field notes and took it with me to all meetings and interviews. Despite the best intentions, I did not find recording field notes easy or particularly helpful in assisting with the collection or analysis of the data. When I reflect on this, I feel it is because I had unlimited access to both the recorded interview and the transcripts of the interview. In addition, the small number of participants in the study allowed me to easily remember or recall the interviews.

Reflexivity allowed me to examine my effect on the data and to shape the way I viewed the data. This allowed me to remain close to the data, and describe and explore the experiences of the midwives participating in the study.

Conclusion

This chapter has provided the rationale and explanation for the use of a descriptive exploratory methodology to examine the experiences of the midwives who have undertaken the credentialling process. The chapter has also provided a description of the methods used in the study. Woven throughout the chapter, is my personal reflection on the process of designing and conducting this study.

The next chapter presents the findings of the study. The themes that emerged during data analysis will be presented and the concepts informing the themes discussed.

Chapter Four - Results Chapter

The Findings of the Research

Introduction

This chapter presents the findings of the study. Five major themes will be presented. The themes are: *preparing for credentialling*; *doing credentialling*; *achieving credentialling*; *valuing credentialling* and *improving credentialling*. When the midwives discussed their experience of credentialling, the themes were always discussed in the order presented in this chapter. Each of the themes, and the concepts that made up the themes, will be discussed separately.

Preparing for credentialling

Preparing for credentialling was an important initial step for all the midwives. Under the theme *preparing for credentialling*, four concepts emerged. The midwives encountered a range of feelings and/or experiences in their preparation for credentialling and the majority of the participating midwives appeared to move through the preparation in a similar order. The four concepts emerged sequentially:

1. Getting started
2. Becoming clearer
3. Moving through
4. Getting there

Getting Started

When the experience of preparing for credentialling was discussed, the majority of midwives used similar terms to express how they felt. All but one midwife stated they found the preparation stressful. They felt that initially it was overwhelming; they were daunted by the requirements and unsure even what it was and unsure how to begin preparing for it. For example:

... Initially I found it all very overwhelming and I was a little bit defensive about even the thought of having to do all this plus that. It just seemed all too much (18).

... Nerve-wracking! I was very very nervous about it, very daunted by it, it looked like a huge amount of work and when we first found out about it the impression was very scattered. You heard a bit here and you heard a bit there (22).

The midwives felt overwhelmed by what was expected in terms of getting their professional portfolio in order. They said:

...getting together a portfolio, was harder than the fact that it was a lot of organisation of paperwork ... harder in that you had to think about what you want to put in (18).

Many of the midwives referred to the portfolio as paperwork only, rather than a way to provide evidence of their practice or ongoing continuing professional development (CPD). They acknowledged that preparing the professional portfolio was a time consuming and confusing part of the process. The confusion was discussed in terms of it being a new process that they knew was constantly evolving and seemed to change often. They said:

...but they [NSWMA] were evolving and changing over the time, so we were thinking, is that the one we go with or do we go with the latest? And how often will they [NSWMA] be changing it? Will we be working on something that's going to be obsolete by the time we're getting ready for the paperwork part of it (21)?

The midwives were aware that they were some of the first candidates to undertake credentialling. They felt that they lacked guidance or an understanding of what was required of them. One of the midwives said::

... the whole thing wasn't like 'here is exactly what you have to do, so go ahead and do it, it was very fragmented and a bit, not plain. That made us very nervous. No-one had done it before that we knew of so we couldn't talk to anyone about it, no-one here had done it, none of our hierarchy had done it, so they weren't any help (22).

Midwives expressed concern at their ability to manage the organisational and technical aspects required to pull together and present a professional portfolio. For example:

... it was quite a bit of time and effort for some people too, because of computer skills and stuff (20).

Others felt that much of their preparation time and effort went into improving skills such as typing, formatting documents, presenting statistics in table or spreadsheet form and electronically collating documents. Some midwives felt that they lacked skills in very basic word processing and use of information technologies in general. Not having these skills was a disadvantage, for example:

... I consider myself semi-literate computer-wise, so trying to format statistics into some sort of manner that was going to be readable and able to be what was needed, just getting computer literate and being able to negotiate around. Plus I only got myself a home computer last year, so that was a big deal, to have to do so many new things all at once (21).

The experience of *getting started* was a stressful one. The midwives felt that getting all the required evidence together was hard work and required considerable time, effort and organisational skills.

Becoming clearer

Although the midwives experienced difficulties in making a start in their preparations for credentialling, after the initial difficulty, the requirements *became clearer*. However, they continued to struggle to come to terms with what was expected of them. Finally realising that what was expected of them was less than they had anticipated. For example:

... Everyone was sort of fumbling initially I think. Putting all the paperwork together was extremely hard and to then read through...they only really wanted a small amount at the end, but we did all these things which needed to be done and then there was just a small amount that we needed to send off [to NSWMA] (20).

Clarity around the portfolio requirements seemed particularly important. The midwives repeatedly referred to the confusion around the requirements of the portfolio. This was reflected in comments like:

... We made up a lot of it as we went along, until we got more clarification. I think everyone was in the same position (23).

One strategy identified, was to follow a systematic process or to break down the requirements into manageable sections and proceed from there. The midwives described this process which worked for many of them:

... there was too much of it and we had to break that down a bit and find out what we actually needed to do (28).

... I just copied them onto a work folder [computer] and then just sorted them out. And it's systematic when you know that you've got all of those things—you've almost got a checklist that you tick off (38).

As the requirements of the process became clearer, it also became evident to the midwives that they would meet the criteria. They said:

...I think also, trying to understand what the question was, e.g. just going through the competencies, I thought, ooh, do I do all these things? Until we started talking amongst ourselves, we could identify 'this means that' and that's something that you can do, and that should go into that box, and I think a lot of the work that we do, we don't sort of classify it under specific labels, it just becomes a part of our work that we do, or our philosophies. Until you start putting them into little compartments, you think, I don't think I fit all the criteria (21).

Becoming clearer referred to the midwives' ability to understand the requirements of preparing for the credentialling process. *Becoming clearer* also incorporates how the midwives started to feel about their ability to demonstrate how they met the criteria of a credentialled midwife.

Moving through

As the process progressed, the midwives spoke about *moving through* the preparation for credentialling. The concept *moving through* refers to the midwives' realisation that, although the process was daunting, it progressed once they got the preparations underway. As they moved on with their preparations they started to feel that they would be able to complete the process. The midwives recognised that, while the preparation was hard work and at times exhausting, it was not impossible. They said things like:

... we just slowly worked through it... like it was a like a big assignment, like 'I have to get through this and do it (20).'

... just set aside some time to do it, some specific time—what the credentialling process actually asks of you isn't difficult—it just means you have to sit down and work through the process and do it (20).

The midwives realised that they needed to move through the process systematically. After initially panicking, the midwives began to understand what was expected and began to see a way through or move through. This is reflected in the following comment:

... I started changing my way of thinking and thought, 'this will be OK, I can do this (18).'

A deadline to work towards assisted midwives in *getting started* and once they began getting the paperwork in order they found the expectations *becoming clearer* and they felt more able to complete the requirements. Although having a deadline assisted some of the midwives, it also created additional stress and pressure for others, for example:

... timeframes to get certain parts of the paperwork portfolio together so that we weren't lagging behind or having to do everything in a rush. So this was the date and we're working towards it (21).

... We had the deadline... it became like a monster that just kept looming, looming, looming. It was horrible, just revolting (17).

Both having a deadline and increasing clarity around the process allowed the midwives to progress on and *move through* the preparation phase of credentialling.

Getting there

Getting there refers to the midwives realising that they were able collate the necessary evidence to complete the requirements. The midwives discussed ways they were able to reach this point. Many of the midwives suggested that *getting there* was made easier by seeking assistance and/or working together as a group. They said:

...the team that I work with were at an advantage, [this was] because the [other] team that we also work with did their credentialling a number of months before we did, so they had already started the process of finding out the information (21).

... but she [midwifery manager] knew someone who had been credentialled who had gone on to be one of the credentiallers, so she got them to photocopy part of her portfolio, then we got a disc from somebody who had some information on it (22).

Over time, the pool of credentialled midwives available for the midwives preparing for the process to seek assistance and advice from increased. This was recognised by the midwives in the study. The administrators of the credentialling process [NSWMA] also conducted workshops to assist midwives' in developing and preparing for credentialling. Many of the midwives made use of these preparation workshops as seen in these quotes:

... she [previously credentialled midwife] headed me in the right direction, so then I felt quite comfortable. So it was just a matter of seeking that support, and not sitting home dwelling on it. That was a bit challenging but once I sought some help it was OK (18).

... so we talked a lot to other people about what was actually meant and what did they [NSWMA] actually want, and I think I got pretty much prepared (23).

Getting there came more quickly to the midwives who completed credentialling some months after the introduction of the process than those who were among the first midwives to undertake the process. The midwives who were initially recruited as participants in this study were some of the first in NSW to undertake credentialling. This was evident when they talked about seeking support and assistance. One of the midwives said:

... We were the first 3 to actually do it, so nobody else had any idea really, what we were doing (19).

Midwives who completed the credentialling process later were appreciative of the assistance and direction available from those who had gone before. This was evident in the following quote:

... I was chatting to this person in the team about credentialling: she said my portfolio is in the car if you'd like to have a look at it. That was great because it was so helpful, it was so brilliant ... it was so positive to have a look at her book (39).

Summary – Preparing for credentialling

All the midwives interviewed spoke at length about *preparing for credentialling*, with most feeling that the preparation seemed overwhelming or daunting initially. Once the midwives were able to clarify in more detail what was expected of them they began to realise that the process would be manageable. As they *moved through* the preparation they also realised that they would be able to meet the requirements and this was a relief to most of them. The midwives appreciated the assistance and guidance they received from those who had previously undertaken credentialling.

Having undertaken credentialling myself, I recognised many of the participants' feelings surrounding the preparation for credentialling. As midwifery, has traditionally been an apprentice-style way of training, many of the midwives perceived that they did not have the skills required to complete the process. They demonstrate this when they discuss their lack of 'computer or writing skills' or when they talked about being 'certificate trained. I feel this contributed to the angst surrounding the introduction of credentialling. From the midwives experience, seeking assistance from those who had completed the process seemed to be the most helpful in allowing them to recognise that the process was 'do-able', and that if they slowly worked their way through in a systematic way, they could complete preparations.

Doing credentialling

The next theme was *doing credentialling*. The midwives all felt that actually *doing credentialling* – that is, the panel review, was a far better experience than *preparing for credentialling*. The four concepts that informed this theme were:

1. The panel review was great
2. Nothing like I expected
3. Appreciating reviewing practice
4. Enjoying telling my story

The panel review was great

The actual experience of the panel review part of the process was a positive experience. Although the midwives felt the experience was positive, many discussed how nervous they were prior to the panel review. This is evident in the following quotes:

... I don't remember anything bad about it, except how nervous I was (28).

... I had diarrhoea, vomiting, I couldn't talk, I had a nervous rash, I was a gibbering wreck because I don't do well at interviews (23).

Despite the administrators [NSWMA] and the developers [NSW Health] of credentialling for midwives emphasising that the panel review part was peer review and discussion, the midwives constantly referred to the panel review as an interview. The midwives said:

... I don't have a big issue with things like interviews (20).

... they made me feel so comfortable during the interview that it ended up not being a challenge (18).

... they flicked through [the portfolio] but really it was an interview (20).

All bar one midwife used similar words to describe the review process. The responses were overwhelmingly positive. This was reflected in comments like:

... I could relax and get on with what I had to say, so I found the people interviewing were great, very encouraging, so I felt good about that (18).

...I found it very supportive for the situation. The women that came [the reviewers] were quite chatty, it was really quite good, you could just sit back for a minute and let yourself relax I found it really quite good (20).

One midwife felt differently about the panel review. She acknowledged that although the panel were supportive and accommodating, she still felt the experience was stressful. She said:

... I actually had quite a personal traumatic experience with the panel review. Even though the panel tried to put everybody at ease and it was in a non-threatening situation I always get physical symptoms when I am being interviewed. So the actual process was stressful for me, even though I felt sorry for the interview panel because they thought that had done something wrong and they did their best to calm me down, but my personality is that once it [distress] starts, it's very difficult to just switch off (21).

The other midwives used terms like lovely, accommodating, approachable, encouraging and supportive to describe their experience of the panel review.

... found the people interviewing were great—very encouraging (18)

... felt great and it really was like a general conversation (23)

... the panel were great, from the minute I walked in the door to the actual interview, you could see they were affirming and pleasant and lovely (39)

Overall, they felt *the panel was great*.

Nothing like I expected

The midwives enjoyed the panel review although it was *nothing like they had expected*. Prior to the review, they were under the impression that the review would be like an interview. Some of the midwives felt that they would be questioned about their practice in a negative way. They said:

... it was coming from them, but not too interrogating or anything like that, and they allowed you to say extra if you wanted to and gave you the opportunity to add. I found that part of the process much more relaxing than I thought it could have been, when you're not sure what you're going to get and so you sit there, thinking, am I going to be a little bit confronted (20).

... It actually didn't feel like I was being interrogated by another midwife, which it could have felt like (38).

The midwives also expected that the review would be like a pass/fail interview situation. They were pleasantly surprised when they realised that the review was more of a discussion and less of an interview. This was evident in the following comments:

... I didn't feel that I was in an interview where they were judging me; I felt they were there to find out what I knew and what I was going to do with this, what my goals were and so forth (17).

... I felt the girls [the reviewers] that were there just were very relaxed and encouraging, to speak your mind and to say how you felt. I didn't feel intimidated by them at all, they were very approachable (18).

... they made me feel like, hey, part of the team here, they didn't talk down to me, they didn't talk up here over my head—it was nice (23).

... But it did frighten me, it did worry me. And then, when I got in there and I thought thank God, it wasn't so bad! Nothing like I had expected. I thought I would fail everything (23).

The midwives recognised that they had built up a negative image of the review process. Once they had completed the review, they realised that the panel review process was more peer review and discussion than interview, thus, *not at all as they expected*.

Appreciating reviewing practice

The concept *appreciating reviewing practice* refers to how the midwives recognised the purpose of the review panel process. The midwives were initially unsure as to the purpose of the panel review. They expected it to be a difficult interview where they would be interrogated about their practice. The midwives discussed how the way the panel review was set-up and conducted changed their impressions. They said:

... being hospital trained, I just thought, I feel a little bit intimidated, and that's just me being probably a bit too sensitive, because I'm really very happy with my practice, but then I'm thinking, oh, gosh, I'm with all these uni graduates and here I am from the hospital,

maybe I won't be able to get my point of view across as fluently as like someone that's [a university graduate] but no, I didn't feel that at all (18).

...They were really interested, very affirming and they were interested in my story, I knew from the beginning they were keen to hear that. Advanced practices were one thing, but they were looking for something behind that, just a feeling of where I was at with women [I cared for] (39).

There was some hesitation initially about being reviewed by a consumer. After the review the midwives felt that it was appropriate to include a consumer on the review panel. The midwives said:

...I think I was a bit cautious, we talk about we as midwives all the time and it's sometimes quite difficult to get across an emotion that maybe you felt as a midwife, and a woman who may have had a baby or had some sort of connection while she is doing it, but a consumer may not have got that (35).

... The consumer was extremely important. We have more and more to do with consumers and how important they are in the job that we do (38).

There were midwives who expressed, that not only was involving a consumer appropriate, but vital to ensure consumer representation. Involving consumers in the review of practice demonstrated the profession's willingness to be transparent in the care midwives provide. This is evident in the following quotes:

...women are leading the way, but if we're ever going to take our rightful place beside them, then we have to step up to that mark of being willing to be transparent and willing to develop ourselves in that way (25).

... And I absolutely loved having the women as part of the process—it is so important and critical I think, because that's the whole purpose of what we do (38).

Once the midwives realised that the review was not an interview and they felt comfortable and relaxed, they started to appreciate the opportunity to discuss

their practice. They recognised the importance of peer review in developing their practice. This was reflected in comments like:

... I think sitting around and talking about our practice, not in a defensive way, but in a truly exploratory way, is the way we learn and develop. And that should just be part of normal midwifery practice (25).

... this is a nice, really non-threatening way of looking at the way people practice (21).

... So I think for me, it validated that the process I actually did was the right one, that I was actually conscious of what I did and it was important that I think about it and learn from the situation (28).

The midwives' experiences of *reviewing practice* were initially hesitant but as they progressed through the panel review they demonstrated an understanding of the importance of the review process. They appreciated the chance to discuss their practice with both colleagues and consumers.

Enjoying telling my story

The fourth concept in the *doing credentialling* theme describes how the midwives *enjoyed telling their story*. The midwives felt that this was the very easy part of the review. Choosing the right story from their practice proved the most difficult aspect. They said:

... Presenting the story was easy because you had so many stories you could present (19).

...it just becomes like a conversation about what we can do, and telling a story, and the story I picked was something that was pretty recent and that was really easy to talk about for me, not traumatic, it was just really easy to talk about the story (38).

The midwives described how they felt about sharing their story. To them it was a real or everyday part of their midwifery practice so they enjoyed the experience and did not consider it at all challenging at. One midwife explained it like this:

... I was nervous to start with and then I got talking about stories and then it was like they couldn't shut me up. I found the process

really positive. Not very often that you get an opportunity to talk about your practice, and that time is yours only, and I found that in a sort of a selfish way, quite satisfying (28).

They spoke of the importance of relaxing into the telling of the story and allowing their passion for midwifery to come through. Demonstrating their passion was seen as important. For example:

...just show yourself off, if you know that you love any aspect of it, then tell your story about it and show how passionate you are, because you will just get all caught up in it, and we all do, you know (35).

... Once you get in there and start talking the nerves go, because it just becomes like a conversation about what we can do, and telling a story (38).

The experience of *doing credentialling* culminated with the midwives *telling their story*. They enjoyed this part of the process the most. They felt that discussing a situation from their practice and sharing it with the panel not only assisted them to reflect on their practice but allowed them to really *enjoy telling their story* and to shine as midwives.

Summary – Doing credentialling

All the midwives interviewed discussed the experience of *doing credentialling*. The midwives were pleasantly surprised at how much they enjoyed the panel review. Generally, they felt that *the panel review was great and nothing like they had expected*. They appreciated the opportunity the panel provided in terms of *reviewing their practice*. In addition, the midwives *enjoyed* the opportunity to *tell their story*.

Most of the midwives had worked themselves into a frenzy regarding the preparation phase. Constant referring to the peer review as an interview gave insight to how the participants viewed the process. The midwives had not considered that the process might be supportive as opposed to punitive. They all recognised that the panel was about reviewing practice, but worried that the reviewers were seeking to find poor practice. Midwives spend many hours telling stories from practice but often not reflecting more deeply on those stories. This part of the process allowed them to tell their story and demonstrate both areas of

their practice that they were proud of and recognise areas that required improvement.

Achieving credentialling

Achieving credentialling describes the midwives' experiences immediately after the panel review – *doing credentialling*. The two concepts that emerged were:

1. Experiencing immediate relief
2. Feeling personal achievement

Experiencing immediate relief

The midwives were unanimous in *experiencing immediate relief* after the panel review was complete. This is evident in the following quotes:

... We all felt excellent then. It was just like this huge weight off our shoulders (17).

... Completely relieved, I'll tell you. It was just like a chip off your shoulder, like whew, we've done it (19).

... I was elated. I was dancing down the stairs (23).

They were relieved because they had been thinking of the panel review as an interview or examination. The midwives were happy to have 'passed' and not 'failed' the panel review. The midwives said:

... Absolutely elated! The fact that we passed, and got through all that (22).

... if I fail this one, I'm out, I'll never make a good midwife (23).

There was also relief that the preparation was completed and successful. The midwives recognised that it would be much easier next time as the bulk of the required paperwork was completed and from now they would just need to keep it up-dated. They said:

...I've got this great piece of paper with all these records all together, so that when I do come up for my next appraisal, or performance appraisal, that I've done all this to start with, I don't have to worry about that for now, just keep it topped up (21).

... it gives you a sense of tidiness and completeness in a folder rather than a big box (39).

... I will be a bit more organised and things will be already up to date, so I don't have to spend all that extra time pulling everything together (28).

The *immediate relief* experienced by the midwives was in part due to the formal part of the process being completed. The relief was also heightened as the expectation the midwives had prior to the panel review was so negative.

Feeling personal achievement

In addition to *experiencing immediate relief* after the panel review, the midwives expressed a *feeling of personal achievement*. The pressure surrounding *achieving credentialling* was immense. This is evident in the following quotes:

... I also felt a great achievement too and a relief that you did get through it - very stressful, but you did get through it, but you weren't non-credentialled (21).

The midwives felt that achieving credentialling was a major achievement in their lives and in their careers. They said:

... [I felt] fantastic, I felt really good about myself and all the work that I had done over the years, and putting it all together and being able to show that to somebody, just felt really good (18).

... So, for myself personally, I think it was an achievement. It's a feather in my cap that I can say that I've done this (22).

... so I felt like I had improved as a midwife and I probably felt even better about myself because I did those harder yards (18).

Summary - Achieving credentialling

The initial post panel review feelings were of *immediate relief*. Midwives used words like, elated, excellent, fantastic and excited to describe their feelings. After the panel review, the midwives also felt a sense of great *personal achievement*. They had worked hard in the lead up to

credentialling and once credentialled they felt like a weight had been lifted from them.

These feeling stemmed from the belief that the process was arduous and there was an underlying sense of resentment as they were mandated to undertake the process. The sense of personal achievement was heightened as they felt attaining the credential proved that they met a standard not all midwives would be able to attain.

Valuing credentialling

Introduction

The theme *valuing credentialling* reflects the turn-around in seeing the value of credentialling. The midwives were initially unsure as to the value of credentialling. After having time to discuss and reflect on credentialling, the midwives were able to explain how credentialling affected them on a personal and professional level. There were general feelings of confusion around the perceived value of *achieving credentialling* and exactly what it meant for them as midwives. The five concepts in this theme were:

1. Is it just another piece of paper?
2. Assessing and affirming practice
3. Existing advanced level of practice
4. Developing a professional plan
5. Reflective practice

Is it just another piece of paper?

The midwives were unsure what credentialling was all about and they felt their colleagues who were not mandated to undertake the process were even less sure about the value of credentialling. This is demonstrated in the following quotes:

... I wondered what it would all mean, and whether it was really, er, what it would mean to anybody else—whether it was something that was really worth going for or it wasn't (20).

... The core staff in delivery suite are a bit mystified by the process and don't see themselves as being related to it. It's like it doesn't mean anything for them, so it doesn't mean anything to them (38).

As the midwives thought more and discussed the value of the process, many of them still perceived being credentialled in terms of ticking a box. Credentialling was mandated for this group of midwives and they often saw gaining the credential as completing what was required of them. The midwives said:

... I don't feel particularly cynical or dreadful about it though, but it just feels like another piece of paper I suppose (20).

... Another hoop to jump through (28).

... I'm very good at jumping through hoops if I'm asked to do it. I'm a good girl (39).

Some of the midwives recognised that, even though it was a process that they had to undertake, it could also be considered part of ongoing professional development that might contribute to advancing their career. They said:

...something that you could do and I think it's a professional thing and always looks good on the CV that you've done all the things you could probably do. But also I was in group practice, so I think it was being touted around this is what you have to do (35).

... I think for me it was more another tick to go in my career. I've done lots of things in my career I wanted to do and this was just another thing I've done (35).

... it's just a continual education process (28).

The midwives often spoke about feeling undervalued after *achieving credentialling*. This most often referred to the fact that the midwives, their colleagues and managers were unsure whether it meant anything to them. The following quotes demonstrate how the midwives were feeling:

... So we've not had proper congratulations, even from our operations manager or anyone. Nobody really understood just what we've done. The fact now that they're are starting to think about portfolios and that, so I think people are starting filter through finally what we have done and what we are putting into it (19).

... we've had no recognition through the management. Someone [no-one] saying 'Good job done (19).'

... It's never been written about, it's never been talked about, no-one said 'congratulations (23).'

... because I'm the first one to do it, and when you get something like that which is a major achievement in your life, you expect to get some accolades and stuff, but we got 'oh well done'. OK, but there was no 'brilliant! Let's celebrate, let's have a drink' etc, there was none of that (23).

The midwives felt that they had worked hard in *achieving credentialling* and were upset that there was limited recognition. They felt that as no-one really understood the *value of credentialling*, and that because credentialling was only mandated for a particular group of midwives, there was a distinct lack of understanding of the effort required to become credentialled from the broader workplace.

Assessing and affirming practice

The midwives understood credentialling to be about assessing and affirming their practice. When discussing the assessment component of credentialling, they used words with negative connotations. Although they described the assessment in negative terms, the midwives were able to see it as more of a positive process when the assessment affirmed their practice. Initially the midwives described their feelings this way:

... it [working in a midwifery-led model] was always very much an under-the-spotlight way of working, so, because I knew I was always under surveillance (25).

... It's a bit scary to think that you might not be up to scratch, and particularly because the people who are reviewers are midwives that are really well known, and particularly the 2 midwives that were there the day I was there are particularly high-profile midwives who are like leaders in the profession in NSW, so it's like they are high standards to live up to (38).

The midwives likened the process to an interview or examination and placed an emphasis on passing, like you would pass an assessment. The midwives recognised that it was not supposed to be about passing and failing, but about reviewing practice and improving practice, but they said:

...even though in my heart I knew that I shouldn't fail - it was just that failing thing but we were reassured that it's not a failing thing, like something you need to address. You can just sit again a little bit later, but I was reassured not to feel that way, but I still wanted to pass. I still wanted to get through (18).

... Just the whole failing thing. That was probably the hardest, and I know they don't call it that you've failed, but it was really quite [stressful] (17).

The midwives felt one of the purposes of credentialling was to review their practice. When asked what exactly was being reviewed, the midwives felt that safety was a major factor that the panel was looking to ensure. This is evident in the following quotes:

... It's just about whether you're safe and whether you know what you're doing (35).

... That we have to prove to our professional body that we are accomplished or competent (28).

... For me, I always couldn't *not* have been successful, because I know I am a safe practitioner, I don't do dodgy things, I think they [the panel] were assessing safety, documentation, just those main things (25).

The midwives felt the process affirmed their practice. This was reflected in comments like:

...So I think for me, it validated that the process I actually did was the right one, that I was actually conscious of what I did and it was important that I think about it and learn from the situation and not just think, oh well, that's done, but it is something that I've done for a while and I think, in many ways, that relates a lot to the sort of people who want to work in this autonomous way anyway (20).

... It [credentialling] was more an affirmation of my high standard rather than bringing me up to a standard for me. I felt that I was already there (39).

... it [credentialling] probably actually affirmed with my professional understanding of why I do what I do. I don't think it led me to any newer ultimate ways of thinking, it's just re-affirmed why I practice the way I directed myself over the years (28).

Although unsure at times, there was general consensus that assessing practice was part of the credentialling process and it was also an affirmation of their practice.

Existing advanced level of practice

The midwives felt they already had a high level of practice and that the process of credentialling re-affirmed this. The notion of this different or advanced level of practice was discussed when the midwives tried to explain the value of credentialling. This group of midwives felt that they practised at an advanced level and some felt they were unfairly targeted through the mandated credentialling process. There was a level of arrogance that came through when they discussed this. For example:

... we [group practice midwives] do a good job anyway, so you tend to think that through, and it's not something that I think anybody could just push on somebody who is just 'going to work' (20).

... because it was like, if you're not going to credential me then who are you credentialling? I think if you are a safe and good midwife, it's a great process for being able to say 'well, look how good I am (35)!' (35)!

... I tend to think I'm different from the general population of midwives because I actually seek to make a change, whereas a lot of my colleagues are happy just doing the tasks they've been set, and not looking past those (28).

The midwives acknowledged that they were a specific group and they often discussed the seeming lack of recognition of this.. This is evident in the following quotes:

... [in other professions] you do a ticket or you do a something that moves you up somewhere, changes your standing, your income, or

something, and that never happens in this area of work. *(laughs)*
Not that I thought it needed to come with those things, but I thought maybe some sort of a status, for want of another word, whether it would be tagged as another level of working (28).

... I think they [midwives not required to undertake credentialling] tend to think it's not their problem. They think, oh well, it's your mandate if you have to do it, but if we're not mandated then we're not going to do it (28).

Many of the midwives believed the way they practised was at a different level to midwives working in what they referred to as 'general' midwifery. The midwives felt they practiced at an advanced level. This is evident in the following quotes:

... In terms of skilling, I've always up-skilled but I started a while ago [in preparation for credentialling], in particular, with a view to going and doing advanced midwifery-type skills (39).

... Advanced practices were one thing [the panel were assessing], but they were also looking for something behind that, just a feeling of where I was at with women (39).

The majority of the midwives felt they worked at an advanced level of practice and that their practice was somehow different to the 'general' midwives. Many of the midwives felt that they more easily fit the credentialling criteria and that 'general' midwives would struggle with the process.

... Well I think [we are] the ones who are probably going to find it easiest because I think the process used is geared towards group practice midwives (35).

... I don't think you could possibly credential the midwives who work on the wards or in a clinic situation who are in isolation. I think you'd have to have a specific credentialling format for them. You couldn't possibly do it the way we have done this. They don't have the requirements (23).

But I think I am different—I think the general population is quite happy, so long as they can come and do their work they think that's enough (28).

The midwives who were required to be credentialled felt they *practised at a high or advanced level* to those midwives for whom credentialling was not mandated.

Developing a professional plan

When the midwives reflected on credentialling, it affirmed their high level practice, and gave them some direction in terms of goal setting or improving professional practice. They said:

...it did change my practice or the way I thought about my practice when I looked at the goals. There were a couple of areas that I am struggling with in caseload and I have written those as 2 or my 4 goals, so it made me actually focus on them. Although it might sound as if I'm blowing my trumpet about a high standard, I do work and have to work at that high standard, but there is always room for improvement and yes, the credentialling process did highlight a couple of things that I know that I need to work on (39).

The midwives felt that after undertaking the process of credentialling they were able to better identify and formulate a plan for their professional development. The preparation for credentialling helped them to identify areas of their practice that required improvement. They stated:

...I think it makes you reflect on what you need to do, which is good, on the things that you feel you're not quite as competent at earlier, I think that's a good think because you reflect on and think well, in the next 3 years I am going to look at doing this and that (38).

... You could identify areas in your practice that you would like to actually improve and that was quite good. One of them was: Do you do well-baby checks⁹? So that was one of the areas that I could do (22).

The midwives felt that the systematic process such as completing the ACM Practice Development Resource (Australian College of Midwives, 2006c) or the midwifery practice review and development tool provided with the ANMC Midwifery Competencies (Australian Nursing and Midwifery Council, 2006a) that

⁹ Traditionally a newborn received an examination by a Medical Officer in the postnatal period, prior to discharge home. In some areas, midwives are now accredited (locally) to attend this pre-discharge examination.

were available in the [NSWMA] credentialling package actually encouraged them to attend more formal continuing education programs. The midwives said:

... It did motivate me to go to lots of workshops (18).

... And I suppose also, just when I was getting my portfolio ready, I realised it had been a while since I have done any formal education other than conferences, because with the nature of our practice [on-call] the question comes up, well I've got someone coming up [due], what will happen if she goes into labour, will I be able to go to that? So I'll make more of an effort to plan towards outside education (21).

The systematic process the midwives needed to complete in preparation and in undertaking credentialling assisted them in *developing a professional plan* to continually refresh and renew their midwifery practice.

Reflective Practice

The midwives often had difficulty identifying the value of credentialling and were unsure as to the effect the process might have on their practice. They did however, recognise that the process of undertaking credentialling encouraged them to *reflect on their practice* in a more formal way. The midwives felt they already reflected on practice to some degree. They said:

...that was all fine because I do write and reflect on the birth and care, so I had that all sort of done anyway (18).

As they discussed their experiences further, many of them qualified this notion of already reflecting on practice by explaining that the process of credentialling encouraged them to more formally reflect on practice. The midwives said:

... I'll keep stats and keep adding each birth, and education, and I do routine reflection on my care anyway (and have since I worked in continuity of care) really thinking about caring for people, what happens in the outcomes, not the birth outcomes but the woman outcomes and what I would do differently (38).

...really highlighted the importance of reflection and they really did emphasise reflective practice, and I think I am a fairly reflective

person naturally but that really honed what it means to be reflective (39).

Increasing *reflection on practice* was a valuable flow on effect of credentialling. Despite the midwives recognising that this process encouraged more formal reflection, initially most of the midwives did not link that to actual practice improvement.

Summary – Valuing credentialling

When discussing how the midwives *valued credentialling*, there was confusion initially as to the purpose of credentialling for this specific group of midwives. The midwives were unsure of what being credentialled meant. Credentialling was often seen as just being *another piece of paper* or hoop to jump through. The midwives understood that credentialling involved *assessing practice* but this was not always seen as a positive thing. Often the midwives described feeling under surveillance, under the spotlight or under review and they hoped that their practice was up to the standard expected. The midwives discussed their *existing advanced level of practice* and they felt their *advanced level of practice* was *affirmed* by undertaking the process. Although they discuss having an existing level of advanced practice they were able to see some value in the credentialling process. They thought that undertaking the process encouraged them to more formally reflect on their midwifery practice. In addition to *reflecting on practice*, the midwives found the process useful in *planning their ongoing professional development*.

The midwives perceptions regarding levels of practice became evident when they discussed the value of credentialling. Many of the midwives were upset that they were somehow being targeted, and they felt that as they worked in the full role and scope of practice in midwifery, they would be the least likely group in need of practice review. This demonstrated a lack of understanding of both the process and the purpose of credentialling. Very few of the midwives initially saw credentialling in a positive light. Although, I feel, given the opportunity to discuss their experience, allowed them to identify some of the benefits of the process. There was, however, a continual feeling that their level of practice was at a more advanced level than the 'general' midwives, who did not work in midwifery led models of care. This perception of advanced level of practice is explored in more depth in the discussion chapter.

Improving credentialling

Introduction

The final theme was about *improving credentialling*. Given that the midwives were some of the first in the State to undertake credentialling, and credentialling was newly introduced, the midwives were keen to share their experiences and to offer suggestions for improving the process. Three concepts were evident in this theme. They were:

1. Making it applicable to all
2. Making the process clearer
3. Sharing strategies for completion

Making it applicable to all

All of the midwives interviewed felt that credentialling should be *made applicable to all*, not just to a selected group of midwives. They said:

... I think every midwife who is working in any [model of] care should do some form of it [credentialling] (38).

The midwives appeared to understand the introduction of credentialling needed to initially start with a specific group of midwives, but were keen for it to expand to all midwives. This is evident in the following quote:

... The long-term vision is that everyone will have to go through some kind of credentialling process, but it had to be started with a small group initially and then sort of spread it out and develop it, so I think that's happened, but I think it needs to be mandated for the inclusion of a lot of midwives (928).

Many of the midwives felt that as professionals this, or a similar process, should be a part of every professional's ongoing development. Some midwives went further, suggesting it should be linked to professional registration. The midwives said:

...I think everyone should do it. I think it should just be a normal part of midwifery practice and I would really feel that the process should be part of registration requirements and it should be bound into that (25).

...I think that to gain professional registration we should have to go through some kind of credentialling process. I think as a profession we need to be looking at something more formalised than what we have at the moment. And it shouldn't be just a specific group of midwives who are mandated to do that (28).

Although the midwives felt that credentialling should be applicable to all, they recognised that some midwives may struggle to meet the requirements. The process may need to be modified to suit the sometimes fragmented way of working in the current system. They said:

...If you take credentialling to the midwives on the wards and other places, they'll all die. I don't think you could possibly credential the midwives who work on the wards or in a clinic situation who is in isolation. I think you've have to have a specific credentialling format for them. You couldn't possibly do it the way we have done this (23).

... So I'd wonder how other midwives are going to get through to be a credentialled midwife in the system that they work in now. It makes sense to go through Group Practice Midwives first, but any midwife who wanted to be credentialled; I wonder how they could fulfil the criteria in the format that it is (21).

Although the midwives would like to see all midwives having to undertake the credentialling process, particularly in terms of increasing professionalism in midwifery, they were cognisant of some of the challenges this would entail.

Making the process clearer

In addition to making the *process applicable to all* midwives, the midwives felt that *making the process clearer* would be beneficial. As demonstrated in the theme *preparing for credentialling*, there was much angst around the process. Much of this was due to it being newly introduced and constantly evolving. When discussing how the process could be improved, the midwives said:

.... make it quite clear and to provide the templates electronically to download. That took heaps of time and anxiety. A template for that would have been really helpful (38).

...I think maybe streamlining the paperwork a bit because that was quite daunting to start with—not that it was hard to write it down, the births that you’ve attended or education, but going through all the competencies—that was hard work, so maybe streamlining that a bit would help (21).

The midwives felt that demystifying the process would help to make the process clearer and would also assist in changing attitudes to the process. This is evident in the following quotes:

... You need to demystify [credentialling] and people need to realise that they might not pass, or be successful but it’s not the end of the world. You’ll be supported and helped and you’ll do it again (23).

...and I guess in terms of changing the process, what we’d change is the attitude *to* the process, so we can see it as something that actually validates midwifery practice and validate what midwifery practice seeks to do (25).

All the midwives acknowledged that the process was new and required some fine-tuning.

Strategies for completion

The midwives freely discussed strategies that would assist themselves and others to complete the preparation and panel review requirements. Having undertaken credentialling, the midwives felt that there were definitely some tips and suggestions they would share with other midwives *preparing for credentialling*. All of the midwives discussed sharing resources and reviewing others preparations. They said:

... here are our folders, have a look at the disc and already start working towards it, so I think the preparation will be easier for a future team (19).

...so we knew it was coming up, and I suppose, the team that I work with were at an advantage, because the team that we also work with did their Credentialling a number of months before we did, so they had already started the process of finding out the

information from the Midwives Association with the format they wanted (21).

There was a particular emphasis on support from within the midwifery teams where the midwives worked. Often, when asked about how they coped with preparing for, and undertaking credentialling, the midwives would answer using the term 'we' as opposed to 'I'. This demonstrates the teamwork that was often involved, particularly in the preparation stages.

The midwives all felt that the preparation, particularly the first time round, involved a considerable amount of time and hard work. As the process was mandated, some of the midwives felt that preparation time should be somehow accounted for in their work hours. This is reflected in the following:

...I took on a full time position in caseload, but within that I was expected to do an immunisation course, a K2 package¹⁰ and the credentialling and seeing I was the only one doing it I felt quite unsupported. And I ended up doing a lot of work in annual leave and that really made me cross (39).

...give me the time to do it, so that I'm not up late and missing out on my family, doing all of that stuff that's crucial. You're [NSW Health] telling me that I need these credentials and then telling me go through these hoops and work on my holiday to achieve it and that ain't right, as far as I am concerned (39).

When discussing *strategies to assist with completing* the preparations and process of credentialling, the emphasis was on teamwork and sharing.

Summary – Improving credentialling

The theme *improving credentialling* was informed by three concepts. The midwives discussed the importance of *making credentialling applicable to all* midwives, not just a specific group of the profession. When discussing the applicability of credentialling for all, the midwives felt that some modifications would be necessary due to the current context in which many midwives practice. *Making the process clearer* involved streamlining the paperwork and generally

¹⁰ A computer-based training and education package to improve knowledge and skills in assessing fetal wellbeing

demystifying the process. There was consensus in the discussions around providing *strategies to assist others to complete* credentialling and these included an emphasis on teamwork, sharing and the provision of time to complete the requirements.

When discussing improving credentialling, the midwives continued to insist that the process should be applied to all midwives and not just a select group. They again compared themselves with 'general' midwives and felt that the requirements of credentialling would need to change. The midwives felt that their existing level of practice enabled them to meet the credentialling criteria, and they could not see how other midwives could possibly meet the same criteria.

The midwives themselves noted that the process became clearer over time and felt that the introduction of templates and clear guidelines would be of benefit. At the time of the interviews, another process, similar to credentialling was introduced as a voluntary practice review process for all midwives. Midwifery Practice Review (MPR) has similar components to credentialling. In addition to MPR, the professional development framework for midwives, MidPLUS, was also introduced. The MidPLUS package contains templates for self assessment, reflection on practice and planning continuing professional development. The midwives recognised that these would be useful in the future.

Conclusion

This chapter presented the findings of the study on the experiences of midwives in NSW who undertook the credentialling process. Analysis of the data resulted in the emergence of five themes and these were presented in chronological order. *Preparing for credentialling* detailed the midwives experiences and included the concepts *getting started*; *becoming clearer*; *moving through* and *getting there*. The second theme described the experiences the midwives had surrounding *doing credentialling* – the panel review. The midwives felt that *the panel review was great* and that it was *nothing like they expected*. They felt the actual *doing of credentialling* was about others *reviewing their practice* and they appreciated the chance to *tell their story*. Following this, the midwives reflected on *achieving credentialling*, the third theme. The midwives felt and *immediate relief* and a great *sense of personal achievement*.

Following *achieving credentialling*, the midwives were able to think about what it meant and spend some time considering the *value credentialling*, the fourth

theme identified from the data. When the midwives thought about credentialling they initially wondered whether it meant anything, both to themselves and to others in the profession. The midwives often referred to the credential as *another piece of paper* and stated that they felt it was undervalued. They felt credentialling was about *assessing and affirming their practice* as midwives and some considered this unnecessary as they felt they already practiced at an *advanced level*. When the midwives reflected on the value of credentialling they discussed how it allowed them to more easily identify and *develop a professional development plan*. In addition to assisting the midwives with *ongoing development plans*, the midwives also discussed how the process of credentialling encouraged them to more formally *reflect on their practice*. They did feel that they already did this to some degree.

Finally, the midwives described how they felt *credentialling may be improved*. Credentialling was a new experience for all of the midwives and they felt it would be helpful to work on *making the process clearer* by streamlining paperwork and provision of templates for some requirements. The midwives believed that credentialling should be *a process for all* midwives, not just a select group. Making it applicable to all midwives would help demystify the process and assist in improving the general attitude to the process of practice review. When discussing *strategies that would assist others to complete* credentialling, the midwives felt teamwork and sharing of resources was paramount.

The results of this study are presented in the midwives' words. The quotes describe the experiences of the midwives who undertook the process of credentialling in NSW. The next chapter will explore and discuss these results.

Chapter Five – Discussion

Exploring the meaning of credentialling for midwives

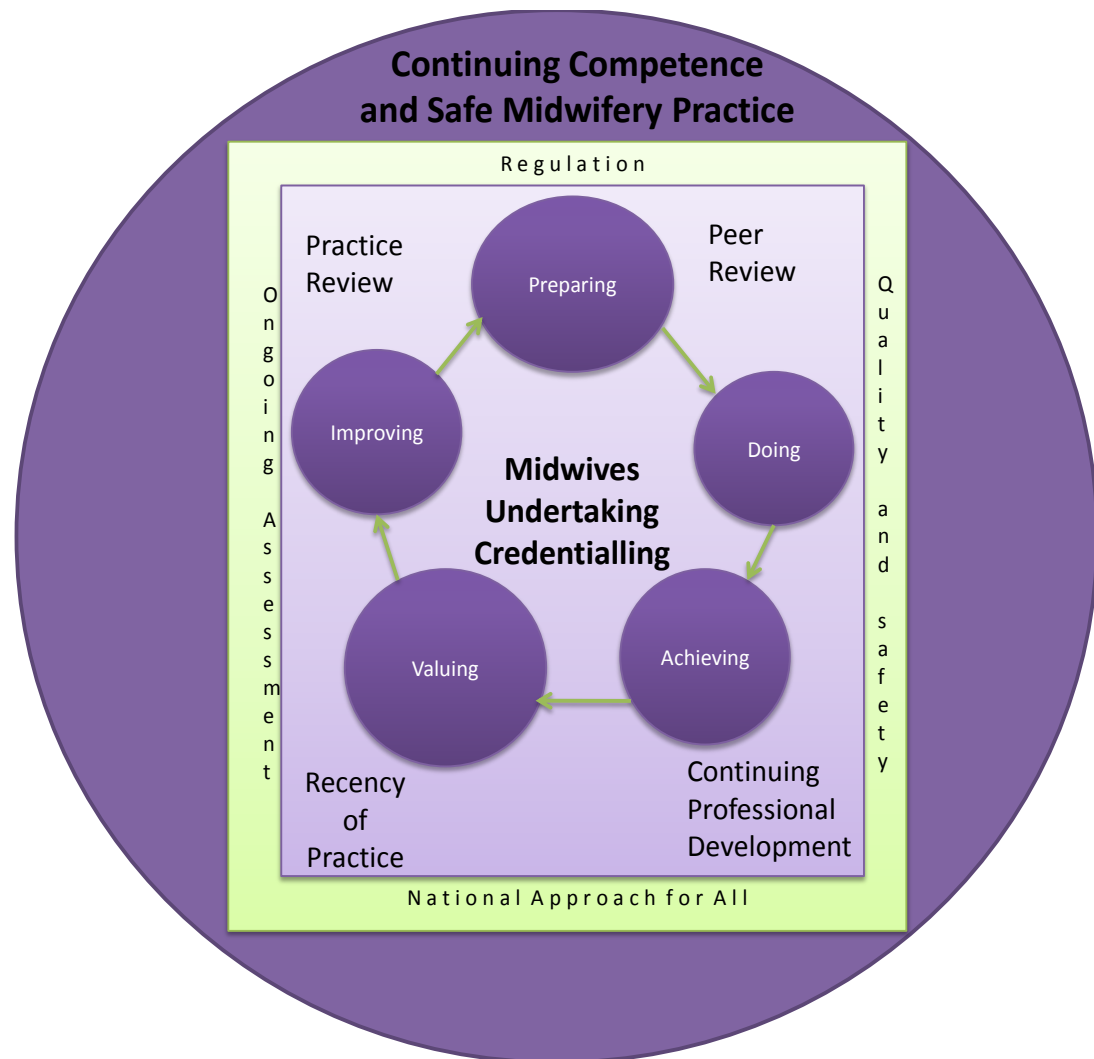
Introduction

This chapter describes, explores and discusses the results of this study that aimed to examine the experiences of midwives who undertook the mandated credentialling process in one Australian state. In this chapter, diagrammatic representation of how the results of the research sit within a framework of continuing competency will be introduced and explained. This chapter will further explore the results and discuss them in relation to the existing body of literature. Much of the discussion will focus on how the midwives saw themselves in relation to others in the profession and how they felt the process of credentialling contributed to their professional development. The limitations of the research will be addressed. Implications for both the midwives who undertake the credentialling process and the administrators of the process will be presented to conclude the chapter and the thesis.

Diagrammatic representation of the findings

Figure 2 below presents the findings of the study. Credentialling is situated within a framework of demonstrating continuing competency, or as the midwives stated, 'proving' safe midwifery practice. When interpreting the diagram, the participants of the study are central to the findings. Surrounding the participants are the five major themes identified in this study. The circles representing *preparing* and *valuing credentialling* are larger, as these were most prominent in the findings. When the midwives discussed credentialling they started describing the preparation and moved through the process in the same order, demonstrated through using arrows to connect themes. The concepts of continuing professional development, recent practice, peer and practice review were easily identified in the findings and formed part of the meaning of credentialling for the midwives. The concepts in the border surrounding the findings represent the 'bigger picture' context that, following deeper reflection, the midwives identified as the value attached to credentialling.

Figure 2: Diagrammatic representation of findings



Credentialling as part of a continuing competency framework

Credentialling, or some such similar process, is commonly used as a component to fulfil requirements of a professional continuing competency framework. The midwifery profession recognises that a process such as credentialling may contribute to demonstration of ongoing competency. Although the midwives in this study did not directly link credentialling to ongoing competency they did equate the specific part of the credentialling process concerned with practice review as being linked to ensuring safety of the individual practitioner. The midwives discussed how credentialling might contribute to assessing safe practice, how it should be part of midwifery regulation and how a standardised approach was needed. They recognised that the actual process assessed and reviewed their midwifery practice. They thought this was to ensure that they were up-to-date with best practice and continuing professional development. Through

recognising, the many components that are commonly considered part of a continuing competency framework, such as practice review, recency of practice and continuing professional development, they were able to link credentialling to components used to demonstrate continuing professional competency. The midwives' experiences of credentialling were discussed in terms of the themes, that is, their *preparation for credentialling*; the actual *doing of the review process*; what it felt like to *achieve credentialling*; what was the *value of credentialling*; and, how *credentialling might be improved*.

Overview of findings

Five major themes were identified from the midwives descriptions of their experiences of credentialling. The midwives described in some detail how they found the preparation for the process time-consuming, difficult and stressful. Much of this was because this was a new process introduced into midwifery in NSW and the midwives in the study were among the first midwives ever to undertake the process. In relation to their participation in the panel review and subsequently achieving credentialling, the midwives were generous in their praise for the panel review process, and were both proud and relieved when awarded the credential. They all had similar suggestions for improving the process. It was not until the midwives discussed the value of credentialling that some of the more interesting experiences came to the fore. These included an impression that they were an 'elite' group who practised at an 'advanced' level and therefore were probably least likely to need their practice reviewed. This led to a general feeling that credentialling was just 'ticking the box', 'jumping through the hoop' or merely completing what was required of them rather than something they, or the women they cared for, would benefit from.

Advanced level of practice or advancing practice?

The analysis has revealed that the midwives viewed credentialling as 'ticking the box' or 'jumping through hoops' because they felt their practice was already at an advanced level and they felt they were the least likely to need their practice reviewed. These midwives believed that they practised at a high level, particularly when they compared themselves with other midwives. This issue of advanced practice is an important one and needs to be explored in more detail. It is likely that working in the midwifery-led models allowed the midwives to advance their

practice, but whether it is 'advanced' practice per se is questionable given the definition of a midwife.

A midwife is a midwife is a midwife

The midwives in the study felt that they had an existing high or advanced level of midwifery practice. The concepts of advanced practice and different levels of practice in midwifery are controversial. There exists the belief that 'a midwife is a midwife is a midwife' from day one of practice. This reflects a view that midwives are educationally prepared to practise to the full role and scope of the midwife from day one and that there are no levels of practice (Leap, 2005; Lewis, 2003; Sookhoo & Butler, 1999). If the midwife is educationally prepared to practise within the full role and scope of midwifery, there is a belief that, the midwifery graduate should be able to 'hang up their shingle'¹¹ as soon as they are registered (Leap, 2005). The use of this term suggests, that from day one of midwifery registration, the midwife should be capable of autonomous midwifery practice and that they should be considered a practitioner in their own right (Leap, 2005).

This belief of a 'midwife is a midwife is a midwife' is supported by the concept of professional competency which holds that if a midwife is deemed competent to enter the profession by demonstrating that they meet the profession's competency standards, then they must be a competent midwife and working to the full role and scope of practice as defined by the International Confederation of Midwives (2005)¹². Given that often, the concept of competency is one of

¹¹ Historically, a shingle was a small sign board that was hung to indicate the office of a professional.

¹² 'A midwife is a person who, having been regularly admitted to a midwifery education programme, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.

The midwife is recognized 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 infant. This care includes preventive measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical 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 community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and childcare.

A midwife may practice in any setting including the home, community, hospitals, clinics or health units.'

reaching a required standard, it could then be argued, that one does not become **more** competent as the end-point has already been obtained (Eraut, 1998).

Levels of competency

There is however, another interpretation of competency. This is where competency is not an end-point, but on a continuum where there are levels of competency. This is based on the premise that, although, on day one, a newly graduated midwife has been deemed competent to practise as a midwife, some would assert that they have demonstrated competency at an entry to practice or novice level (Hunter, 2009). Following continued experience and exposure to practice they would then be able to practise at an advanced or expert level (Billett, 1999). This is where the notion of advanced practice could be contrary to competency in midwifery.

Debate continues within health care professions around 'what is competency', with the two most common beliefs argued that competency can be viewed either as binary scale or in sequential stages (State Government of Victoria, 2009). When viewing competency as a binary scale, the professional is either seen as being competent or not competent. There are no degrees of performance considered when taking this view of competency (State Government of Victoria, 2009). This is the view that would support the 'midwife is a midwife is a midwife' view.

More common, particularly in health professions, is the sequential stages view of competency. In this, the professional progresses from a base competency or novice stage through to the expert stage. This sequential view is based on the well-recognised Dreyfus Model of Skill Acquisition that Benner applied to the profession of nursing many years ago (Benner, 1984; State Government of Victoria, 2009). Benner (1984) asserted that the student or new graduate [nurse] starts at the novice stage and through experience and application of theory, moves through the following stages; advanced beginner; competent; proficient; and finally to expert practitioner. This view of competency supports those in the midwifery profession who propose that, upon graduation, the new midwife has a base level of competency, and through practice and experience, that level of competency improves, thereby allowing the midwife to practise at an expert or advanced level.

Levels of practice

There has been much debate around the concept of advanced practice in midwifery. There is no clear definition or agreement on what advanced practice entails over and above normal or full scope of practice in midwifery. Adding confusion to the argument for and against introducing the concept of advanced practice into midwifery is the current situation in the profession of nursing. In Australia, recognition of midwifery as a profession distinct from nursing, and not a sub-specialty of nursing, has only occurred in recent years (Fahy, 2007). Within the nursing profession, many recognised sub-specialties exist. Some of these sub-specialties have formed professional associations and many of them have developed their own competency standards (Chiarella, 2006). Examples of these include mental health nursing and critical care nursing. Both of these professional associations utilise a voluntary process of credentialling. In addition, as a profession, nursing supports and has further developed the concept of advanced practice, through the award level of Nurse Practitioner¹³. The nursing profession embraced the concept of advanced or specialist practice and, as previously discussed, used to refer to midwifery as a specialisation of nursing and not a profession in its own right. As midwifery has historically been aligned, and oft compared with nursing, and many midwives have also practised as nurses this advanced practice concept continues to exist in midwifery.

The ACM has a professional opinion on advanced practice in midwifery. This view is displayed in their position statement on the introduction of the advanced practice award of Midwifery Practitioner (Australian College of Midwives, 2005b). In the position statement, ACM assert that midwives who work within the full role and scope of practice of the midwife are not working at an advanced or specialised level; they are merely fulfilling the defined role and full scope of practice of a midwife. Midwife Practitioners, as a role, have not been embraced in Australia, with only two endorsed Midwifery Practitioners in NSW. To a degree, this stance from the ACM may have been effective in limiting formal recognition of advanced or expert practice in midwifery. Nonetheless, the debate continues.

In the UK, both the midwifery professional body, the Royal College of Midwives (RCM) and the midwifery regulatory body, the Nursing and Midwifery Council

¹³A nurse practitioner is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role (Nurses and Midwives Board of New South Wales, 2007).

(NMC), insist that it is not necessary to introduce levels of practice, referred to Higher Level Practice (HLP) into midwifery. This is due to the belief that, upon registration into the profession, midwives practise at a specialist level (Lewis, 2003; Sookhoo & Butler, 1999). A well-defined scope of practice for midwifery that includes autonomous practice provides support for this argument. In addition, comparisons with the profession of nursing further sustain this debate, due to the nursing profession having consensus and clarity of regulation concerning general practice and advanced or specialist practice (Lewis, 2003).

Full role and scope of midwifery practice

When the midwives in this study discussed their role, they often compared themselves to what they referred to as 'general midwives'. As the midwives in the study worked in 'midwifery-led' models of care, they felt they practised to the full role and scope of practice of the midwife and therefore were at an 'advanced' level when compared with midwives who work in the current system of fragmented care provision.

Within Australia, there is widespread recognition that, although it is firmly believed that midwives should be educationally prepared to work in the full role and scope of practice of a midwife upon registration and at any time in their career, this is not always the reality. In the last 25 years, barriers that prevent this from being a reality have been repeatedly identified, discussed and debated, but often not resolved (Barclay, 1985; Barclay et al., 2003; Brodie & Barclay, 2001; Gamble & Vernon, 2007).

Barclay (1985), in her analysis of Australian midwifery education, training and practice concluded that midwifery education systems were questionable and attempts to regulate practice were of dubious worth. Eighteen years later, in the Australian Midwifery Action Project (AMAP) report, similar issues were identified. AMAP (Barclay et al., 2003), reported the following issues that hinder Australian midwives from practising in the full role and scope of midwifery practice:

- Inconsistent regulation;
- Inconsistent midwifery education;
- Workforce shortfalls;
- Inadequate recognition of midwifery knowledge and skills; and

- Limited availability of the midwifery models of care that support midwives to practice fully according to the internationally accepted definition of the midwife.

(Barclay et al., 2003)

More recently, Gamble and Vernon (2007) again revisit the same issues in their discussion on barriers to comprehensive midwifery practice in Australia. Furthermore, these issues were again identified most recently, in the Commonwealth Government's Review of Maternity Services discussion paper (Commonwealth Government of Australia, 2009). Clearly, midwifery is in a process of transition and change towards a new way of conceptualising the full scope of practice and how continuity of care fits into the role of the midwife.

Working towards change

Although the profession of midwifery, through the ACM, is constantly working towards addressing the barriers and issues, progress is slow. One strategy has been the development of consistent education standards.

A working party was formed in 1999 to develop national standards for midwifery education. Initially this working party concentrated on setting educational standards for the newly introduced Bachelor of Midwifery courses. From these early meetings, it was recognised that midwifery education standards were required to enable the introduction of pre-registration midwifery courses. To this end the ACM formed the Australian National Education Standards Taskforce (ANEST). This taskforce and its subsequent revised committee, the Midwifery Education Standards Advisory Committee (MESAC) of ACM have developed national standards for all pre-registration midwifery courses. These have been endorsed by some, but not all, of the NMRAs. It is expected that in 2010, with the introduction of a national regulatory authority, these educational standards will be endorsed nationally (Australian Health Workforce Ministerial Council, 2009). New national standards for education of midwives will assist the profession with correcting the problem of inconsistent midwifery education standards. It should also support those that argue that a midwife is able to practise according to the full role and scope of practice from day one of registration and that levels of practice in midwifery do not exist. In addition to regulatory changes, and ensuring consistency in pre-registration midwifery education, other changes will be

nessasary to ensure all midwives have the support required to work to their full professional capacity. These changes include:

- Expanding midwifery models of care;
- Changes in funding arrangements for maternity care provision;
- Increasing recognition and acceptance of midwifery as a profession in its own right; and
- Introduction of a continuing professional development framework for midwives

Such changes would support education, regulation, professional development and midwifery practice. Therefore encouraging and supporting all midwives to practice at the same level, fulfilling the full role and scope of practice and according to the internationally accepted definition of the midwife (International Confederation of Midwives, 2005).

One level of practice

Although one level of practice, that is, to the full role and scope of practice, is expected in midwifery, currently, due to the issues described, this is not always the case. Indeed, the midwives in the study, who are most likely to work within the full role and scope of practice as they care for women throughout pregnancy, birth and the early postnatal period, do not believe that all midwives practise at the same level. As said before, the midwives saw themselves as practising at an advanced level. Credentialling gave them the opportunity to assess and affirm the way they practised.

‘Credentialling was more an affirmation of my high standard of practice, rather than bringing me up to a standard. I felt I was already there (39).’

This view, from these midwives, is obviously in contrast to those in the profession who believe that levels of practice – in particular, advanced practice, do not exist in midwifery. Furthermore, the midwives in the study saw themselves as different to ‘general midwives’ [sic]. In addition, they felt their practice was least in need of assessment.

Maintaining scope of practice

In the current context of midwifery in New South Wales, it is not surprising that the midwives who work in midwifery-led models of care, view their practice as

being at a higher level than those who work in the system that provides mostly fragmented care. The vast majority of Australian midwives provide care in a fragmented and service based system of maternity care provision, as opposed to a woman centred, continuity based system (Commonwealth Government of Australia, 2009). There is an assumption that all midwives would be able to demonstrate that they are able to work within the full scope of midwifery practice. However, this is often not the case (Australian Nursing and Midwifery Council, 2005). It is common to find midwives working within the system who have, for the past decade or two, worked entirely in a single area of midwifery. As a result, it would prove difficult for such a midwife, who for the previous 15-20 years has only practised in an Antenatal Clinic, to be able to demonstrate or in fact claim to be proficient at working within the full role and scope of practice of the midwife. As a result of this, the midwives in this study made comment on the difficulty 'general midwives' would experience, if and when, the credentialling process would be mandated for all midwives.

Creating levels of practice in midwifery?

When midwifery care started to move from fragmented system-based care provision to models that provided continuity of care, there was recognition that the midwives who moved into the new models of care might be considered somehow different or 'elite' (Sandall, 1995). Working within a continuity model of midwifery care provided midwives with the opportunity to practise within the full role and scope of midwifery practice. However, due to the organisation of many of the initial models, radical changes to the way midwives traditionally worked were required (Sandall, 1995). These changes meant that some midwives were unable, or unwilling, to work in this way (Sandall, 1995; Stevens & McCourt, 2002; Todd, Farquhar, & Camilleri-Ferrante, 1998). For instance, midwives with dependent children and limited social support found the on-call and flexible hours difficult to manage and therefore needed to remain working in the traditional shift work model. Sandall (1995) claimed that this situation could create a two tiered midwifery workforce. She discusses the possible division of midwifery into the 'rank and file midwife who may be expected to pay the price for the professionalising elite' (Sandall, 1995, p. 207). This division is evident in the findings in this study with the midwives who work in the midwifery-led models of care comparing their perceived level of practice with 'general midwives'.

In Australia, the ACM, has attempted to prevent the creation of a two tiered midwifery workforce. ACM has lobbied for legislative and regulatory support to ensure midwifery remains a united profession. Their position statement on Midwife Practitioner, discussed earlier, is one example of this (Australian College of Midwives, 2005a). Although the ACM has actively lobbied against the introduction of levels of practice in midwifery, this requires constant attention. The Commonwealth Government recently announced plans in the Federal Budget to provide midwives with Medicare Benefits Scheme (MBS) and Pharmaceuticals Benefits Scheme (PBS) access, thus allowing midwives to truly practice in an autonomous fashion and to the full scope of midwifery practice. However, they have put conditions around the MBS and PBS access for midwives. In the Federal Budget announcement in May 2009, the Government have used phrases such as 'advanced professional requirements for eligible midwives' and development of an 'advanced midwifery credentialling framework' (Australian Government, 2009). It is unknown, at this time exactly what is meant by these terms and following discussions with midwifery peers and leaders in the profession, there is concern that these requirements may lead to creating levels of practice in midwifery. My colleagues and I expect that this is likely to cause further debate in relation to the notion of advanced practice in midwifery.

Although the ACM seeks to ensure levels of practice are not applicable to midwifery, some within the profession assert that levels of practice currently exist. The midwives in this study felt that their practice differed from other midwives. They knew that working in a continuity model of care allowed them to work to the full role and scope of practice of the midwife and they were able to identify the challenges of working to the full role of the midwife in fragmented care models. The midwives in this study do work at a different level of midwifery practice because they are able to practice according to the accepted international definition of the midwife. When compared to what is expected of a midwife in practice, their practice is at the required level. When compared to others that work in a fragmented system of maternity care, their practice is at a different level as they have the opportunity to work within a midwifery-led model of care. Here lies the challenge for the future – ensuring that the required level of practice can be possible for all.

Professional Development

In addition to the midwives seeing credentialling as a means of assessing and reviewing what they see as their advanced level of practice, they also felt it contributed to increasing professionalism through continuing professional development, demonstrating safe and high quality care and promoting reflection on practice.

Increasing professionalism

Initially, the midwives in this study were self-focussed in their understanding and impressions of the value of credentialling. They saw credentialling as another 'hoop to jump through' or 'tick in the career box' and not as a valuable process to improve the quality of the care they provided. For the most part, they did not demonstrate an understanding of credentialling as a risk management strategy to protect themselves, the models of care they worked within or the women they cared for (New South Wales Department of Health, 2004a).

From my involvement in the introduction of mandated credentialling for this specific group of midwives, it was clearly a point of contention within the midwifery profession. Some of the midwives saw the introduction of credentialling as a necessary move by the profession – although it was not the profession that introduced the process, it was the state's Department of Health (New South Wales Department of Health, 2004a). Those who believed this explained how credentialling might provide a robust way for midwives to demonstrate their ability to work autonomously (Kinnear, 2009). Others felt that they were being unfairly targeted and felt they were continually expected to prove their practice. Despite these contentions, the midwives were cognisant of the need for a process that encouraged those in the profession to take responsibility for their ongoing professional development. They recognised the lack of a formal framework that could ensure midwives were able to demonstrate that they remained current, safe and competent in their practice.

Supporting continuing professional development

The process of credentialling encouraged the midwives to better plan their continuing professional development. In fact, many of the midwives initially saw this as the primary purpose of credentialling.

The midwives in this study, like others, equated attendance at or involvement in CPD as assurance of competent practice (Nursing & Midwifery Council, 2008; Smith & Topping, 2001). They did not recognise or discuss the fact that merely

attending CPD activities does not necessarily ensure continuing professional development or continuing professional competency. Professional development frameworks generally recommend structured reflection on any CPD activities undertaken (Monaghan & Shorten, 2008). This is to maximise the benefit of the activity and promote deeper understanding on how the CPD activity might actively contribute to developing, changing or improving the participant's professional practice.

Promoting reflective practice

A positive aspect of the credentialling process that all the midwives identified was its ability to help the midwives reflect on their practice in a structured way. Reflective practice is about reviewing and examining experiences in practice in order to identify areas in need of development (Ralston, 2005). In addition, reflective practice is considered a vital professional activity, particularly for health professionals (Levett-Jones, 2007; Mamede & Schmidt, 2004; Taylor, 2005).

Although many of the midwives in the study felt that they already reflected on their practice to some degree, they found the more formal process [credentialling] encouraged them to reflect more deeply. The midwives felt this in-depth level of reflection assisted them in further developing their practice. When present, acknowledgement of this beneficial aspect of the credentialling process, tended to come late in the interview with the midwife. During the initial stages of the interview, the midwives claimed that credentialling had little impact on their practice. This may have been due to them feeling that they already practised at an advanced level, particularly when compared to 'general midwives'. However, the more the midwives discussed and reflected on how the experience of credentialling affected them, the more they were able to identify positive aspects of the process in terms of developing and improving their midwifery practice through reflection.

The manner in which the midwives discussed reflective practice indicates that the technical and practical aspects of their practice were reflected upon more commonly. Technical reflection focuses on skills and procedures and, although necessary, it does not assist practitioners in developing social understanding (Taylor, 2005). The midwives were readily able to reflect and identify a particular area of practice that required developing. For example, when completing the Midwifery Practice Development Resource Assessment Tool (Australian College of Midwives, 2006c), the midwives reflected on practice areas such as assisting a

woman to give birth in water. They would then identify whether they had the required technical skills or knowledge to provide safe care in this instance. If they did not they would then work on developing this aspect of midwifery practice. Practical reflection assists the practitioner to make sense of, and gain insight into human interactions (Taylor, 2005). The midwives stated that they reflected on 'births and such'. When asked what this meant, they clarified by explaining that they thought about how they interacted with the woman or her support person(s), rather than just the technical skill of assisting a birth.

Recognition of the importance of technical and practical reflection on practice was evident. However, only one midwife discussed reflecting in what Taylor (2005) refers to as emancipatory reflection. Taylor (2005) asserts that this form of reflection leads to transformative action, or in other words, a sustained change in practice. She explains that emancipatory reflection considers how power relationships, assumptions and oppressive forces shape nursing and midwifery practice. The ability to recognise the underlying forces that effect and shape practice therefore encourages the practitioner to address those forces when changing practice. Consequently, this change in practice is sustainable (Taylor, 2005). Clearly, more is needed to fully sustain effective and transformative reflection for these and other midwives.

Summary

Undertaking credentialling, as part of a continuing competency framework, should encourage the midwife to reflect on, analyse and identify areas of midwifery practice that require development. Reflecting only on the technical and practical aspects of midwifery may not be enough to ensure a sustained change in practice. Possessing a belief that their level of practice is already at an advanced level may limit the ability of these midwives to identify professional development needs.

Limitations

Limitations of this study

The findings of this research demonstrate both benefits and challenges around the introduction of the credentialling process in NSW. Due to the size of the sample and the specific context of the research, there are several limitations to this research.

Firstly, the major concepts in the body of literature related to the study are poorly defined and are known to be used interchangeably. For example, the concepts of credentialling, accreditation and competency have no agreed definition and are often used interchangeably. This could create a theoretical limitation, in that the results will only be transferable if similar definitions and context are the used in the same way as they are in this research (Lavender et al., 2004). Fortunately, in this research, clear definitions of credentialling and the process, were available through the mandated policy directive. All midwives in the study undertook the same process. Having clear definitions and a standardised process for the participants of this study should then limit possible confusion arising from interchangeable definitions in the body of literature relating to credentialling.

While the findings report the experiences of midwives undertaking the credentialling process in NSW, the specific context must be kept in mind when trying to generalise the results. Specific context issues include; the process being a mandated policy directive; the process being a completely new process for the midwives involved; including participants who were among the first in NSW to undertake the process and having the process applied to one specific group of midwives. These issues of context would limit the generalisability of the results. Despite this, these midwives reflected experiences that I have heard from many of the midwives who have undertaken credentialling in NSW and those considering undertaking the process.

The small population available for selection and the study requirement of needing to have undertaken the credentialling process, purposive sampling was employed. Although purposive sampling can provide rich data, a non-random sample provides results that are less generalisable as this increases the chance of bias (Burns & Grove, 2005). For example, those that are very unhappy with the process of credentialling may be more likely to volunteer for the research, as it would provide them with an opportunity to have their views heard. These limitations are difficult to control. All midwives who took part in the study did so voluntarily. The purpose of the study was to explore and describe these midwives' experiences of the credentialling process. With this as the aim, the reduced generalisability of the results is of limited concern.

My proximity to the process of credentialling is a limitation of this research. Being involved in the introduction of the credentialling process and having been in the first group of midwives credentialled, has led to some assumptions on my behalf.

Having undertaken the process, I needed to ensure whilst conducting the research that I was involved as researcher and not as a credentialled midwife. I did this by not being involved in the process of credentialling for the duration of the study. In addition to distancing myself from the process, after each interview I critically reflected on my ability as a researcher and scrutinised my ability to respond as researcher and not fellow credentialled midwife.

Implications for practice and future research

The findings of this research have implications for midwives undertaking credentialling or some similar process, for the administrators of these processes and for the midwifery profession in general. In particular, as the Australian Federal Government has just announced that it will provide support for midwives to practice in an autonomous capacity, provided that they are assessed for quality and safety purposes through an 'advanced midwifery credentialling framework' (Australian Government, 2009). Furthermore, with the introduction of the National Registration and Accreditation Scheme, due to commence operation in 2010, that plans to link the annual renewal of professional registration to demonstration of participation in a continuing professional development program, this research is timely.

The introduction of a credentialling framework, Midwifery Practice Review (MPR), or some similar process whereby all midwives will be required to demonstrate continuing competency is imminent (Australian Nursing and Midwifery Council, 2009). It is likely that this requirement will be linked to health professional's registration (Australia's Health Workforce Online, 2009) and the renewal of annual practising certificates. Currently, the process of credentialling is mandatory for only one group of midwives, namely, midwives in NSW who work in midwifery-led models of care. If the process of credentialling in NSW were to become the, or part of the, process that the Australian Government (2009) refer to when stating that midwives who undertake an 'advanced credentialling framework' will have MBS and PBS access, there are a number of lessons that would be useful. These include making the process clearer; making the process applicable to all; and, sharing strategies for completion.

Making the process clearer

The midwives in the study felt that improving the clarity of information available on the specific requirements of the process was necessary. For example, it would

be helpful to include more detailed information on what is required in the professional portfolio and what the panel review entailed. In addition to this, as part of the requirements involved sending a synopsis of the professional portfolio to the administrators in advance of the panel review, clearer instructions on what documents were required would have been beneficial.

A move towards standardising the process through provision of document sets or templates that midwives could easily access when preparing for credentialling was also considered necessary in trying to ensure the process was clear and systematic.

Making the process applicable to all

Standardising the process and applying the process to all midwives would work toward addressing the perceived 'advanced practice' notions that have evolved through targeting only one group of midwives. Although, standardising the process to be applicable to all may be difficult in that many midwives currently do not work in a system that provides for ensuring all midwives practice in the full role and scope of practice of the midwife.

If credentialling or a similar mandatory process is adopted nationally, then increasing the number of models of care where midwives can practise according to the international definition of the midwife must accompany this change.

Sharing strategies for completion

Credentialling in NSW assisted in informing the development of MPR, as a result, the documentation available that supports midwives who undertake the process of MPR is standardised and clear (Australian College of Midwives, 2007b). The midwives in the study identified this as an important factor.

In addition to improving the clarity of information, provision of educational seminars, workshops or modules to assist midwives in the preparation stages of the process was identified as being a strategy that would assist the midwives in completing the process of credentialling.

Providing midwives with a peer support network or mentor to assist in their preparation and completion of the credentialling process was also identified as a strategy that would assist midwives to complete the process.

Implications for further research include the possibility of comparing the experiences of midwives who undertake the mandated process of credentialling with midwives who undertake the voluntary process of Midwifery Practice Review. In addition, investigating the widely believed but not well-evidenced idea that credentialling or some such similar process has a positive effect on quality and safety in maternity care.

Conclusion

This qualitative descriptive exploratory research set out to describe and explore how midwives, working in midwifery-led models of care in NSW, experienced the newly introduced and mandated process of credentialling. The results indicate that, in general, the midwives found preparing for the process to be time-consuming and arduous. The panel review part of the credentialling process turned out to be enjoyable, which is something the participants did not expect. The midwives felt a sense of relief and achievement on completing the process and were happy to suggest improvements to the process to make it less stressful for those in the future. When discussing how they valued credentialling, initially the midwives could not see much personal or professional value in undertaking the process. It was as though the discussion allowed them to reflect more deeply on the process and after some time they started to recognise some further benefits of having completed the process. The benefits included; increased professionalism; a better understanding of the importance of reflecting on and improving practice; provision of a systematic process to assess and address professional development needs; and affirmation of what the midwives saw as their existing 'advanced' midwifery practice.

Consequently, much of the discussion focussed on the 'advanced practice' in midwifery debate. Both ends of the spectrum concerning this argument were presented and discussed. Firstly, the idea that a 'midwife, is a midwife, is a midwife' where it is firmly believed that a midwife should be able to practise as an autonomous practitioner from day one. Then, the argument for and against levels of practice such as the 'novice to expert' view was presented. The Australian context and contributing barriers to comprehensive midwifery practice were included to explain possible reasons for the levels of practice view.

Exploration of the findings of this study, highlight to me, the midwifery profession's need to discuss, debate and address the increasing perception that

levels of practice, and in particular, advanced practice, currently exist in midwifery in Australia. The findings of this study demonstrate that the midwives, working in midwifery-led models of care, see their practice as being at a different or advanced level to those midwives working in the fragmented model of care most common in the current system.

The limited availability of midwifery-led models of care, has contributed to the inability of many midwives to practise according to the full role and scope of midwifery practice. The fact that only some midwives, through working within these midwifery-led models, have been accorded the opportunity to practise to their full role, has contributed to the creation of perceived 'levels' of practice. It may not be that the midwives in the study practice at an advanced level but that many of the midwives who work in the fragmented model of care provision are unable to work to the full role and scope of midwifery practice.

The discussion then moved to the views the midwives had on how credentialling might contribute to increasing professionalism through professional development and highlighting the importance of reflecting on practice.

The chapter concluded with a discussion on the factors that may assist the progression of the introduction of a clear and standardised approach to ensuring all midwives have a structured way of demonstrating continuing competency in the full role and scope of midwifery practice.

For the midwives working in midwifery-led models of care, the process of credentialling has provided positive affirmation of their ability to work in the full role and scope of midwifery practice. The credentialling process encourages formal reflection on their practice and encourages midwives to plan their continuing professional development.

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Appendices

Appendix I – Consent form

Faculty of Nursing, Midwifery and Health
Level 7, Building 10
PO Box 123
Broadway NSW 2007



CONSENT FORM

Name of Project: What are the experiences of midwives who undertake the credentialling process in NSW?

HREC approval no: _____

I, _____ (name of participant) _____ (address) consent to my participation in the above research study. I have read the information attached to this consent form and I understand my role as a participant in this research. I also understand the following in relation to this study:

- I will make contact with the researcher by telephone or email to arrange a convenient time for an interview
- This interview will be tape-recorded;
- The interview time should not exceed 60 minutes;
- The interview with me will be de-identified, accessible to the researcher only, and used only for the purposes of this study;
- This de-identified interview data may be used in publications arising from this research;
- My confidentiality, and that of the facility in which I am employed, will be maintained at all times, and in all publications;
- I can withdraw from this study, at any time, and for any reason without any consequence;
- I can contact the researcher if I have any questions or concerns about my participation in this study.

Signed _____ Dated _____

(Research participant)

Signed _____ Dated _____

(Researcher)

Researcher's name: Rachel Smith
Address: Faculty of Nursing, Midwifery and Health
University of Technology, Sydney
Level 7, Building 10
PO Box 123
Broadway NSW 2007
Email: Rachel.smith@uts.edu.au
Phone: 02 9514 4913

NOTE: This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer (ph: +61 2 9514 9615 Research.Ethics@uts.edu.au). Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

INFORMATION SHEET

CREDENTIALLING: MIDWIVES EXPERIENCES

WHO IS DOING THE RESEARCH?

My name is Rachel Smith and I am a student in the Master in Midwifery (Hons) at UTS. My supervisors are Caroline Homer and Pat Brodie.

WHAT IS THIS RESEARCH ABOUT?

This research is to find out about the experiences of midwives in New South Wales who undertake the credentialling process.

IF I SAY YES, WHAT WILL IT INVOLVE?

Should you consent to be involved in this research, you will need to contact me so that we can arrange a time to meet for a face-to-face interview. The interview will take no longer than one-hour and will be at a time and place that is most convenient for you.

WHY HAVE I BEEN ASKED?

You are invited to be included in the study because you have undertaken the credentialling process and would be able to contribute significantly to understanding how midwives feel about the process and what it means to them

DO I HAVE TO SAY YES?

You don't have to say yes.

WHAT WILL HAPPEN IF I SAY NO?

Nothing. If you do not contact me, I will presume you do not wish to be involved in the study.

IF I SAY YES, CAN I CHANGE MY MIND LATER?

You can change your mind at any time and you don't have to say why. I will thank you for your time so far and won't contact you about this research again.

WHAT IF I HAVE CONCERNS OR A COMPLAINT?

If you have concerns about the research that you think my supervisor or I can help you with, please feel free to contact me (us) on:

Rachel Smith
Rachel.smith@uts.edu.au

Ph. 9514 4913

Caroline Homer
caroline.homer@uts.edu.au

Ph 9514 2975

If you would like to talk to someone who is not connected with the research, you may contact the Research Ethics Officer on 02 9514 9615, and quote this number - 2006-291.

Policy Directive



Department of Health, NSW
73 Miller Street North Sydney NSW 2060
Locked Mail Bag 961 North Sydney NSW 2059
Telephone (02) 9391 9000 Fax (02) 9391 9101
<http://www.health.nsw.gov.au/policies/>

Midwives - NSW Health - Credentialling Framework

Document Number PD2005_615
Publication date 29-Aug-2005
Functional Sub group Clinical/ Patient Services - Maternity
Personnel/Workforce - Recruitment and selection
Summary Area Health Services are required to ensure that midwives working in midwifery-managed models of care are credentialled. This is to optimise the quality and safety of maternity care through the provision of a skilled and competent midwifery workforce.
Author Branch Nursing and Midwifery Office
Branch contact Ann Kinnear 9391 9515
Applies to Area Health Services/Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Affiliated Health Organisations, Public Hospitals
Audience Nursing and midwifery
Distributed to Public Health System, Community Health Centres, Health Associations Unions, Health Professional Associations and Related Organisations, NSW Ambulance Service, NSW Department of Health, Public Hospitals, Tertiary Education Institutes
Review date 29-Aug-2010
File No. 04/2184
Previous reference N/A
Status Active

Director-General

Compliance with this policy directive is **mandatory**.

Appendix IV – Participant characteristics

Participant	
Age range (years)	32 - 51 (Ave. = 40.1)
Number of years working in midwifery	6 - 38 (Ave = 15.8)
Number of years in midwifery led model	0.5-5 years
Fulltime or part-time	All fulltime