A case study of SWIM with ME:

Matching a model of student education to a continuity of care model in midwifery

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CERTIFICATE OF ORIGINAL AUTHORSHIP

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 the 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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ABSTRACT

Maternity services are required to provide relevant midwifery education to employed Graduate Diploma of midwifery students, which fulfils the requirements of the Australian Nursing and Midwifery Council (ANMC) for midwifery registration. One of the requirements is for each student to “follow through” a number of women from early in their pregnancy until 4 weeks after the birth of their baby. At the same time the maternity service is also required to provide choice for women in relation to a particular model of care known as ‘continuity of care’. Continuity of midwifery care is a consistent philosophy or organisational structure underpinning the care provided by midwives across the antenatal, intrapartum and postnatal periods which is different to the concept of continuity of carer. Continuity of midwifery carer describes care by a midwife whom the woman has previously met, feels she has developed a ‘relationship’ with and believes she knows’ (Homer, Brodie & Leap, 2008). Continuity of midwifery care experience (CoMCE) means the ongoing midwifery relationship between the student and the woman from initial contact in early pregnancy through to the weeks immediately after the woman has given birth, across the interface between community and hospital settings (ANMC, 2009). The intention of providing the continuity of care experience for the education of student midwives to is to enable students to experience continuity with individual women irrespective of the availability of midwifery continuity of care models (ACM advice to the ANMC National Accreditation Standards project 2008–09). In the context of this study it is the continuity of midwifery care experience (CoMCE) which is being explored. For many organisations, meeting these simultaneous requirements for the care of women and the education of student midwives is difficult to achieve. This study will use case study methodology to describe in detail how one organisation has addressed this issue through a model of midwifery education in clinical practice. Aspects of this case may resonate with midwives and maternity service managers attempting to match the model of midwifery continuity of care with student midwife clinical education.

PUBLICATIONS AND PRESENTATIONS ARISING FROM THIS THESIS

Gilroy, G., Sim, J., Foureur, M. & Gray, J. 2012, 'Midwifery education and continuity of care', Midwifery Matters, no. September, pp. 28- 9.

Gilroy, G. & Sim, J. 2012. 'Sink or SWIM? Matching a model of education to a model of care in midwifery: A five year evaluation', paper presented to Midwives Fit for the Future Conference, Australian College of Midwives Queensland branch SeaWorld Queensland.

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Gilroy, G. 2008. 'Sink or SWIM? Midwifery Education in Midwifery Practice', A Showcase of Innovation, Nurses and Midwifery Office, State Library Sydney

Sim, J. & Gilroy, G. 2008, 'Swim with Me: Collaboratively', paper presented to the 'Minding your P's & Q's' Partnering professionally'. Women's Hospitals Australasia, Manly, Sydney, 19th November.

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GLOSSARY

ACM Australian College of Midwives

ANMC Australian Nursing and Midwifery Council

ANMAC Australian Nursing and Midwifery Accreditation Council (ANMAC) is the independent accrediting authority for the nursing and midwifery professions under the National Registration and Accreditation Scheme. ANMAC commenced operations on 1st July 2010. ANMAC regularly reviews and improves accreditation standards used to assess programs to ensure their continued relevance and effectiveness in contemporary education and health care environments.

Continuity of Midwifery Care Experience (CoMCE) follows the same definition as the follow through experience above and this term has been used throughout this thesis.

> *Continuity of care experience means the ongoing midwifery relationship between the student and the woman from initial contact in early pregnancy through to the weeks immediately after the woman has given birth, across the interface between community and hospital settings. The intention of the continuity of care experience is to enable students to experience continuity with individual women through pregnancy, labour, birth and the postnatal period, where practicable and irrespective of the carers chosen by the woman or of the availability of midwifery continuity of care models*. (ACM advice to the ANMC National Accreditation Standards project, 2008–09).

Continuity of midwifery care is a consistent philosophy or organisational structure underpinning the care provided by midwives across the antenatal, intrapartum and postnatal periods.

Core midwives are Midwives in maternity unit who are not working in midwifery continuity of care. Core midwives are usually based in one clinical area

(antenatal, birthing unit, postnatal) however in Hornsby maternity unit most midwives rotate to all areas of maternity services.

Follow through experience means the ongoing midwifery relationship between the student and the woman from initial contact in early pregnancy through the weeks immediately after the woman has given birth, across the interface between community and hospital settings (Australian College of Midwives Inc. 2001). CoMCE is the term used for this experience in this thesis.

Health service providers are health units or other appropriate service providers, where students undertake a period of supervised professional experience as part of a course, the graduates of which are eligible to apply for midwifery registration (adapted from definition for 'clinical facilities' in the ANMC National Accreditation Framework).

MESAC Midwifery Education Standards Advisory Committee

MGP means Midwifery Group Practice also known as case load. MGP's are small groups of midwives who provide all antenatal, intrapartum and postnatal care to a defined number of women.

N3ET National Nursing and Nursing Education Taskforce

Professional experience placement is the component of midwifery education that allows students to put theoretical knowledge into practice within the consumer care environment (adapted from the ANMC Standards for Registered Nurses). It must include but may not be limited to continuity of care experiences. It excludes simulation.

Professional Experience ANMC 2010

In Standard eight of the National Accreditation Standards and Criteria, the ANMC states:

The course provider is required to demonstrate the inclusion of periods of professional experience in their course so students can complete all these

minimum supervised professional experience requirements, regardless of the length of course:

1) Twenty (20) continuity of care experiences. Specific requirements of these experiences include:

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

b) Participation in continuity of care models involving contact with women that commences in early pregnancy and continues up to four to six weeks after birth

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

d) Consistent, regular and ongoing evaluation of each student's continuity of care experiences

e) A minimum of eight (8) continuity of care experiences towards the end of the course and with the student fully involved in providing midwifery care with appropriate supervision

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

g) Provision by the student of evidence of their engagement with each woman (Australian Nursing & Midwifery Council 2010).

Supervision and/or support is where, for instance, an academic staff member or midwife supports and/or supervises a student undertaking a course for entry to the midwifery profession on a professional experience placement. It includes supervision and/or support provided in relation to the student's participation in continuity of care experiences.

SWIM with ME is an acronym for 'Students with Women Innovative Model with Midwifery Education'. This original nomenclature of the model is now referred to as SWIM by the organisation, students and women.

SWIM is the student midwifery model of education for the CoMCE for graduate diploma in midwifery students at Hornsby Hospital. SWIM is the title of the model used throughout this thesis.

Transitional Midwife is a newly qualified midwife in an educationally supported role in a maternity service. These transitional midwives had been educated through SWIM for their CoMCE.

Women-centred care is a concept that implies that midwifery care:

- ❖ Is focused on the woman's individual unique needs, expectations and aspirations, rather than the needs of institutions or professions involved.
- ❖ Recognises the woman's right to self-determination in terms of choice, control, and continuity of care from known care givers.
- ❖ Encompasses the needs of the baby, the woman's family, her significant others and community, as identified and negotiated by the woman herself.
- ❖ Follows the woman across the interface between institutions and the community through, through all phases of pregnancy, birth and the postnatal period, therefore involving collaboration with other health professionals when necessary.
- ❖ Is 'holistic' in terms of addressing the woman's social, emotional, physical, psychological, spiritual; and cultural needs and expectations. (Homer, Brodie & Leap 2008)

CHAPTER ONE: INTRODUCTION

BACKGROUND

Maternity services are required to provide clinical education experiences for midwifery students, in order that the students meet the requirements for midwifery registration. One of the requirements is for each student to "follow through" a number of women from early in their pregnancy until 4 weeks after the birth of their baby. This is called the Continuity of Midwifery Care Experience (CoMCE) (Australian College of Midwives 2013). At the same time maternity services are also required to provide choice for women in relation to a model of care known as "continuity of care"(Homer, Brodie & Leap 2008). Continuity of midwifery care describes care by a midwife or small group of midwives whom the woman has previously met, feels she has developed a 'relationship' with and believes she knows' (Homer, Brodie & Leap 2008). For many organisations, meeting these simultaneous requirements for the care of women and the education of student midwives is difficult to achieve. This thesis uses case study methodology to describe in detail how one organisation has addressed this issue through an innovative model of midwifery clinical education called 'SWIM with ME'. 'SWIM with ME is an acronym for 'Students with Women Innovative Model with Midwifery Education' hereafter called SWIM.

This opening chapter presents the background to the study by outlining key changes within maternity services and their educational role over the last twenty years. How service changes have influenced midwifery education standards, particularly in relation to continuity of care and the CoMCE requirement are outlined and I describe how these changes relate to postgraduate midwifery students[1] employed within the maternity services. The chapter concludes by describing the development of SWIM[2], a continuity of midwifery care model that aimed to meet the needs of both student midwives and childbearing women.

[1] Postgraduate midwifery students are Registered Nurses enrolled in a one-year postgraduate midwifery program, in some States and Territories these students are concurrently employed by a maternity unit and are therefore part of the workforce. A Bachelor of Midwifery student is an undergraduate student enrolled in a three-year midwifery degree who is supernumerary to the workforce.

[2] To be detailed later in this Chapter.

Why I am interested in this issue

I have chosen to explore this issue primarily because of my role in midwifery education. I am a clinical midwifery educator and have been involved in the education of student midwives in both clinical and academic environments for 10 years. My discussions with student midwives have revealed that many do not feel supported by their clinical facilities to achieve the requirements of the CoMCE, particularly since many maternity units do not have clinical models of care that provide continuity for women, into which the students could be placed.

The impetus for CoMCE to be included in midwifery education in Australia

The drive for implementing the CoMCE into midwifery education in Australia arose in part from the findings of national and state maternity service reviews conducted over almost three decades. All of the reviews [listed in Table 1] revealed long term support for the premise that continuity of midwifery care should be offered to all women as it is a model of care that best meets women's needs. Twenty five years ago the NSW-based Shearman report clearly stated the need for continuity of care for women (NSW Health Department 1989). Many years later the NSW Framework for Maternity Services provided five-year goals and strategies for how continuity of care could be achieved (NSW Health 2000). In adopting the following philosophy statement for developing maternity services, NSW Health took a step further by not only embracing the philosophy of Continuity of Care, but also tying it to the concept of preparing a workforce able to provide it competently:

> *NSW Health recognises pregnancy, labour, birth and parenting as significant and meaningful life events and acknowledges the right of consumers to access safe maternity care and quality maternity services.*
>
> *Continuity of care and consistent information is essential to the provision of care that is culturally sensitive and appropriate.*
>
> *Collaboration between health workers at all levels plus the development of a competent and flexible workforce are critical factors in ensuring safe*

services and the availability of a range of models of care (NSW Health 2000).

Ten years later, the most recent NSW report, "Towards Normal Birth" (NSW Health 2010) continues the call for continuity of care and has now set targets for this to be achieved. As Table 1 reveals, one step of "Towards Normal Birth" stipulates that at least 35% of women in NSW should be accessing midwifery continuity of care programs by 2015 (NSW Health 2010).

Table 1: Timeline of Maternity Services government reports recommending women have access to midwifery continuity of care

Year		
1989	Shearman Report	Ministerial Taskforce on Obstetric Services in NSW. A review of Maternity services. Clearly stated the need for Continuity of care for women.(NSW Health Department 1989)
1991	NSW Maternity Services: an update	Implementation of the Shearman report 1989-1991. Many recommendations promoting continuity of care were addressed including Birth Centres and Early Discharge Programs
1996	Options for effective care in childbirth	Families want satisfaction, relating to • Continuity of care • Access to and sharing of information • Control over the birth process (National Health and Medical Research Council 1996)
2000	NSW Framework for Maternity Services	The NSW Health Department convened a Maternity Services Advisory Committee to consider a range of issues regarding the provision of maternity services in NSW and to develop a five year plan for maternity services in NSW. A major focus was the vision to enhance continuity of care across antenatal, delivery and postnatal services (NSW Health 2000, p. 19)
2003	Models Of Maternity Service Provision Across NSW	Progressing implementation of the NSW Framework for Maternity Services Continuity of care enables women to develop a relationship with women and consistent information is essential to the provision of care that is safe, sensitive and appropriate (p.11).
2008	Australian Health Ministers Advisory	Primary Maternity Services in Australia: A framework for implementation. (Australian Health Ministers Advisory Council 2008) Describes continuity of care as the preferred practice for maternity

Year		
	Council	services. “There is strong level 1 evidence which demonstrates that continuity of midwifery care in pregnancy, birth and the postnatal period (Hodnett, 2001) is as safe as traditional models of care and can achieve beneficial outcomes” (p.9)
2010	Towards Normal Birth (NSW Health 2010)	Ten step plan including: Provide or facilitate access to midwifery continuity of carer programs in collaboration with GPs and obstetricians for all women with appropriate consultation, referral and transfer guidelines in place. The stated requirement is that at least 35% of women are accessing midwifery continuity of carer programs by 2015 (NSW Ministry of Health 2010, p. 9)
2010	National Maternity Services Plan	Five year vision for maternity services. States “Appropriately trained and qualified maternity health professionals will be available to provide continuous maternity care to all women”(Department of Health 2010, p. 32).

While many of the reviews were initiated in NSW, it is clear that continuity of care is integral to Australia-wide delivery of maternity services as evidence by the 2010 National Maternity Services Plan;

> *Continuity of care, as a feature of maternity care, is very important for women. There is an increasing demand for midwifery continuity of care models. There are also many women who choose to access continuity of care from general practitioners (GPs) and specialist obstetricians. It is recognised that these choices should be respected and supported by improved access for those who choose to use them. (Department of Health 2010, p. 13).*

The National Maternity Services Plan identified a five-year vision for maternity services as;

> *Maternity care will be woman-centred, reflecting the needs of each woman within a safe and sustainable quality system. All Australian women will have access to high-quality, evidence-based, culturally competent maternity care in a range of settings close to where they live... Appropriately trained and qualified maternity health professionals will be*

available to provide continuous maternity care to all women. (Department of Health 2010, p. 3).

An emphasis in this report was on the appropriate education of maternity health professionals, including midwives, to equip them with the skills to confidently and competently provide continuity of midwifery care. Addressing these educational needs of midwives has proven to be a challenge for a range of reasons as the next section reveals.

The Separation of Midwifery from Nursing in Australia

Over a similar time period to the reviews in maternity services many changes occurred within the midwifery profession in Australia. Arguably midwifery has had a history of invisibility in Australia (Brodie 2003). Whilst other countries such as New Zealand, Canada and the United Kingdom had developed a robust midwifery identity, in Australia midwifery was subsumed into the nursing identity until recent years. Midwifery was an additional course entered into by Registered Nurses and as such it was a post nursing registration course. Both nursing and midwifery theoretical and clinical education were provided within hospitals where nursing schools were based until the late 1980's. Hospitals were staffed by trainee nurses and midwives employed within the health service. A major shift occurred in nursing education when it was transferred from hospitals to the tertiary sector from 1984 onwards. In order to gain clinical experience, university educated nurses were now supernumerary in the healthcare setting. Following the introduction of the Bachelor of Nursing, midwifery remained a post graduate degree and the status quo continued with registered nursing qualification being required for enrolment into a midwifery program. The postgraduate diploma in midwifery remained an employed model, where the student midwives were employed by the health service for 32 hours a week and attended university one day a week. The Graduate Diploma in Midwifery for Registered Nurses remained the only pathway to midwifery registration until the introduction of the Bachelor of Midwifery in 2002. The result is that there are now two pathways to qualifying as a midwife; the undergraduate degree where students are supernumerary to the workforce and the post nursing registration course where in most areas of NSW, students work

in an employed model and are not supernumerary. Being part of the workforce while undertaking the postgraduate midwifery program has direct relevance to the students' flexibility and access to their CoMCE; an issue that underpinned the model explored in this thesis and one to which I will return. However, there is one further development in the re-emergence of midwifery in Australia that has impacted the experience of students as discussed in the following section.

Introduction of Midwifery Education Standards which Incorporated the CoMCE

The emergence of the Bachelor of Midwifery required the simultaneous development of national midwifery education standards. Establishing standards was crucial to consistency across Australia-wide university curricula. Table 2 provides a broad overview of the timeline for the development of the standards and the changing nature of the requirements for a certain number of CoMCE to be achieved within the timeframe of both the 3-year degree and the 1-year postgraduate diploma programs leading to registration.

Table 2: Timeline of the development of Midwifery Education Standards

1999	ACMI (Australian College of Midwives Incorporated) Bachelor of Midwifery Taskforce	1999-2002 the taskforce involved all stakeholders, developed the ACMI Bachelor of Midwifery Education Standards and by 2002 the first Bachelor of Midwifery program commenced in Australia.
2009 Rev. Nov 2010	ANMC Report. Developed with input from the ACM in consultation with MESAC (Midwifery Education Standards Advisory Committee)	Standards and Criteria for the Accreditation of Nursing and Midwifery Courses Leading to Registration, Enrolment, Endorsement and Authorisation in Australia—with Evidence Guide

In 1992 the Australian Nurses Council (ANC) was established to regulate nurse education. In 2004, ANC expanded its role to include regulation of midwifery. Its new name Australian Nursing and Midwifery Council (ANMC) became a well-known, peak national body. ANMC facilitated a national approach to nursing

and midwifery regulation. On 1 July 2010, the Australian Health Workforce Ministerial Council appointed ANMC as the independent accrediting authority for the nursing and midwifery professions. Following this appointment, ANMC changed its name to ANMAC to reflect its principle role as an accrediting authority. This new name officially took effect on 24 November 2010.

Discussions about the standards have been a major topic in midwifery education circles for over a decade, particularly around the continuity of care or 'follow through' experience. The original midwifery standards recommended a minimum of three occasions where students were to be provided with access to women receiving continuity of care throughout the childbearing continuum (Faculty of Nursing Midwifery and Health 2005). This requirement increased to 15 in 2006 and since 2010 the standard has been increased to 20 (Faculty of Nursing Midwifery and Health 2006).

Conversation and consultation regarding standards continues today as seen by ongoing revisions particularly regarding the numbers of births and CoMCE required as described in Table 2. Much emphasis has been on Standard eight which is detailed as follows:

> **Standard eight: Professional Experience**
>
> *Twenty (20) continuity of care experiences.*
>
> *Specific requirements of these experiences include:*
>
> *a) Enabling students to experience continuity with individual women through pregnancy, labour and birth and the postnatal period, irrespective of the availability of midwifery continuity of care models*
>
> *b) Participation in continuity of care models involving contact with women that commences in early pregnancy and continues up to four to six weeks after birth*
>
> *c) Supervision by a midwife (or in particular circumstances a medical practitioner qualified in obstetrics)*

d) Consistent, regular and ongoing evaluation of each student's continuity of care experiences

e) A minimum of eight (8) continuity of care experiences towards the end of the course and with the student fully involved in providing midwifery care with appropriate supervision

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

g) Provision by the student of evidence of their engagement with each woman. (ANMAC 2010 p.19)

It is difficult for postgraduate students in an employed model to meet these standards because of their workforce commitment and rostering within the maternity service, therefore maternity services have called for reducing the number of CoMCE required. This causes a problem for the quality of educational experiences for the students and so is an ongoing source of debate. There continues to be widespread consultation involving all stakeholders (ANMAC 2013)[3]. The Nursing and Midwifery Board of Australia (NMBA), the Australian College of Midwives (ACM) and ANMAC continue to receive feedback on what should be included in the midwifery education standards. Maternity services have requested the CoMCE numbers to be reduced as there is concern that student midwives would find these numbers unachievable in the current health care setting. A greater concern may be the 'watering down' of the requirements which may be a detrimental step for midwifery education. As stated by Joanne Gray (2013)

[3]The NMBA approved the ANMAC Midwife Accreditation Standards (2014) on 30 October 2014. The revised standards were released by ANMAC on 17 November 2014 following completion of the publication process. Following extensive consultation there are three significant areas of change. The change relating to this thesis is in Standard 8 – Management of midwifery practice experience. This change includes; flexible counting of valuable midwifery practice experiences and a reduction in continuity of care experiences from 20 to 10. These changes were not in place at the completion of this thesis.

> *There are serious implications for the future of midwifery education in Australia if the professional experience requirements are reduced for pre-registration midwifery education programs. The future for midwifery education in Australia relies on considered discussion and leadership to ensure that these standards provide the best possible opportunity for midwifery students to meet competency standards. (Gray 2010, p. 6).*

Consensus on numbers of clinical midwifery experiences for student midwives may be hard to achieve. The concept of the CoMCE within the midwifery curriculum is supported. At the time of writing up this research the number of women the students support through the continuum was twenty. The feedback to ANMAC was that more than twenty created difficulties for students (Gray 2010) and any fewer had the potential risk of students not gaining any value from these experiences. How student midwives achieve this continues to be a challenge and this case study addresses one organisation's approach. The major reason for the importance of the CoMCE to be included in the standard for midwifery education is that the benefits of continuity of midwifery care are well documented as described in the next section.

Benefits of Continuity of Midwifery Care for women and midwives

The weight of evidence around the benefits for women, of continuity of midwifery care, has been published extensively in the midwifery literature. The core concept is that care is woman centred and based on relationships with a known carer. The women experience safety, choice, continuity and control (Sandall 1995). For midwives there is the opportunity for high satisfaction, meaningful relationships and occupational autonomy. In order to avoid burnout the midwives need an environment of support at home and work, back-up for when they are not available and strong teamwork.

The intention here is not a detailed discussion of the benefits of continuity of care, but to highlight relevant work in this field as it relates to the student CoMCE. In 2013 a systematic review of the literature was conducted to compare midwifery led models of care with other models of care for women and

babies (Hatem et al. 2013). The selection criteria were all published and unpublished trials in which pregnant women were randomly allocated to midwifery led or other models of care, and where care was provided through the continuum (Hatem et al. 2008). The review looked at trials conducted in Australia, Canada, US and UK. The results showed that women who experienced midwifery led continuity of care were: less likely to have antenatal hospitalisation, regional anaesthesia, episiotomy or instrumental birth. These women were more likely to experience spontaneous vaginal births, have a reduction in preterm birth, have a known midwife at her birth, feel in control during childbirth and initiate breastfeeding.

Setting up midwifery led models of care

Midwifery continuity of care models come in many shapes and forms and are interpreted by organisations in relation to their context (Tracy et al. 2013; Turnbull et al. 2009; Waldenstrom & Turnbull 1998). The term midwifery continuity of care generally refers to the care of childbearing women provided by midwives. In this model, care begins in early pregnancy, and continues throughout pregnancy, labour and birth and the postpartum period (Homer, Brodie & Leap 2008) Continuity of midwifery care is a consistent philosophy or organisational structure underpinning this care provided by midwives and can be provided in a variety of ways. This can include a variety of models such as team midwifery, MGP and care from an independent midwife (Homer, Brodie & Leap 2008). The manner in which continuity of care is successfully provided is dependent on several factors outlined below:

- Systems of funding for midwifery
- Government and health services policy
- Priorities of maternity services
- The setting in which the care is provided
- The support of obstetricians, managers and other midwives
- The level of autonomy (on call, employed, self-employed)
- Organisational structures and culture
- Historical issues

- Midwifery education, practice review and continuous professional development
- Individual support from family and friends.

(Homer, Brodie & Leap 2008, p. 6)

These factors are important for maternity services to consider in developing their own models of continuity of care. “Continuity of midwifery carer” describes care by a midwife whom the woman has previously met, feels she has developed a relationship with and believes she knows (Homer C, Brodie P & Leap N 2008). This is usually seen in caseload models where a midwife has an agreed number of women for whom she is the primary caregiver and usually has a backup midwife to support her and for whom she provides support. Midwifery Group Practice model (MGP) is where a greater number of midwives work together in a locally arranged agreement, the focus is to maximise continuity of care for these women. It describes a group of midwives working together with individual caseloads, supporting one another with shared on-call. This approach to care often results in greater satisfaction and reduced burnout for midwives (Sandall et al. 2009). The ideal number of midwives in an MGP model is yet to be defined. CoMCE is based on the same philosophy as an MGP model with continuity of care being the central premise. According to the ANMC requirements for the education of midwives,

> *The continuity of midwifery care experience (CoMCE) means an on-going midwifery relationship between the student and the woman, from initial contact in early pregnancy through to the weeks immediately after the woman has given birth, across the interface between community and hospital settings*. (NMB 2008, p. 2).

The relationship between the midwife (or student) which aims to engender trust is regarded as relational continuity Relational continuity alone is not sufficient for the woman to receive safe care; however a combination of informational, longitudinal and relational continuity of care contributes towards safe practice as defined in Table 3.

Table 3: Hierarchical definitions of midwifery continuity of care Adapted from (Homer, Brodie & Leap 2008)

Level of Continuity	Description
Informational	An organised collection of medical and social information about the woman that is readily available to any health professional providing care.
Longitudinal	In addition to informational continuity, each woman has a 'place' where the woman accesses most of her care from an organised team of providers. This team is responsible for organising quality and appropriate care.
Relational	In addition to informational and longitudinal a trusting relationship develops between the woman and her midwife. This midwife takes responsibility for all midwifery care and arranges 'back up' is the midwife is not available.

These definitions provide a structure enhanced by the core principle of woman centred care described in the NSW Health Midwifery Continuity of Carer Model Tool-Kit (NSW Ministry of Health 2012) illustrated below;

> *Care is focussed on the woman's individual unique needs, expectations and aspirations, rather than the needs of the institutions or professions involved.*
>
> *Care recognises the woman's right to self-determination in terms of choice, control and continuity of care from a known or known caregivers.*
>
> *Care encompasses the needs of the baby, the woman's family, her significant others and community, as identified and negotiated by the woman herself.*
>
> *Care follows the woman across the interface between institutions and the community, through all phases of pregnancy, birth and the postnatal period, therefore involving collaboration with other health professionals when necessary.*
>
> *Care is 'holistic' in terms of addressing the woman's social, emotional, physical, psychological, spiritual; and cultural needs and expectations.* (NSW Ministry of Health 2012).

Few Health services have been able to embrace the concept of continuity of care in their models of service delivery for a range of reasons beyond the scope of this thesis to discuss. This discussion has detailed why continuity of care is important to offer to pregnant women. It is logical that the CoMCE should be embedded in the midwifery curriculum.

Thus CoMCE is a vital element in the students' journey to becoming a midwife. In her doctoral thesis Gray (2013) discussed how the 'follow through' experience was developed; how it was experienced by undergraduate Bachelor of Midwifery students and the challenges that they faced (Gray 2010). Gray did not research the journey of the Graduate Diploma midwifery student in their CoMCE and acknowledged that this was a limitation of her study. The journey of the Graduate Diploma in Midwifery student differs from that of the Bachelor of Midwifery student due to the length and structure of the two midwifery programs which will be discussed in the following section.

The challenge of providing the CoMCE to Graduate Diploma student midwives within maternity services

The clinical requirements for the undergraduate Bachelor of Midwifery students and the postgraduate Graduate Diploma in Midwifery students are the same. However, currently the Bachelor of Midwifery is a 3 year course and the Graduate Diploma in Midwifery a one year course. In 2007, the then Nurses and Midwives Board (now ANMAC) held a Midwifery Forum with key stakeholders to discuss the length and structure of midwifery programs. The Forum recommended an increase in the number of structured weeks in midwifery programs leading to registration as a midwife. The recommendation was an 18 months program for postgraduate midwifery for registered nurses (NMB 2008). This is in keeping with the founding principles from the International Confederation of Midwives which include an agreement that the minimum length of a post-nursing/ health care provider programme is eighteen (18) months (ICM 2010). Consensus was not achieved within Australia therefore the increase in length of education has not eventuated. The length of the program in which the students must complete 20 CoMCE or 'follow-through' experiences remains 12 months which presents significant logistical challenges.

These challenges also provide an opportunity for universities and health service providers to consider innovative ways to prepare competent and confident future midwives.

ANMC define health service providers as maternity units, where students undertake a period of supervised professional experience as part of a course, the graduates of which are eligible to apply for midwifery registration (ANMC 2010). The role of these maternity units is to assist student midwives to meet the requirements for registration by providing opportunities for a number of student attended births, antenatal and postnatal student experiences (ANMC 2010 p.19). The greatest concern within the clinical environment has been the ability of the Graduate Diploma students to meaningfully fulfil the clinical requirements of 20 CoMCE in the limited time period of one year. A major constraint for student midwives is that their employed status has the potential to limit their availability to care for these women through the continuum.

Women's gestational period is 40 weeks and in NSW women access care through their maternity care provider at approximately 14 weeks gestation. In order to achieve the requirements of continuity of care for 20 women in one year, ideally the estimated birth dates for these women should be spaced throughout the course, similar to MGP models. In MGP models the midwives routinely book 4 women to birth per month, base the women's antenatal care around this and organise their on call as required. For MGP midwives continuity of care is the focus of their role; they generally provide care for 40 women annually (Homer, Brodie & Leap 2008) so in effect the students have to carry half the workload of a full-time MGP midwife. Postgraduate student midwives (in an employed model) are also required to work a thirty two hour week rotating roster throughout the maternity service and be on call in their own time for 20 women. The complexity of these requirements reveals the student midwife journey is challenging and therefore making it rewarding, supportive, achievable and relevant is important.

CHAPTER SUMMARY

Maternity services are required to provide relevant clinical education opportunities to employed Graduate Diploma of Midwifery students, which fulfils the requirements for midwifery registration, particularly the CoMCE. The intention of providing the CoMCE for the education of student midwives to is to enable students to experience continuity with individual women irrespective of the availability of continuity of care models within the health service. This Chapter has described what aspects of the Australian context have influenced the development of midwifery and educational standards in Australia. It briefly outlined changes within maternity services and educational requirements in the last thirty years and acknowledged how these have influenced midwifery education standards and how these relate to continuity of care and the CoMCE requirement. My particular interest in this topic is acknowledged, as are the specific needs of the postgraduate midwifery students.

OVERVIEW OF THIS THESIS

This first chapter has provided a background into the changes in midwifery education in recent years; the relevance of continuity of care for women and the introduction of the CoMCE into midwifery education standards.

In Chapter Two I present a review of the sparse amount of available research literature that explores how the issue of the clinical preparation of student midwives has been addressed in maternity settings in Australia and internationally.

In Chapter Three I set out the detailed study design of a case study of a model of student midwife clinical education known as ‘Students with Women Innovative Model with Midwifery Education’ (SWIM with ME) referred to as SWIM in this thesis.

In Chapter Four I present the analysis of the range of documents that detail the processes involved in identifying the need for SWIM in one maternity service. It addresses the planning and implementation phase and creation of an evaluation process.

Chapter Five describes the results of Womens' and Students' evaluations 2007-2011.This chapter presents an analysis of the data from the womens' and student midwives surveys which forms part of the documentation section of this case study.

Chapter Six presents the findings of the focus group and interviews with the stakeholders of this case study; midwives who were educated through SWIM, midwifery managers and facilitators of the model.

Chapter Seven concludes the thesis with the synthesis and discussion of the case study findings and describes the steps that other maternity services and education providers might consider in enabling and facilitating the CoMCE experience for Graduate Diploma of midwifery students.

CHAPTER TWO: LITERATURE REVIEW

INTRODUCTION

As Chapter one revealed, it is now well established that the CoMCE is relevant and necessary for the education of student midwives in Australia but that there are particular challenges for employed student midwives to gain this experience. In order to explore whether other researchers and/or educators had grappled with the issue of providing continuity of care and/or continuity of carer experiences for student midwives, a search of the literature was undertaken. In the following chapter I present a review of the located literature and I begin by exploring the evidence that underpins the concept of the CoMCE.

Continuity of midwifery care

The concept of continuity of midwifery care has been at the forefront of national and international midwifery literature for at least the last decade (Anderson & Lewis 2000; Homer, Brodie & Leap 2008; Page 2003). There has been strong lobbying in Australia by midwifery leaders in all states and territories which has resulted in the development of midwifery group practice models (MGP) in a growing number of health services (Homer, Brodie & Leap 2008). In 2009 Hatem and colleagues completed a systematic review with the objective of comparing midwifery-led models of care with other models of care for childbearing women and their infants which was later updated in 2013 (Hatem et al. 2009; Sandall et al. 2013). In 2013 the authors reviewed 13 trials involving 16,242 women. The findings were: women who had midwife-led continuity models of care were less likely to experience regional analgesia, episiotomy and instrumental birth and were more likely to experience no intrapartum analgesia/anaesthesia, spontaneous vaginal birth, attendance at birth by a known midwife and a longer mean length of labour. There were no differences between groups for caesarean births. Women who were randomised to receive midwife-led continuity models of care were less likely to experience preterm birth and fetal loss before 24 weeks' gestation although there were no differences in fetal loss or neonatal death of at least 24 weeks or in overall fetal or neonatal death. There was also a trend towards greater maternal satisfaction

and cost savings to the organisation. The recommendation was that most women should have access to midwifery led continuity of care models with some caution to be exercised regarding women with substantial complex needs. There is also evidence from a systematic review of randomised controlled trials comparing midwifery led antenatal care to general practitioner/obstetrician led care, that midwifery led clinics do not compromise quality of care, increase women's satisfaction and decrease costs of care (Khan-Neelofur, Gülmezoglu & Villar 1998). The literature pertaining to continuity of midwifery care is extensive. The systematic review by Sandall et al. (2013) has demonstrated its importance and it is not in the remit of this review to further explore continuity of care alone as it is the CoMCE which is the focus of this case study. Continuity of midwifery care has been evidenced as safe, is satisfying for women and should be available to all women. It is therefore relevant that student midwives should be educated to confidently and competently provide this care.

Continuity of care experience and midwifery education in Australia

In Australia the continuity of midwifery care experience was introduced into the NSW curriculum with the introduction of the first Bachelor of Midwifery course leading to registration as a midwife (Australian College of Midwives 2001, 2006). Initially, the expectation was for 3-5 longitudinal case studies or "follow-through" experiences, until 2006-7, when the numbers of CoMCE increased to 30 for Bachelor of Midwifery students and 15 for Graduate Diploma in Midwifery students. The different numbers required for each cohort directly reflected the length of their midwifery course that is Graduate Diploma students course length was one year and the Bachelor of Midwifery course was three years. The rationale for the increase in numbers was provided by an Australian based Delphi study conducted by Pincombe and colleagues which indicated the consensus amongst key stakeholders in the midwifery community was that prescriptive criteria were required to demonstrate competence in midwifery students (Pincombe et al. 2007). Elsewhere, Gray (2010) has described in detail the development of the educational requirements for midwifery registration and also the experience of the stakeholders and undergraduate

Bachelor of Midwifery students in NSW. Broadly, the standards and criteria were developed in conjunction with a steering committee of key industry stakeholders including regulators, professional bodies and academics leading to the publication in 2010 of new '*Standards and Criteria for the Accreditation of Nursing and Midwifery Courses Leading to Registration, Enrolment, Endorsement and Authorisation in Australia'* (ANMC 2010). Standard eight, "professional experience", directly addressed the responsibilities of the health service provider to provide a clinical placement for the student to meet the standards.

In 2010 the requirements for the CoMCE for Graduate Diploma of Midwifery students increased to 20 while the Bachelor of Midwifery numbers decreased to 20. The intention was that both cohorts of student midwives should meet the same educational requirements. One university requested a reduction in the number of continuity of care experiences as their students were finding it difficult to complete the minimum practice experiences in a one-year period (NMB 2008), however this did not eventuate at that time. This acknowledgement that there were difficulties for the Graduate Diploma students to fulfil these requirements, provides evidence that a specific student continuity of care model could assist the journey of the student midwife. This literature explores how this requirement of midwifery education has been addressed in a range of settings.

Literature Search Strategy

A search of the literature was undertaken to explore how students of midwifery are supported to experience continuity of midwifery care during their education program. The databases searched were CINAHL, MEDLINE, Science Direct, CIAP, Maternity and Infant Care and OVID, for the years 1997-2011. The search terms used were 'midwifery education', 'student midwives' and 'continuity of care'. Using SCOPUS (Elsevier) the search 'midwifery education' identified 4,800 results which were not specific enough for my investigation of a student midwife model of care, so I limited my search to 'Australia', 'student midwives', 'continuity of care' and 'organisational constraints'. The reason for this search criterion was my aim to discover the Australian experience. I

discovered there was minimal Australian information regarding the Graduate Diploma of Midwifery students within continuity of care models. There is however one extensive study by Gray (2010) regarding the undergraduate, Bachelor of Midwifery "follow-through" experience which is detailed later in this chapter. I then widened my search to include European countries as well as Australia. After reviewing the abstracts of the articles I was able to identify only 11 that met my search criteria. They were chosen on the basis of their relevance and currency pertaining to; the history of why the CoMCE was implemented in the Australian curriculum; its relevance to the student experience of CoMCE in midwifery education today and any article describing this experience in Europe or Australia. In the following section I provide a critical appraisal of the 11 articles identified, beginning with the experience of countries with a longer history of midwifery than Australia.

The European experience of midwifery students and the continuity of care experience

The United Kingdom

In the United Kingdom (UK) new standards for midwifery education introduced in 2009 required that undergraduate midwifery students be given the opportunity to experience working in a caseload model of midwifery care (NMC. 2009). Subsequently, Rawnson and colleagues have undertaken research and published a series of papers which describe the journey of Bournemouth University (BU) in setting up a model of midwifery continuity of care for their Bachelor of Midwifery students (Fry, Rawnson & Lewis 2008; Fry, Rawnson & Lewis 2011; Rawnson 2011; Rawnson et al. 2009). These papers describe the introduction, implementation and delivery of this experience which has now become a lynch pin of their Bachelor of Midwifery programme.

Fry and colleagues (2008) presented a descriptive study designed to inform the reader about the practicalities of preparing and supporting undergraduate student midwives to manage a caseload. The authors described how undergraduate student midwives were offered the opportunity of a CoMCE, 18 months into their three-year course. The paper discussed how BU addressed

professional issues such as ensuring safe practice, creating professional boundaries and avoiding burnout. The key points were that: educational preparation and support are essential elements in caseloading; a caseloading handbook assists the student in managing their personal caseload and, tripartite meetings between the student, midwife and tutor are important for adequate communication and supervision (Fry, Rawnson & Lewis 2008). These key points could be included in a framework to assist others developing similar models for the education of undergraduate student midwives. It is however important to bear in mind that the undergraduate student is supernumerary to the workforce of the maternity service and so is potentially more likely to be more flexible in attending to allocated women in a continuity or caseloading model of care, than an employed postgraduate student which is the situation in many parts of Australia.

The second study from the Bournemouth University group was an action research study undertaken to evaluate the model which was called, the 'Bournemouth University Midwifery Programme' (BUMP) (Rawnson et al. 2009). There were two action cycles to elicit student views. First year students were not invited to participate as they were not exposed to caseload in their first year. The first cycle involved a questionnaire administered to all 220 second and third year students with a response rate of 66% (146). The responses revealed that students valued caseloading; however the question exploring the availability of support received a mixed response. Therefore the authors adopted a focus group approach to explore this topic more thoroughly. Sixteen students elected to take part in one of four focus groups. Analysis of the focus group data revealed four themes: preparation to undertake a caseload; knowing your mentor; tripartite meetings and relevance of caseloading to their learning to become midwives. The findings suggested that the students valued their experience and believed that it increased their confidence and competence (Rawnson et al. 2009). A limitation of the study is that only 16 out of 220 students who were invited chose to join a focus group. With only 8% of the cohort attending, this may not be seen as a representative group; however 66% did answer the initial survey which can be seen as a representative sample. The overarching theme of the importance of support for students is seen in many of

the papers describing the student midwife experience and is central to the BUMP.

A more recent paper from this group has examined the problems and practicalities of student caseloading (Fry, Rawnson & Lewis 2011). The researchers used a series of case studies to explore the student experience in the antenatal, labour and birth and postnatal areas of care. The student midwives could choose the number of women for whom they provided continuity of care, which could range from 1-18. The case studies explored the key areas of record keeping, accountability and communication that are central components of woman centred care. A concerning issue raised was the requirement for midwives to countersign any documented care provided by the student. The authors stated their intention was to assist other maternity units to develop similar approaches to learning for their student midwives (Fry, Rawnson & Lewis 2011). There was no evidence in this paper as to how the case studies were obtained and who the students or midwives were who wrote them.

The final paper from BU is from Rawnson whose objective was to explore whether BU third year undergraduate student midwives perceived continuity of care had impacted on their learning journey to become a midwife (Rawnson 2011). This qualitative study used grounded theory principles and collected data from semi structured interviews. The participants were eight final year student midwives who had completed their caseload experience. The core category developed from the findings was named by Rawnson as ‘making it good’. The major categories around this central theme were: developing and managing a caseload; learning partnerships; feeling like a midwife and afterwards. The key conclusions in this study highlighted the students’ perception that the CoMCE had increased their confidence, competence and preparation for practice. It also highlighted the students concern that they did not want to let the women down. Support for the students was again seen as an integral part of the CoMCE. Limitations of this study are the small number of student midwives interviewed and it was based in one university. This was however the only university adopting this approach to midwifery education. Another consideration is that the numbers of CoMCE were not described. The author eludes to the fact that the

numbers were limited as the student midwives were balancing the course commitments, the commitments of the CoMCE and their own personal needs.

These studies describe different aspects of the journey that BU have travelled to enable student midwives to access continuity of care experiences in their undergraduate, three year, midwifery program. They highlighted the student experience and the importance of support mechanisms to deal with any potentially negative aspects of caseload midwifery that may be experienced by student midwives. Some students expressed feelings of inadequacy and believed they may have 'let the woman down' in some way (Rawnson 2011). Regular support meetings with mentor and tutor were recommended to assist the student midwives with these challenges. The researchers also described the close connection that the university tutor has to the students' continuity of care experience, which is evidenced by the tripartite meetings. This series of papers has also shown that students identified the importance of providing care and support in a meaningful and woman-focused manner from early pregnancy throughout the childbearing period and viewed this as a valuable learning experience. These studies could be relevant to the Australian context and would be valuable for our Bachelor of Midwifery cohort. However, as the UK students are not part of the employed midwifery workforce, the study may not be transferable to Australian NSW Graduate Diploma students who are the focus of the SWIM program.

In an earlier grounded theory study conducted in the UK, Currie used a qualitative research design to interview midwives and student midwives training in an 18 month postgraduate midwifery course (Currie 1999). Her research aimed to investigate how a student develops the skills to become an independent practitioner (which could be translated as a caseloading midwife). She used purposive and convenience sampling of senior students who had completed 14 months of an 18 months midwifery course. The participants were seven student midwives, with seven identified midwives as supporters and four night duty midwives. One student was male and six were female. The students and midwives were interviewed individually and the night duty staff as a group. The major themes in the findings related to recognition, incorporation and facilitation. This study concluded that students displayed non-assertive

behaviour, because they observed conflict within the maternity unit. This conflict was perceived as the midwives struggled with the desire to provide woman centred care in hospital environments that operate to restrict the midwives practice. The recommendation was for the midwives to be aware of factors that may influence their midwifery autonomy and how their actions influence the student midwives perception of midwifery. Reflection was considered to be important in this study. Currie expressed concerns regarding the ability of the supervising midwife and student to reflect on experiences within the clinical environment. This could be as a result of a busy maternity unit or as Currie suggests, some midwives have limited awareness of the importance of reflection (Currie 1999). Reflection is a key component of the Australian midwifery practice portfolio and the CoMCE. The CoMCE was not addressed in this study, however the challenges for postgraduate student midwives to meet their educational requirements were acknowledged. In New South Wales the Graduate Diploma of Midwifery course is 12 months and not 18 months as seen in the UK from this study. The study did not state whether these student midwives were in an employed model.

The Southern Ireland Experience

Student educational support within the practice environment of hospitals can be variable as revealed by Begley who studied the first intake of students at all seven maternity schools in Southern Ireland in 1995 (Begley 2001). Her aim was to explore the student midwives' journey through a two-year midwifery program. Data were collected via individual and group interviews, questionnaires and diary-keeping. The findings and implications for practice revealed that student midwives in this study often felt unsupported and emphasised that a respectful attitude towards students is essential in order to produce caring midwives in the future. The study also suggested that a re-organisation of the hierarchical midwifery management structures would lead to an improvement in experiences for both the women and student (Begley 2001). However the concept of a continuity model was not discussed and the two-year course is dissimilar to the Australian context where Graduate Diploma students have only one year of clinical midwifery.

The Norwegian Experience

A relatively recent Norwegian study was located that was directly related to the post graduate student experience (Aune, Dahlberg & Ingebrigtsen 2011). In Norway health care educational guidelines require student midwives to attend a 2-year full-time postgraduate programme in midwifery. The researchers described a pilot project conducted in 2009-2010 at Sør-Trøndelag University College (Aune, Dahlberg & Ingebrigtsen 2011). The objective of the study was to gain insight into how continuity of care can increase student midwives' understanding of midwifery where the emphasis is on the promotion of normal pregnancy, childbirth and postnatal period. The students volunteered to participate in the project, 6 months after they had started their 2-year postgraduate midwifery education. Six students, working in pairs, provided continuity of care to 58 women in an 18 month period. A qualitative approach was chosen for data collection with these six student midwives participating in a focus group interview at the end of the project. Data was analysed using systematic text condensation. Three main themes were relational continuity, personal development and health promotion perspectives. The key finding from this pilot was that 'relational continuity' is a key concept in the student midwives' learning process and their comprehension of midwifery (Aune, Dahlberg & Ingebrigtsen 2011). Through relational learning the students found meaning in their learning and began to care for women in a holistic sense. Relational continuity in this context indicated that the students experienced 'Interdependent trust and partnership' with women in their care (Aune, Dahlberg & Ingebrigtsen 2011). A limitation of this study is the small numbers of student midwives involved. A further limitation is that it was only their experience of the model that was explored. It would have added to the strength of the study, if the reader was informed of the practicalities of this model. The approach to the focus group questions may be useful within my research however a limitation of this research relates to context. The Australian context in NSW differs from the Norwegian in that our post graduate student midwives have one year not two to complete their midwifery education and the twenty continuity of care experiences are not a requirement for Norwegian midwifery registration.

This group of European based studies describe the challenges student midwives experience and suggest that a model of midwifery student education including case loading or continuity of care is important. Two universities, Bournemouth University and Sør-Trøndelag University, have promoted and supported students to achieve this experience in two and three year programs where the student is supernumerary. In each of these papers there is no required number of CoMCE for midwifery registration. These studies are not directly relevant to the Australian NSW Graduate Diploma of Midwifery student who usually complete her/his course within one year, while concurrently employed as part of the hospital workforce. Being part of the workforce means the student must meet rostered and rotating shift requirements as well as completing university requirements and the CoMCE. In addition, any model for employed Graduate Diploma of Midwifery students has to consider the varying commitment to education made by the hospital system and the costs attached. In the next section I review the located literature that revealed the Australian experience.

The Australian Experience

The literature search located five Australian studies relating to the issue of midwifery student education and continuity of care. A paper describing reflections on a one to one mentoring model, with one Graduate Diploma of Midwifery student attached to one midwife. In Hornsby Hospital, was published by Griffith & Partington (2007). This was a pilot project where one employed Graduate Diploma student midwife was mentored by a team midwife. This student was ‘buddied’ by the mentor on all shifts. The finding was that a high level of support was gained when the student roster mirrored that of the midwife. This article was a simple description of the participant’s experience so its contribution to knowledge in the area is limited. A limitation in the Australian context at this time was that the model explored in the paper is not considered a cost effective model for organisations when the student is in an employed model of midwifery education, however it could be valuable in an undergraduate, non-employed model.

Studies and opinion pieces by Glover (2003), Brooks and Barnes, (2001) and Gobbe and Cutts (2007) described how the experience of the CoMCE is valuable to the student learning experience.

Glover's editorial (2003) described the Bachelor of Midwifery element of the follow through experience. Glover outlined guidelines describing how recruitment and supervision of students could be achieved. She recognised the potential threat to midwives who may be unable or unwilling to work in a continuity of care model and emphasised the need to work collaboratively with medical colleagues. Glover emphasised the time commitment required by the students and noted at that time no evaluation had yet been published on the experience. This is an editorial and not a research study but is valuable to provide a framework for those new to the midwifery educational requirements of the CoMCE. The acknowledgement of the lack of research was relevant; however the CoMCE in 2003 was a new concept (Glover 2003).

As part of a larger evaluation of educational techniques, Brooks and Barnes (2001), had also looked at the CoMCE as part of the student learning journey in Brisbane, Australia. These researchers used a feminist methodology to undertake a study exploring the learning needs of Graduate Diploma of Midwifery students. This paper outlined an evaluation of experiential learning activities that have been used in a tertiary based midwifery program to assist students to appreciate childbearing from the childbearing womans' perspective. The activities commenced early in the first semester of the course and some continued into the second semester, with students attending some aspect of these activities each week. The activities included: attending a childbirth education program and support group; interviewing childbearing women about their experiences; and following a woman throughout pregnancy, labour and the postnatal period. The research involved interviews with women and the students who were involved in one CoMCE. The activities focused on enabling students to hear women's stories of childbearing firsthand and understand these stories from the women's perspective, thus validating personal experience (Brooks & Barnes 2001, p. 22). The themes that arose from this research were; knowing and sharing; learning tolerance and relationships with women. These themes were arrived at by a combination of learning logs, reflective techniques,

focus groups, program evaluation and documentation. How these themes were arrived at is not described in this paper nor are the numbers of women or students involved in this evaluation. A limitation in this study is that the authors were exploring the experiences of students involved in one CoMCE when the requirements at the time of writing are much larger at 20. In 2001 the CoMCE was not embedded into midwifery education standards. This study did address the experiences of the Graduate Diploma of Midwifery students which is relevant to my research question. What this study did add to the literature is that there is value in student midwives learning through the CoMCE.

Relevant to the student experience is the learning journey described in the study by Gobbe & Cutts (2007). This article was a descriptive account of the experiences of two Graduate Diploma in Midwifery students who were required to complete 15 CoMCE's as part of their clinical midwifery experience. These students were based at Nepean Hospital in NSW and they were in a twelve month employed model of midwifery education. The students identified a number of the hindrances to their recruitment of women which were: they had to plan to book women to birth when they were going to be rostered into the delivery suite; women had to be happy to attend the antenatal clinic on the days the students were rostered and the students were only rostered in antenatal clinic for six months. This meant that student availability for the women in the antenatal period was limited. The students expressed how much their CoMCE for 15 women was both a positive and rewarding part of their training, as well as challenging. The challenges they described as time depleting and exhausting, however they extolled the virtues of the CoMCE and were pleased to have engaged in this experience. This paper discussed two students experience of the CoMCE, which was the first description I found in the literature for this cohort. The relevance here is that these students experienced caring for 15 women, in an employed model without a specific model of care to support them. The learning for me here is the complex challenges that students have to meet in order complete their course.

A further Australian study by Gray (2010) described the journey of the three year Bachelor of Midwifery students in the CoMCE. Gray used a qualitative research methodology with an interpretive paradigm. Data collection included

surveys and semi-structured interviews. The participants were current and former Bachelor of Midwifery students as well as course providers and midwives. The aim was to explore the CoMCE then known as the follow-through experience in order to better understand the impact on midwifery students, education providers and midwives. The key findings of this research were; the CoMCE provides Bachelor of Midwifery students with unique learning experiences; mainly because the student is placed with the woman; it can be achieved even if the woman is not in a continuity of care model; the experience needs to be embedded in the course and maybe 30 experiences is too many (Gray et al. 2013). Two key findings for me in Grays' work were that the relationship with the women led to 'serendipitous' learning and that;

> *Students are more likely to learn from these experiences if they are embedded within their courses, where support is provided for reflection and where they are not forced to take a superficial approach due to an excessive workload (Gray 2010 p.250).*

Gray stated that limitations to this research were that only the experiences of undergraduate student midwives, enrolled in or who had completed the three year Bachelor of Midwifery degree were explored and that those who responded to the survey may have done so because they held strong views. A further limitation was that the research was focussed on one course in one university. However, the range of stakeholders surveyed provides the reader with a broad perspective of the CoMCE. Though much of Grays' work can be related to Graduate Diploma students, she stated a limitation of her work was the specific exclusion of this group.

The gap in the literature

The located literature indicated that student midwives often feel unsupported, undervalued, with limited access to continuity of care models or opportunity to reflect on practice The BU experience described the value of tripartite support for the student midwives to decrease their feelings of inadequacy. The literature search also revealed that studies of models of student midwife education around the CoMCE predominantly describe the undergraduate student who is

supernumerary to the workforce. Most studies have been conducted outside of Australia despite at least a 10 year history of the requirement for Post Graduate students to undertake continuity of midwifery care experiences as an integral component of their education. Therefore the aim of my research is to fill this gap in the literature.

CHAPTER SUMMARY

It was not the intention of this review of the literature to explore continuity of care as a concept or the student midwife experience. These have been reviewed by others. The intention here was to explore what models, if any, were described in the literature to assist Graduate Diploma of midwifery students, in an employed model, achieve the CoMCE for midwifery registration. The gap in the literature is that there were no Australian studies identified that examine a specific student midwifery model of care for employed Graduate Diploma of Midwifery students. It appears that providing a student midwifery led continuity of care model has been difficult to achieve or simply unachievable in many maternity units; however there remains the need to meet the requirements for the education of student midwives and the needs of women accessing maternity services. The aim of my case study is to increase knowledge in this area and describe a model of midwifery education to address this need. In the following chapter I provide the detailed study design for a case study of how one unit met the simultaneous needs of women and student midwives to experience continuity of midwifery care.

CHAPTER THREE: RESEARCH DESIGN AND METHODS

INTRODUCTION

This study uses a descriptive case study design as this type of case study is used to describe an intervention or phenomenon and the real-life context in which it occurred (Yin, 2003). This case study focuses on the description of SWIM.

> '*Descriptive* means that the end product of the case or phenomenon is a thick prose description, usually qualitative, using literary techniques to describe, evoke images and even analyse a situation.' (Merriam 1998, p. 30).

The descriptive nature of case study can show the influences of personalities on the issue; obtain information from a wide variety of sources and present information in a wide variety of ways and from the view point of different groups (Merriam 1998, p. 31). By concentrating on a single case, the aim is to uncover the interaction of significant factors, that is the stakeholders' journey and examine the documentation relating to the model. The underlying phenomenon in this case is the SWIM continuity model and its real life context is Hornsby Hospital.

Case study is an appropriate research design for this topic as it is a research method which aims to explore both the underlying process and its context (Pettigrew 1985) . The case study is preferred in examining contemporary events, when the researcher can have direct observation of the events being studied and interviews of the persons involved in the events (Yin 2009). A case study strength also lies in its ability to deal with a full variety of evidence including documents, interviews, and observations, which I have examined in this thesis. There are a number of opinions and approaches to case study as method and methodology. Thomas (2011), Stake (2005) and Yin (2012) provide rich descriptions of their methods, which have guided me in my research perspective when approaching this descriptive case study of SWIM.

CASE STUDY RESEARCH METHODOLOGY

Researcher Robert Yin (1984) defines the case study research methodology as an empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used. Yin also suggests that case study is an appropriate approach when the degree of focus is on contemporary as opposed to historical events (Yin 1989). As a research strategy, the case study is used in many situations to contribute to our knowledge of individual, group, organisational, social, political, and related phenomena (Yin 2012). The case study methodology is a good fit for the research issue stated as I, the researcher have appropriate knowledge of the issue and also the development of the SWIM program. When the researcher is present in the organisation, access to participants and contemporary documentation is more readily available, which assists in the data collection appropriate for case study methodology.

Critics of the case study method suggest that by studying a relatively small number of cases the results can offer no grounds for establishing reliability or generality of findings. There is also the suggestion that the action of studying the case may bias the findings. There are others who dismiss case study research as useful only as an exploratory tool (Soy 1997). There has however been an increase in the use of case studies as a research methodology as a result of the rapid changes in health and the perceived inability to address these using quantitative research methodologies (Kohn 1997). Case study methodology is frequently applied in program evaluation studies. Bachor (2000) believes that the re-emergence and acceptance of case studies as a relevant research method is its ability to capture an individual or group situation, within a specific time frame and as such is able to provide an identifiable situation to which the reader can relate. This can be seen as 'face-value credibility.' In describing the art of case study, Stake (1995) asserts the crux of case study is particularisation and not generalisation. The first emphasis is in understanding the case itself, what it is and what it does and implies that the case is different and unique to others.

Using multiple data sources as described in Table 4 this case study aims to address the following assumptions relating to the SWIM model

- SWIM fulfills the CoMCE requirements of the ANMC for midwifery registration.
- SWIM provides continuity of care for women at Hornsby Hospital.
- SWIM provides a sustainable CoMCE at Hornsby Hospital.
- All maternity unit stakeholders have an understanding of the SWIM program.

Table 4: Common sources of evidence in Case Study (Yin 2009)

Sources of Evidence suggested by Yin and planned to be used in this study		
	Yin's Suggestions	**Sources Used In This Study Of SWIM**
1	Documents	newspaper articles, emails, letters and reports
2	Archival records	2007-2011 women's' & students questionnaire results, proposal, the evaluation and conference proceedings
3	Interviews & focus groups	Interviews with midwives, educators & managers
4	Direct observation and participant observation	My role as a researcher, but also filling a real life role in the scene being studied
5	Physical artefacts	Student's CoMCE diary, banners, pictures and certificates

The intention of case study is about seeing something in its completeness and viewing it from many angles. Thomas describes the case study approach as 'good science' and emphasises that both a rich picture and an endeavour to gain analytical insights is also the crux of case study methodology (Thomas 2011). The definition used by Thomas is;

> *"Case studies are analyses of persons, events, decisions, periods, projects, policies, institutions or other systems which are studied holistically by one or more methods. The case that is the subject of the inquiry will be an instant of a class of phenomena that provides an analytical frame-an object-within which the study is conducted and which the case illuminates and explicates" (p. 23).*

Case studies have certain characteristics which are particularistic, descriptive and heuristic by nature. Particularistic means the case is focussed on a particular event or program such as SWIM in this case. Descriptive means the

'thick' description, a term from anthropology which means the complete, literal description of what is being investigated (Merriam 1998, p. 29). Heuristic means that the case study may illuminate the reader's understanding of the case, revealing previously unknown relationships of the variables. The characteristics of case study are illustrated in Table 5, further revealing the usefulness of case study research.

Table 5: Case study characteristics (After Merriam 1998)

Case Study Characteristics
Particularistic Nature
It can suggest to the reader what to or what not to do in a similar situation
It can examine a specific instance but illuminate a general problem
It may or may not be influenced by the researchers bias
Descriptive Nature
Illustrate the complexities of the situation- the fact that many factors contributed to it
Have the advantage of hindsight yet can be relevant to the present
Show the influence of personalities on the issue
Show the influence of the passage of time on the issue
Include vivid material-quotes, interviews, and newspaper articles.
Obtain information from a wide variety of sources
Present information in a variety of ways and from the viewpoint of different groups
Heuristic Nature
Explain the reasons for a problem, the background of the situation, what happened and why
Explain why the innovation worked or failed to work
Evaluate, summarise and conclude thus increasing its potential applicability

The intention of this descriptive case study is not generalisation, but particularisation. In studying this case the intention is not to learn about other cases, but this case alone, purely out of interest of itself, not for a secondary motive (Thomas 2011). Stake (2005) describes a case as being intrinsic if the researcher wants a better understanding of this particular case, and agrees

> *It is not undertaken primarily because the case represents other cases or because it illustrates a particular trait or problem, but because in all its particularity and ordinariness, the case itself is of interest (p. 445).*

I am describing this case alone. The temptation is to use it to generalise to other cases and the reader may be able to use the findings of this case study to assist them to develop a similar model, but must take into consideration that this case is bounded by its context.

Setting

The setting for this case study was Hornsby Ku-ring-gai Maternity unit which is situated in the upper north shore of Sydney Australia and is a metropolitan hospital with 1200 births each year. Women accessing this unit for their maternity care are considered to be low-moderate risk. Women developing complications of their pregnancy are referred to a tertiary level unit for care. There are 65 midwifery staff employed on a full time and part time or casual basis, as well as a midwifery educator and midwifery consultant. The unit has

Geographically the maternity unit is located all together on one floor of a general community hospital, with antenatal clinics, delivery suite and postnatal stay rooms all co-located and within very short walking distances from one another. Until 2011 Hornsby maternity unit had no consistent continuity of care models of maternity service provision. SWIM was created in 2007 and each year three Graduate Diploma of midwifery students were employed by the hospital to gain their relevant midwifery clinical education experience within this model. The first component of the case study research design was to identify and select research participants.

METHODS

Overview: Case studies typically rely on several sources of information to give a complete picture (Stake 2005; Yin 1994). As this is a qualitative descriptive case study several information sources were collected. As recommended relevant evidence related to the planning and implementation of the model included project documents, computerised data and a range of reports (Neale, Thapa & Boyce 2006). Data were also collected through interviews with key stakeholders of the program, including two Maternity Managers, two Facilitators who supervised the model and four Transitional Midwives who participated in the SWIM model for their midwifery education. Data collection was performed

with two key objectives for analysis in mind: triangulation of data from multiple sources and triangulation of perspectives from multiple participants. Figure 1 illustrates the complete dataset for this case study.

Figure 1: Participants in the case study and the data collection involved

Selection of research participants

In this case study I used purposive sampling as I was researching a specific population; the stakeholders associated with SWIM and only its members were included. Stakeholders included midwifery managers, midwifery student facilitators (midwifery consultant and educator), and transitional midwives (recently graduated student midwives who had experienced SWIM).

Two representatives from the organisation were midwifery managers who were invited to participate in a face to face semi structured interview. By conducting a semi-structured interview the researcher has the ability to word questions spontaneously in a conversational style. Patton (2002)) suggests that semi-structured interview technique allows the researcher to, 'explore, probe, and ask questions that will elucidate and illuminate that particular subject' Patton (2002, p. 343). Two further interviews were undertaken with the Clinical Midwifery Educator (CME) and the Clinical Midwifery Consultant (CMC), the senior midwives who supervised the SWIM program. In this interview these participants are called facilitators' so the comments cannot be attributed to an individual. These stakeholders are also called the facilitators' throughout this

document. An appropriate interviewer was sourced to conduct these interviews, as I am one of the senior midwives. The participants were given the option to be interviewed together or separately. The managers and the facilitators chose individual interviews.

Semi-structured interviews.

Semi-structured interviews are non-standardised and are frequently used in qualitative studies. The interviewer does not do the research to test a specific hypothesis (David & Sutton 1984). The researcher has a list of key themes, issues, and questions to be covered. In this type of interview the order of the questions can be changed depending on the direction of the interview. With qualitative research interviews the purpose is to try to understand something from the subjects' point of view and to uncover the meaning of their experiences (Kvale 1996). Interviews allow people to show to others a situation from their own perspective and in their own words. The transitional midwives were asked if they would like to participate in individual semi-structured interviews or a focus group; they chose a focus group.

Focus group

The use of focus group for the transitional midwives aimed to use group interaction as part of the method. Instead of asking each person to respond individually to a question, the midwives were encouraged to talk to one another and comment on each other's experiences and points of view. Kitzinger (1995) suggests that one main aim of focus groups is;

> *'Generally to facilitate the expression of ideas and experiences that might be left underdeveloped in an interview and to illuminate the research participant's perspectives through the debate within the group' (Kitzinger 1995, p. 299).*

Participation in a focus group was offered to the 2010 and 2011 cohort of midwives who were educated in the SWIM model. All participants were female. The maximum sample size was therefore predetermined. Literature on sample

size suggests that four to six can work well for focus groups. (Guest, Namey & Mitchell 2013; Kitzinger 1995).

To facilitate data collection it is recommended that participants are provided with a copy of the research instrument in this case the trigger questions prior to their scheduled interviews to familiarise them with the questions. This ensures that participants are not surprised or made uncomfortable by any of the questions, and enables them to consider the questions beforehand, thereby facilitating a more focussed response during the actual interview (Maimbo & Pervan 2003). The intention of using these research tactics was to contribute to higher quality data and help to manage possible time constraints by ensuring smoother interviews.

DATA COLLECTION: DOCUMENTATION AND INTERVIEWS

Documentation

In detail, the relevant documentation for this case study included the organisational evaluation of the model; the initial proposal to commence a student midwives clinic; a planning gant chart for implementation of the model and operational documentation regarding availability of a venue & equipment for the antenatal clinic, spacing of antenatal appointments and rostering of student midwives.

The Quality Improvement submission made to the organisation's Quality department outlining the needs, planning and implementation of the program was analysed and acknowledged as is the Nursing and Midwifery Office (NaMO) submission for a Models of Care Innovation scholarship in 2008. Presentations at workshops and conferences and data pertaining to the student midwives 'Follow through' experience log and evidence of continuity of care is included. A full description of the women and the student midwives' experience of their journey is presented from data collected in the Women's satisfaction survey 2007-2011 and Student midwife satisfaction survey 2007-2011.

Interviews: Midwives, Managers and Facilitators.

Transitional Midwives' focus group

Participation in this focus group was offered to the 2010 and 2011 cohort of midwives who received their clinical midwifery education in the SWIM model. One potential participant in the focus group was on leave and another working for a different Local Health District and was unable to attend on the day nominated by the other participants. The sample size for this focus group was appropriate as 4 out of 6 potential participants were available and those not available asked the other members to express their views as they felt they would be similar in content. With this number we were able to facilitate open discussion (Guest et al., 2006; Higgenbottom, 2005) and many of the comments mirrored those expressed in the student midwives evaluations. A letter of offer to the midwives to participate in the focus group was sent two weeks prior to the agreed focus group date. The date was chosen by the participants as a day when they were all available, which is a specific consideration in a profession where shift work is the norm. The midwives were offered three potential interviewers to facilitate the focus group; they chose the researcher who was also a facilitator on the model. The participants also supported the presence of the clinical support officer, as an independent observer taking notes and ensuring the audio equipment was used correctly. This independent observer also transcribed the audio records verbatim.

Considering reflexivity at this stage, I was aware that being connected to the SWIM program that my presence at the focus group may affect how the participants approach the trigger questions. The members had the opportunity to choose an alternate group facilitator, but they declined. During the focus group discussion, the midwives appeared oblivious to my presence and focused on the discussion with one another. The focus group participants were sent the trigger questions prior to the day of the focus group and these questions provided the structure of the interview**.**

The aim was to give the midwife participants an open opportunity to express their experience of midwifery education in the SWIM model. The focus group interviews were recorded on a digital voice recorder. Time allocated was 60 – 90 minutes and took 60 mins. The venue and time was chosen for convenience by the participants and was the education room in maternity. Open ended questions and prompts were developed as a result of incidental comments made by the participants to the researcher at the completion of their SWIM experience; results of the student midwife exit evaluation completed by the participants at the completion of their student midwifery experience and with guidance and consultation with my supervisors. The trigger questions used were:

- What was your understanding about the SWIM model when you first started your midwifery at Hornsby Hospital
- Tell me about your journey through the model and how it impacted on your student year.
- What did you enjoy most?
- Were there any challenges relating to this model?
- Were there any benefits or opportunities?
- How did you feel about your journey through the model at the completion of your training?
- Do you feel the model fulfilled your requirements for registration as a midwife?
- How do you believe learning through this model has/will impact on your practice?

Each set of trigger questions was specifically related to the stakeholder's relationship with the model.

Maternity Manager's interviews

The current Midwifery Unit Manager and the Assistant Director of Nursing and Midwifery who was the Divisional Manager of Women, Children's and Family Health at the implementation of SWIM were interviewed. Trigger questions had an emphasis on the organisational perspective:

- What is your understanding of the SWIM model?
- Tell me about your connection with the model and how it impacts on your role as manager?
- Were there any challenges you could anticipate setting up this model?
- Are there any benefits or opportunities?
- How do you believe that learning through this model will impact on a new midwife's practice?

In order for the participant to feel in control of the process, the interview took place at a venue chosen by each participant. The interviews took 40 minutes and the venue was their office. Lavender et al., (2004) recommend participant choice of time and place in order to least inconvenience them.

Facilitator's interviews

The CME and CMC facilitators were interviewed individually by a third person (since I am the CME). The trigger questions were similar to those of the other participants interviewed

- Tell me about your connection with the model and how it impacts on your role as educator/consultant?
- Tell me about your experience as educator facilitating the students' journey through the model.
- How do you manage the succession planning from one group of students to the next at the completion of each year?
- Do you feel the model fulfilled the CoMCE requirements for registration as a midwife
- Were there any challenges when you developed this model?
- Are there any benefits or opportunities?
- How do you believe that learning through this model will impact on a new midwife's practice?

These took place in the facilitators' offices at a time chosen by them and took 30 minutes. The choice of time and venue was important as the intention was to not inconvenience the participants.

DATA ANALYSIS

Qualitative data in this study took the form of interview transcripts collected from research participants who have participated in the experience of SWIM. Transcripts of the interviews and focus group were analysed manually using thematic analysis. Thematic analysis is an appropriate method to use for this qualitative descriptive study. Thematic analysis requires an effort on the part of the analyst to move away from merely listing topics participants brought up in interviews and toward describing the pattern of responses or themes raised (Sandelowski, 2007).

Thematic analysis is a method for identifying, analysing and reporting patterns or themes within data and is appropriate tool for case study analysis. It's a tool to organise and describe the data set in rich detail (Boyatzis 1994). Thematic analysis in its simplest form is a categorising strategy for qualitative data; it helps researchers move their analysis from a broad reading of the data towards discovering patterns and developing themes. Thematic analysis is a process that can be used with many kinds of qualitative data including that of the interviews, focus groups and documents associated with this case study.

Boyatzis (1994) describes thematic analysis as a process of "encoding qualitative information" (p. vii). The researcher develops "codes," words or phrases that serve as labels for sections of data. Depending on the methodology and research question, codes can come in many shapes and sizes. Referring to a set of codes, Boyatzis explains, "This may be a list of themes, a complex model with themes, indicators, and qualifications that are causally related; or something in between these two forms" (vii). Rubin & Rubin (1995, p. 226) claim that analysis is exciting because 'you discover themes and concepts embedded throughout your interviews'. Boyatzis (1998) demonstrated how one could take a variety of approaches to using thematic analysis and essentially get the same rigour. He argues that all approaches have something

to offer qualitative data analysis. The benefit of thematic analysis is it is flexible and what researchers do with the themes once they uncover them may differ based on the intentions of the research and the process of analysis. I have used thematic analysis as a way of getting close to the data in order to develop some deeper appreciation of the content of the case study described.

The process of familiarising myself with the data involved reading and rereading the transcribed audio files of the interviews and focus group. The interviews were transcribed by a clinical support officer with limited midwifery and medical knowledge. By reading and rereading this data, I was able to develop ideas which assisted me in selecting initial codes. These codes were developed in a systematic fashion to span the entire data set. Numerical data was used for the women's evaluations as this consisted of 130 sets of responses. This approach was also used for the student midwives' evaluation data which comprised of comments. The commonly occurring words and phrases used were collated and grouped and themes developed from these groupings.

The interview and focus group data also involved generating initial codes and then initial themes were developed. A thematic map was developed which grouped codes which connected to themes. The themes were then redefined and named. The aim of defining and exploring these themes is to enable the overall analysis to reveal the story behind the data.

My role as Case Study Researcher

As the researcher I was aware that there are six common case researcher roles they are teacher, advocate, evaluator, biographer, theorist and interpreter (Yin 1994) . Although there is the potential for these roles to overlap my initial role was that of teacher. My intention was to describe the SWIM program in a logical manner so that the reader could extrapolate some meaning from the development of this program, almost from a 'how to' perspective. I am also aware that by describing this program that different readers will focus on or interpret different things, depending on their world view or previous experiences. Therefore, some unanticipated learning for the reader may be a result of this case study. Although the researcher is close to the case,

evaluation was not the intention. Some of the documentation within the case study is evaluative; however the interview data was not constructed as evaluation, but as a reflection of each stakeholder's experience of the model, therefore outcomes data has not been used in this case study. In some ways the case can also be seen as biographical, if you view the SWIM program itself as a player in the script. The biography lies in the SWIM program's birth and journey to maturity and the challenges and opportunities met along the way. The case study researcher has a role as interpreter and this role is central to understanding the case.

Interpretation of data is a distinctive component of qualitative inquiry. Fred Erickson (1986) described the researcher's pursuit of the interpretation of data should be from the perspective of the people being studied and not the researcher's perspective. Erickson calls these interpretations, assertions and a form of generalisation. Stake (1995) acknowledges that the researcher/observer of a case may draw their own conclusions; however a mature researcher presents the case from a variety of perspectives therefore giving these assertions or interpretations more credence. Producing a good case study requires patience, reflection and a willingness to see the point of view and perceptions of all the people or actors in the case being studied. Acknowledging the multiple realities of the players in the case was important and this has been addressed in this case study. The perceptions of the women, students, managers and facilitators have been acknowledged in the evaluation and interview data. This is supported by the documentation review as by reviewing the documents associated with the program I have endeavoured to offer a greater understanding and perspective. It is important to ensure that my presence in the research is acknowledged as I too am an 'actor' and as such it not possible to remain 'outside' the case being studied. Reflexivity within this research has been a continuous process as I was aware that my presence, in whatever form, could have some kind of effect. Reflexive research takes account of this researcher involvement.

RIGOUR IN CASE STUDY RESEARCH

In order to establish credibility the researcher should explain in detail why the data was selected and how the researcher produces or decides on the findings. One of the greatest challenges with analysing case study evidence is the amount of data to be analysed. By developing a general data analysis strategy in the case study design, Yin (1994) suggests it should include what is to be analysed and why. In this way the researcher can ensure that the data collection strategies and the technique for analysis are appropriate. Strategies to ensure the rigour of this research involved establishing an audit trail in the form of a chain of evidence, using multiple data sources in the form of documents and interviews of the stakeholders; analysing the data using thematic analysis and rich description; addressing ethical, consent and reflexivity issues throughout the research. Addressing the concept of rigour is important to assess the strength of the research findings. Lincoln and Guba (1985) described a framework to determine the rigour of the research which is illustrated in Table 6.

Table 6: Approaches to rigor (After Lincoln and Guba 1985)

Approaches to Rigour	Strategies
Credibility	Triangulation. Peer and Supervisor support and debriefing Ethical approval of questions from 3 areas
Dependability	Reflexivity Audit trail
Confirmability	Reflexivity Audit trail
Transferability	Thick Description

This framework addresses the strategies of credibility, dependability, confirmability and transferability. Credibility is similar to validity and refers to the value and believability of the findings. The aim is to demonstrate credibility by determining if the research was conducted in a 'believable' manner (Leininger

1994; Lincoln & Guba 1985). Dependability is similar to the concept of reliability in quantitative research and refers to how stable the data are (Graneheim & Lundman 2004; Tobin & Begley 2004). Confirmability is closely linked to dependability and addresses the accuracy of the data (Tobin & Begley 2004). Transferability refers to whether or not particular findings can be transferred to another similar context or situation (Leininger 1994). Transferability can be problematic in case study research as the case is bounded and contextual, however by using rich description the reader may be able to adapt the findings of the case to their own context.

One approach to providing credibility in the research was to obtain multiple perspectives from the stakeholders of SWIM and analyse the documentation pertaining to the model in order to look at it from a variety of angles. This could be seen as an approach to triangulate the data.

Credibility

Credibility and Triangulation

Credibility can also be enhanced with triangulation which is the use of more than one data collection method in the one study with the aim to gain a greater understanding of the case or phenomenon (Burns & Grove 2005; Rees 2003). The purpose of triangulation is to confirm the data. Validity, in qualitative research, refers to whether the findings of a study are “true” in the sense that research findings accurately reflect the situation, and “certain” in the sense that research findings are supported by the evidence (Creswell & Miller 2000; Guion, Diehl & McDonald 2011) .Triangulation is a method used in case study research to establish validity and credibility. Patton (2002) reminds the researcher that the goal of triangulation is not necessarily to arrive at consistency across data sources and that inconsistencies should be anticipated. In a case study such as describing an educational and clinical model of care inconsistencies may be likely given the varied roles and perspectives of the stakeholders. In Patton’s view, these inconsistencies should not be seen as weakening the evidence but may be an opportunity to view the data from a fresh perspective. Silverman (2001) states that triangulation can enhance the

validity of a study. There are several approaches to triangulation and in this case “data triangulation” has been used.

Credibility and Supervisor Support

In order to ascertain credibility and reliability within case study research it is important to have more than one perspective of the data tools and analysis. With academic supervisory support, I was assisted to develop the trigger questions for the interview and focus group data and also assisted to develop the themes from the interview transcripts. This addressed the concern as to whether the interviews were reliably and validly constructed and were the contents of the interviews properly analysed. The research proposal including trigger questions were also assessed by three ethics committees and approved as described below.

Credibility and Ethical issues

All forms of research produce concerns about validity and reliability, seen as credibility and dependability in this case and a major concern is that the research is conducted in an ethical manner. It is essential when conducting research on human participants that the researcher gain informed consent.

> “Informed consent means the knowing consent of individuals to participate in an exercise of their choice, free from any element of fraud, deceit, duress or similar unfair inducement or manipulation.” Berg 1998

Ethical approval was obtained from the Human Research Ethic Committee at the University of Technology Sydney (HREC 2012000396); Northern Sydney Central Coast Area Health Service (1206-182M) and Site Specific Approval from Hornsby Hospital 1206-202M (Appendix 10). The participants were invited to take part in the research at a time and place of their convenience and they were informed that even after consenting that they could withdraw from the study at any time. An information sheet regarding this research was sent with a consent form to all participants. Within this information sheet I described the purpose of the research, that the data collection was in the form of a taped interview (using the principles pertaining to each) and that the results were de-

identified and confidential. As the participants were known to me, I allocated each a numeric code relating to the order in which they were interviewed. The interview data has been kept separate from the participants' names and locked in separate filing cabinets. Following data collation and analysis, this data and information will remain in a locked cabinet for seven years. It is worthy of consideration that all prospective students received a written introduction to the SWIM model prior to interview for the position of Graduate Diploma of Midwifery at our facility (Appendix 4) and all women are consented to SWIM using the UTS consent form and given written information about the model (Appendix 7 & 8). Both students and women participated in a satisfaction survey at the completion of their experience (Appendix 6). The midwives at the completion of their student midwifery year indicated that they would be happy to participate in further research and members of the organisation also suggested that an organisational perspective would be valuable.

All the interview participants were known to the researcher and although not in a position of power there was an ethical consideration that this may influence their responses. Therefore the participants were offered an alternate choice of interviewer and focus group facilitator. It was essential that I assured all the participants that the interview was confidential and that the aim was to explore their experience of SWIM. As a researcher I was acutely aware of my role in the research and developed strategies to ensure there was an open and transparent interview technique.

Dependability

Confirmability; Establishing an audit trail

This case study data was organised and categorised as it was collected. A locked filing cabinet was used within the maternity unit where the research took place. The key of the filing cabinet was kept locked separately in the clinical midwifery office. Within this filing cabinet the hard copies of all documents relating to SWIM were securely locked including, audio recorded interviews, interview transcripts, survey and evaluation data, analysis of data and conference proceedings. A case study database should be planned and

maintained throughout the research process. Yin (1994 pp. 96-98)) suggests four general categories for a case study database; case study field notes, case study documents, tabular materials such as surveys and quantitative data and narratives, notes taken by the researcher during data collection which integrate or interpret some of the data or evidence collected.

Confirmability: Reflexivity

Qualitative interviewing involves a continuous process of reflection on the research. Reflexivity is the process of examining both oneself as researcher, and the research relationship within that context (Malterud 2001) addresses the researchers' effect on the research and findings by stating;

> *A researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions" (pp. 483-4)*

As the researcher, self-searching involved examining my own conceptual framework, my assumptions and preconceptions, and how these affected my interpretation of the findings. I was one of the facilitators who developed the SWIM program and I have continued to facilitate this model. I was close to the research; the stakeholders knew me and my perceptions were also described in this case study. Reflecting on the research relationship involved examining my relationship to the stakeholders who I interviewed and acknowledging that the relationship dynamics may affect responses to questions. As a descriptive case study, which also acknowledged the stakeholders understanding and perspectives of SWIM, there was no expectation from the participants that they needed to evaluate the program. The approach of using case study as both method and methodology was a deliberate attempt to describe the case from a number of perspectives.

Transferability:

Rich, Thick Description

In case study research the case is bounded by context and may not be generalised to another context. However, when the researcher provides, rich, thick description of the case, the reader has the opportunity to determine if the research context being described could be applicable to their own context and that if the knowledge is transferable (Merriam 1998). Within this 'thick' description, the researcher should aim to describe the context, the research methods and examples of raw data, some in the form of quotations, so that readers can consider their interpretations and consider adaptations to their own context to enhance its transferability (Graneheim & Lundman 2004; Yin 1994). This aim of this case study of SWIM is to provide a rich description of the context at Hornsby Hospital. The development and implementation of the model will be richly described as will the perceptions of the stakeholders' associated with the model.

CHAPTER SUMMARY

Case study methodology has been used for this descriptive case study. I have an intrinsic interest in this case as I have had input in its development and facilitation and it is this case alone which is studied. A reflexive approach to research has led me to examine my connection with the research, any influence on the outcomes or preconceptions that I may have. The approach of using case study as both method and methodology was a deliberate attempt to describe the case from a number of perspectives and not just my own. As such my aim was to triangulate the data. Data triangulation involved collecting data from a variety of sources, in this case documentation attached to the model, archival records connected to the planning and implementation of the model and interview data to gain the perspectives of the stakeholders which in this case was the women, student midwives, managers, facilitators and transitional midwives. In keeping with case study methodology I have addressed the various roles of the case study researcher. In addition to the descriptive component a degree of interpretation or illumination of the assumptions relating

to the SWIM program will be addressed in the following chapters. This type of case study is used to describe an intervention or phenomenon and the real-life context in which it occurred (Yin 2009). Throughout this document there are figures and tables to assist the reader to understand the context and to provide a richer description of the SWIM model. This case study focuses on the holistic description of SWIM. The next chapter presents a detailed description of the documents associated with SWIM and their role in the implementation of the CoMCE for students and women.

CHAPTER FOUR: DOCUMENTS DESCRIBING THE DEVELOPMENT AND IMPLEMENTATION OF SWIM

INTRODUCTION

This chapter presents a detailed description of the development and implementation of SWIM through reviewing of a range of documents describing aspects of the process. One challenge of using descriptive data specifically with case study methodology is describing the data within a framework that is accessible to the reader. As this case study concerns a midwifery clinical education program, it is appropriate to describe the data using an adult learning framework. Therefore I have chosen Caffarella's (2001) Interactive model of program planning to provide a structured approach to the description.

There are three major factors that make the Interactive Model of Program Planning a viable resource they are;

> '*the practicality and usefulness as a technical description of the planning process; the emphasis on people being the heart of this process and the importance of context as a centering point for action.' (Caffarella 2002, p. 367)*

Describing the process, the people at the heart of the process, and the context, are also factors at the heart of case study methodology. While Caffarella intended the interactive model to be used as a checklist or guide for tasks and skills required in planning a model of education for adult learners, it will be used in this case study as a post event framework. The tool will aid reflection on the development of SWIM as revealed though its documentation and will provide a structure for detailing the story. The documents accessed for the detailed description of the development of SWIM are listed in Table 7 and the adaptation of Caffarella's model is presented in Figure 2.

Table 7: SWIM documentation used in this case study to describe the model

	Document or archival record title	Chapter	Appendix
1	Needs Analysis 2006 Maternity unit activity report Sept 3rd 2007 (Figure 4) Report of the Maternity Services Review (Nicholl & Adams 2005) Conference presentations (Gilroy 2012; Gilroy & Sim 2012; Sim & Gilroy 2008b)	4. 1	1
2a	Student midwives' clinic proposal 2006 (Sim & Gilroy 2006)	4. 2	
	Quality improvement proposal and summary 2007/8		2
2b	NAMO innovations presentation (Gilroy 2008)	4. 2	3
2c	Welcome to SWIM for student midwives	4. 2	4
3	Student clinical area roster and on call roster	4. 2	
4	Women's satisfaction surveys 2007-2011 – analysis	4. 3	5
4	Student midwives' evaluations 2007-2011 – analysis	4. 4	6
5	Welcome to SWIM letter	4. 2	7
	UTS Follow through brochure		8
6	Student midwives CoMCE portfolio	4. 2	
	SWIM women tracking sheet		9
7	SWIM Logo, newspaper clippings (Combe 2014)	4. 2	

The framework begins with *discerning the context and identifying the need* for the program and subsequently explores each of the framework elements in a clockwise fashion. The circular format of the framework implies that the framework elements are not actioned in a sequential manner but can occur simultaneously. However for ease of writing they will be described in a linear fashion.

> '*An interactive model recognises the non-sequential nature of the planning process discerns the importance of context and negotiation and attends to preplanning and last minute changes. There is an acceptance that program planning is a practical art, and that program planners are themselves learners.' (Cafarella 2001, p. 2)*

Cafarella (2001) implies that the interactive component of this model is dependent on the context and the players involved. She states that the model is

interactive and has no beginning and no end and that program planners can use any or all of the steps in any order and adapt them to their own context (p. 21). Program planners collaborate and share ideas and adapt to the needs of the learners and the organisation in which the program is implemented. The adaptation of Cafarellas' model depicted in Figure 2, acknowledges the organisational context of Hornsby Hospital and the stakeholders involved.

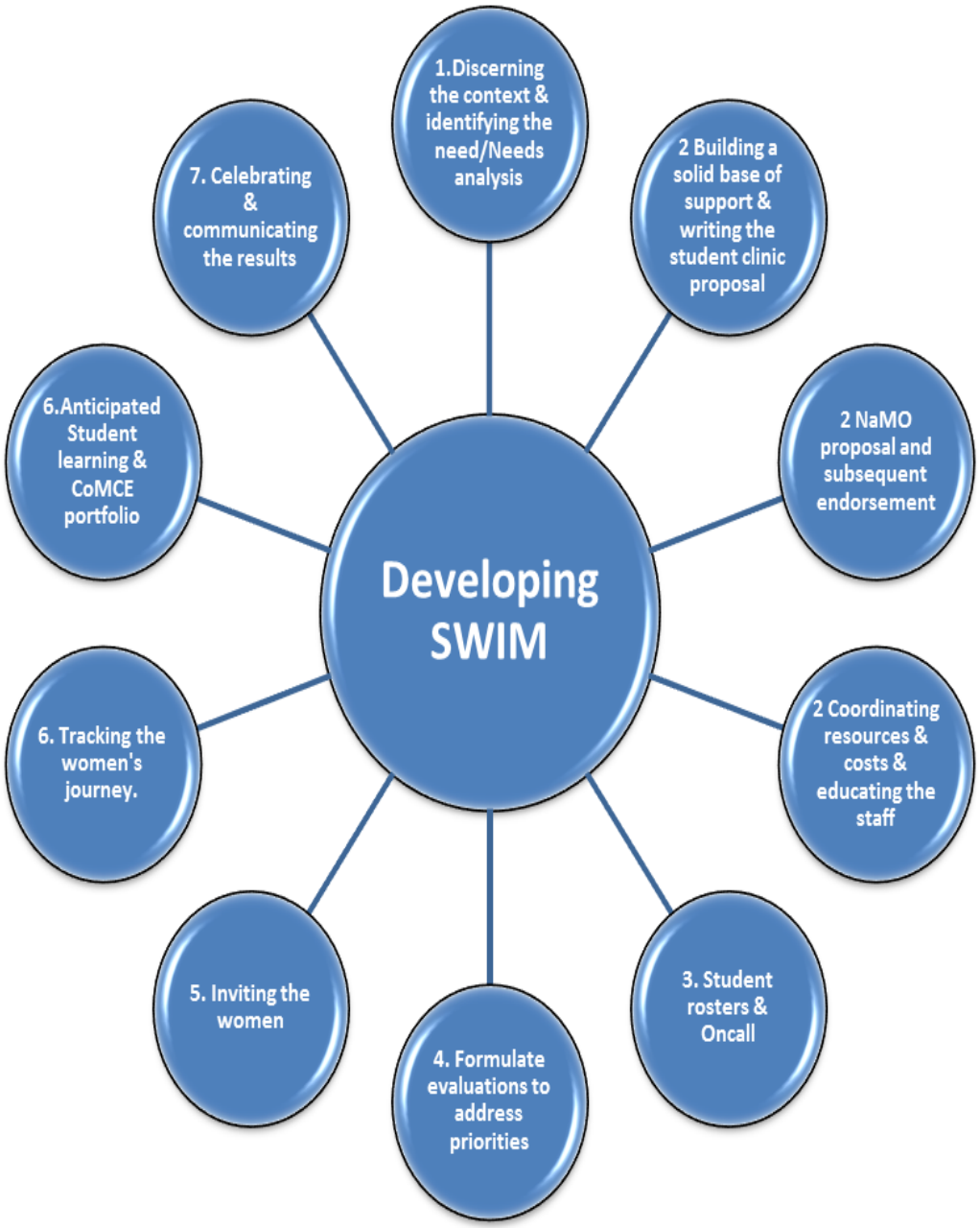


Figure 2: Developing SWIM. Adapted from Caffarella's Interactive Model of Program Planning (2002).

DEVELOPING SWIM

Discerning the context and identifying the need

As described by Yin, Stake and Caffarella, a sound awareness of the organisation and its context are important in both describing a case study and planning an educational program within that context (Caffarella 2002; Stake 2005; Yin 1989). The context described here is Hornsby Hospital maternity unit and addresses its organisational structure in 2006-2007. This time period directly correlates with the timing of the planning and implementation of SWIM.

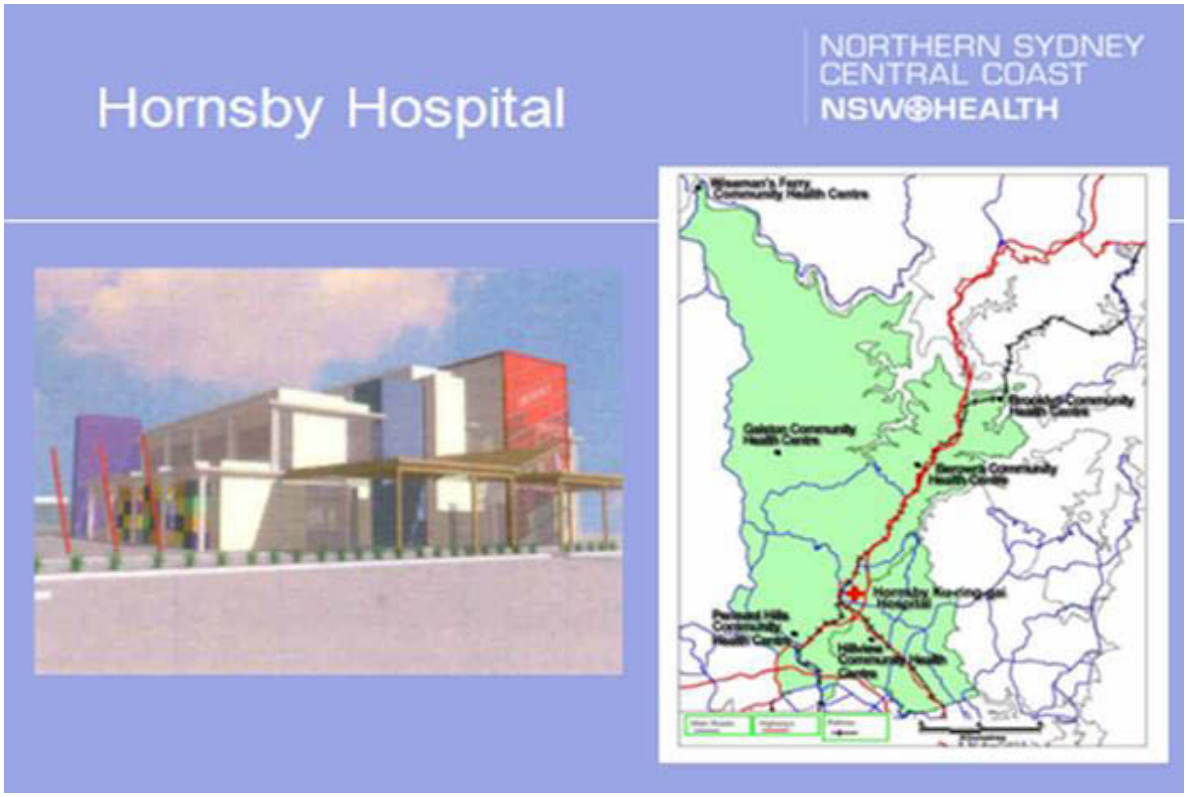


Figure 3: The HOPE building (Gilroy 2008)

Several major changes occurred within Hornsby Maternity services between 2006 and 2007, which may have contributed to the development of SWIM. These included:

Student midwives needs analysis 2006 (Appendix1)

Change in Midwifery education requirements regarding CoMCE (Faculty of Nursing Midwifery and Health 2006)

Decommissioning of a 50yr old maternity unit and opening a new site in November 2006 with decreased size of new maternity unit and anticipated increase in activity.

Births in the area projected to rise (Figure 4)

Maternity Services Review NSCCAHS increased motivation to consider different models of midwifery care. (Nicholl & Adams 2005)

NSW Health Strategic Directions (illustrated in Table 6).

Change in the HKH hospital management structure in 2007.

Each of these factors will be examined in order to develop an understanding of how they may have influenced the development of SWIM.

Student needs analysis

This section provides a description of the 'needs analysis' undertaken with four graduating student midwives from the 2006 cohort at Hornsby Hospital (Appendix 1). This needs analysis was a key step in the development of the model of SWIM. At the time the model was developed the hospital employed three Graduate Diploma of Midwifery students on a contract of thirty two hours per week for the duration of their twelve month clinical midwifery education.

In 2006 there was an increased requirement for the CoMCE for Graduate Diploma of Midwifery students (Faculty of Nursing Midwifery and Health 2006). The requirement was to care for 15 women per year (increased from 3-5 per year) in the continuum of pregnancy, birth and the postnatal period in a continuity of care model (Faculty of Nursing Midwifery and Health 2005). Primarily many maternity units do not provide effective continuity of care models and for those that do, employed student midwives did not have support in accessing them. One reason for limited access for Graduate Diploma of Midwifery students may be that being in an employed model of midwifery education; these students are considered an integral part of the rostered and rotating workforce. As employed workers allocated to either antenatal, postnatal, or birthing areas of the maternity unit, budget constraints can affect the ability of the midwifery unit manager (MUM) to roster students to attend their own group of women in the antenatal clinic. Without access to their "own specific" women, achieving the clinical requirements of the registration board

has been problematic for students. The introduction of the CoMCE previously known as the “Follow through Experience” encouraged this maternity unit to assess how this clinical educational requirement could be achieved within the service.

Within Hornsby Kuring-Gai Hospital Maternity Service there was awareness that there was no system in place to enable students to access the increased number of continuity of care women required by each student. A ‘needs analysis’ of previous student midwives’ was conducted with the aim of understanding the current student journey. The organisation’s intention was to develop a student midwifery led model of care to fulfil these requirements, provide satisfaction, model best practice for students and be a continuity of care model for women. A survey in the form of a Needs Analysis formed part of the background to the development of the SWIM model (Appendix 1). The midwives who had been students in the previous year were approached to give feedback on their antenatal clinical midwifery experience in the form of a needs analysis. These four new midwives responded to seven items/statements that were measured on a 5 point likert scale ranging from strongly agree to strongly disagree. The most striking results came back in relation to opportunities to provide continuity of care in the antenatal period and whether sufficient education was provided to learn, maintain and update skills, specifically in the antenatal period.

Table 8: Statements on the Needs Analysis

Needs Analysis for students prior to implementation of SWIM (see Appendix 1)
1. I felt I was regularly given opportunities to provide continuity of care to women in the antenatal period
2. I felt supported in the Antenatal Clinic by all staff.
3. Sufficient education was provided to learn, maintain and update my skills.
4. I feel confident when using the ACMI referral guidelines
5. I feel that the student midwife workload in the clinic was at an appropriate level.
6. I feel that the student midwife clinic would have been valuable to my acquisition of midwifery skills during my midwifery training
7. I feel that women would value the continuity of care provided by a student midwives clinic

In all cases the responses of the student midwives indicated that the antenatal educational experience within this maternity service did not fulfil their needs. One student revealed that the only continuity of care she was able to provide was to her four 'follow through' women and she attended these visits in her own time;

> *I was not given the opportunity [at work] to provide continuity of care to women except for my 4 follow through women required as per course, I attended all appointments in my own time.*

The students' role in antenatal clinic did not model midwifery practice as they reported only taking blood pressures for the doctors whilst working in the clinic;

> *Minimal exposure as student as not in midwives clinic and only taking BP for doctors.*

The lack of access to midwives' clinics impacted on the students' ability to learn as was noted in the answers to Question 3. All participants disagreed with the statement that sufficient education was provided to learn, maintain and update their skills in the antenatal clinic. It appears the participants saw their student role as assisting the organisation in the smooth running of the clinic and not in learning how to provide skilled midwifery care. As expressed by one participant;

> *A lot of time was spent in the Doctors Clinics taking blood pressures, stripping beds and calling patients – did not provide sufficient opportunity to learn/update skills.*

This was echoed by another who stated;

> *The workload was appropriate but most of my time was in the doctors' clinic which is not an ideal learning environment for learning to manage antenatal women.*

This participant felt supported by the midwifery staff but uncomfortable around the medical staff;

> *The staff [midwifery] was very supportive but I felt unable to learn when doctors were around as I felt like I was in their way.*

Although all participants agreed that they knew the National Midwifery Guidelines for Consultation and Referral (Australian College of Midwives 2004) none expressed confidence to discuss or refer to the medical team;

When questioned whether the participants believed a student clinic would have been valuable to their acquisition of skills and knowledge 100% strongly agreed. One participant felt that access to a student clinic would be beneficial as she needed more time to develop her skills;

> *[I] was not given much time in midwives clinic to develop- skills needed.*

Another expressed the importance of a student clinic to facilitate the opportunity for student midwives to manage the care of women independently yet under supervision;

> *Student midwives need a patient load of 2 – 3 women to manage independently with guidance.*

Whereas these participants expressed the need for an available, approachable, supportive facilitator to ask questions of and consult with;

> *There are always questions to be answered at every stage of training and [we are] often made to feel 'stupid' if there is no one approachable or responsible for students to ask questions of.*
>
> *[We] must always have someone to consult with if required.*

Occasionally the student midwives had the opportunity to access a midwife's clinic and as this participant noted, her best learning happened in this environment;

> *I feel that the student midwife clinic would be a very valuable asset as my best learning was in midwife's clinic with [Midwife].*

This student has expressed her disappointment that she did not have access to a student midwives clinic during her clinical midwifery experience and belief that it would have been a valuable learning environment.

The responses from these midwives indicated that they perceived their student antenatal clinic experience to be less than ideal. The response to this survey was then called the needs analysis for the implementation of SWIM. All the previous students felt that they were not regularly given opportunities to provide continuity of care to women in the antenatal period; that they did not receive sufficient education to learn, maintain and update their skills and they felt that a student midwife clinic would have been valuable to assist them to acquire their midwifery skills. It also indicated that their antenatal clinical placement involved limited exposure to a continuity midwifery model of care, limited educational supervision and lacked consistent professional modelling of expert midwifery practice (Appendix 1).The results of this needs analysis led to the proposal to have an antenatal clinic that was staffed by the three student midwives under the supervision of the Clinical Midwifery Consultant and the Clinical Midwifery educator. This model of care was initially named the Friday Midwives Clinic as that was the allocated day available, but within months of its inception it developed its own as identity SWIM with ME. Soon after the Needs Analysis obtained from the student midwives Hornsby Maternity unit moved to a new facility.

In November 2006, Hornsby Maternity unit was moved from a much-loved 50 year old maternity unit with 26 beds, to its newly commissioned but smaller facility, the Hope building, which is illustrated in Figure 3 (Gilroy 2008). The inpatient section of the new facility consisted of four birth rooms, 14 ante/post natal beds in the maternity ward and a six cot special care nursery. The outpatient section had six antenatal clinic rooms, a procedure room and day assessment unit. There was a stable, cohesive midwifery workforce, many of whom expressed anxiety about the move as many of the midwives had worked in the original maternity unit for more than 20 years

There were 60 midwives employed in the organisation on a rotational roster basis with the ability to work in all areas of the maternity service. The unit had a lactation service and a midwifery support service which provided home visits. There was one divisional manager, two midwifery unit managers, a CMC and a CME. The unit provided clinical midwifery education to three post graduate midwifery students. At the time of data collection for this case study, Hornsby

Hospital did not provide clinical education to undergraduate Bachelor of Midwifery students.

As revealed in Figure 4, the maternity unit had an annual birth rate of 1000 in 2006 with an anticipated increase to 1200 by the end of 2007. When the anticipated increase in bookings was realised, there was an impact on all aspects of the maternity services that became a driver for changes to be made.

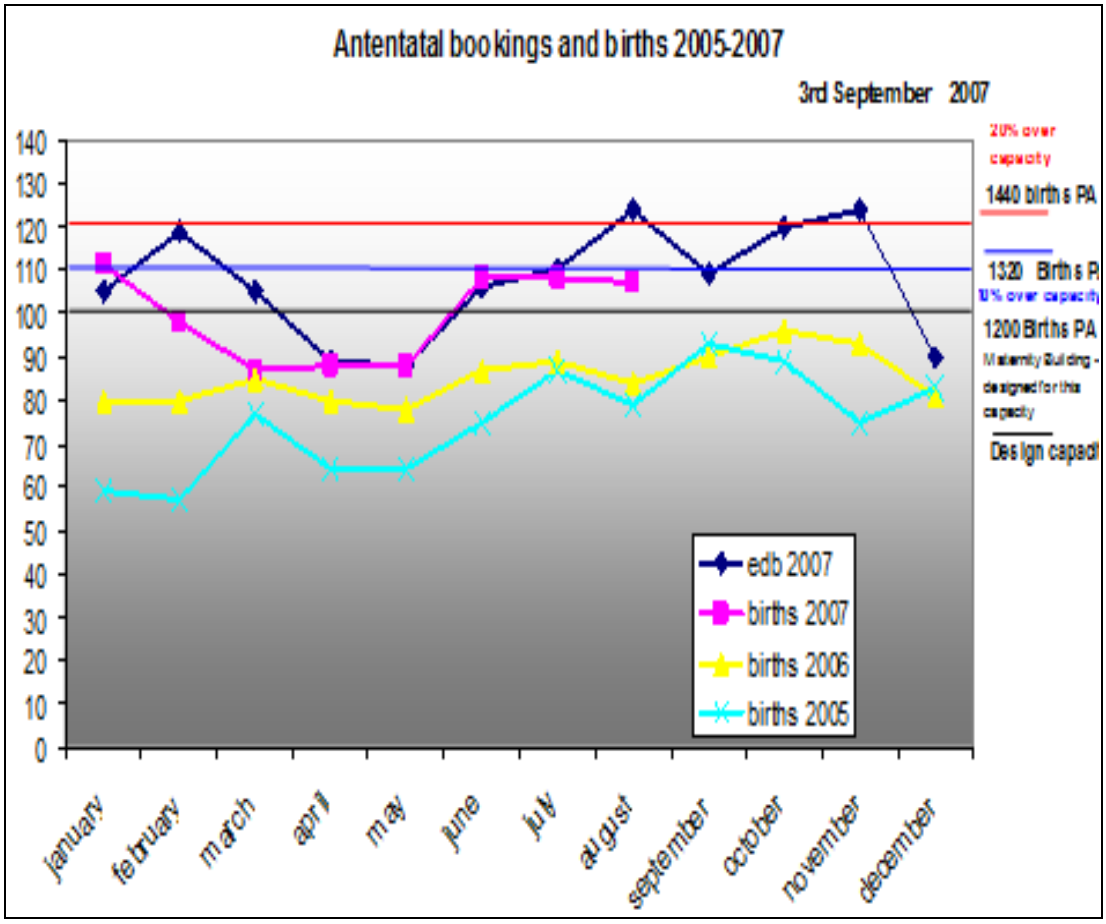


Figure 4: Maternity Unit Activity 2005-2007 (Sim 2006).

Several divisional meetings were held with a focus on assessing the business of the maternity service as a whole. By September 2006 other hospitals in the Maternity Services Network to which HKH belonged, began setting up and recruiting Midwifery Group Practice (MGP) midwives to provide one to one continuity of care for women. At that time Hornsby had a Team Midwifery approach with a shared philosophy of care but with 8 midwives in the team it became apparent that continuity of care was not consistently provided to

women (Sim 2007). The Maternity Services Network developed an operational plan for the local health services in order to address some of the recommendations of the Maternity Services Review (Nicholl & Adams 2005). Northern Sydney Central Coast Area Health Service was engaged with NSW Health Seven Strategic Directions (Table 9) which was to form the basis for development of all strategic planning and processes in the Area.

Table 9: NSW Health Strategic Directions (NSW Department of Health 2007)

	Strategic Directions
1	Make prevention everyone's business
2	Create better experiences for women and their families using maternity services
3	Strengthen primary health and continuing care in the community
4	Build regional partnerships for health
5	Make smart choices about costs and benefits of health and health support needs
6	Redesign and reinvigorate the health workforce
7	Be ready for new risks and opportunities

All of the strategic directions were a focus for this maternity unit. With each strategic direction there was a documented objective, measure and strategic initiative to achieve by 2010. Strategic Direction 2 was to 'Create better experiences for women and their families using maternity services' with the first objective to effectively integrate woman centred care. The strategic initiative to 2010 was to redesign care processes from the woman's perspective to create a better health experience. Strategic direction 6 was to 'Redesign and reinvigorate the health workforce' and the objective was to provide high quality undergraduate and postgraduate training. This was to be measured by surveying student's experiences using a similar approach to the evaluation of the women's experiences. The strategic initiative to 2010 was to establish a coordinated approach to midwifery education across the network. This strategic direction promoted the need for midwifery led models of care in this facility and the adoption of a student educational clinic had the potential to address this requirement.

The changing educational requirements and needs of the student midwives were acknowledged by the CME and CMC. In 2006 just prior to the

implementation of SWIM the student midwives did not have access to a midwifery continuity of care model to assist them become competent midwives or assist them to fulfil the (Faculty of Nursing Midwifery and Health 2006) requirements of the then 'follow though' experience for midwifery registration. At that time there was no MGP and student midwives were seen as part of the workforce, particularly in the clinic (Appendix 1). The results of the needs analysis described in this chapter, underlined the need for a continuity of care model for student midwives, not only to assist them to become competent midwives, but also to fulfil the CoMCE component for midwifery registration.

This section has addressed and acknowledged that within the context of the organisation at that time there were many changes. A new maternity unit was being completed and there were plans to move to the new facility in November 2006; there was anticipated increase in activity with no robust continuity of care models available to the women; the Maternity services review (Nicholl & Adams 2005) outlined priorities of care which were embraced by linking the operational plan to the NSW Health Strategic directions. Maybe the organisation was ripe for change. An identified need for a renewed approach to streamlining maternity care was a major focus. Acknowledging the need to address the student educational needs was important. The program planners of the SWIM model of care were aware that negotiating the power issues within management and the multidisciplinary team was crucial to the success of its implementation. Gaining stakeholder support was an important step in building a strong base of support for planning and implementing this educational model of care called SWIM.

Building a solid base of support and writing the student midwife clinic proposal

Gaining access to written documents and interactions with individuals in the organisation can assist in understanding the power dynamics in planning a learning program (Caffarella 2002). The key stakeholders in this organisation were the Midwifery Unit Managers (MUM), Divisional Manager, Clinical Midwifery Consultant (CMC) Clinical Midwifery Educator (CME), medical team, midwives, consumers (women), the student midwives and multidisciplinary team. The support of stakeholders was crucial to the model's implementation.

Initially there had been some resistance in Hornsby maternity unit towards developing a student midwife clinic. As evidenced by the email conversations below, adequate supervision of students was a concern expressed by both the maternity service manager and medical team;

Email from manager dated 10th July 2006;

> *I am not in favour of this. [CME] is a mother with children and may take leave; [CMC] is busy in her role…how can we be sure the students are supervised and they are committed to this [commencement of the student clinic]?*

Email from Staff specialist;

> *Will these students be supervised? I believe supervision is crucial.*

Risk assessment and student supervision had been addressed in the proposal (Sim & Gilroy 2006). The proposal stated that; "*Student midwives will be supervised by named facilitators"*. The negativity towards the proposal may have been the perception of risk.

Early in 2007 there was a change in Divisional Manager and later both midwifery unit managers. The new Divisional Manager was interested in innovation and was supportive of the proposal for the student midwives' clinic (Peregrina 2007). A comprehensive in-service education program was offered to all staff informing them of the proposed initiative. Medical & multidisciplinary staff were invited and attended. There is no evidence in the documents that consumer input was obtained. There was a positive response to the proposal in 2007, assisted by support from the Divisional Manager, a comprehensive roll-out of education regarding the program and motivated facilitators/educators promoting the program.

Obtaining NAMO endorsement

Following the acceptance of the proposal for this student clinic, the Divisional Manager encouraged the CMC and CME to apply for a scholarship. This was also an impetus to name the model and create a logo, which was a joint

collaboration between the facilitators and the 2007 students. The SWIM model applied for and obtained a Models of Care Innovation scholarship from the Nursing and Midwifery Office (NaMO) in 2007 which assisted in strengthening the program's support. The funding from this scholarship was $10,000 which was used to support the clinical education hours associated with the model. There was a requirement from NaMO that a report and presentation was made to the Models of Care conference within 12 months (Appendix 3). A Quality Improvement project was also submitted to the clinical governance department in Hornsby Hospital, which also required reporting on specified outcome measures and this in turn reinforced the need for a robust program which would fulfil the needs of women, students and the maternity unit (Appendix 2). The next step was to prepare the organisation for the changes and coordinate education and resources in the facility.

Coordinating costs and resources and educating the staff

Once there was support from the key stakeholders, planning and implementing the model was the next step. Identifying potential costs, accessing suitable resources and educating all staff were central to successful implementation. An anticipated timeline for planning and implementation of SWIM was developed and was attached to the proposal of the model (Table 10). Following the needs analysis from previous students, the proposal was presented and accepted. In-service education was provided to all staff over the following months to ensure all stakeholders had an understanding an input into the model. The new Graduate Diploma of Midwifery students commenced in March 2007 and they were educated about the new student midwifery clinic. Women were being invited to join the model and the clinic commenced in April of that year. Women were also invited to evaluate their journey through SWIM and these evaluations commenced in June 2007. This timeline incorporated the years 2007-2008. The process is illustrated in the Gantt chart Table 10 below.

Table 10: Timeline for the Planning and Implementation of SWIM developed by Sim and Gilroy (2006).

2007	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Proposal												
Student Education												
In-service education												
Recruitment of women												
Commence Clinic												
Needs Analysis	Previous students											
Women's postnatal Evaluation												
2008 onwards	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Student Education												
In-service education												
Recruitment of women												
Continue Clinic												
Women's postnatal Evaluation												
Student Midwife Exit Formal evaluation												

Once the program was established recruitment of women was an ongoing process. Women continued to evaluate their experience and the exiting students were given the opportunity to evaluate at the end of their clinical midwifery experience. New student were introduced to the model at the commencement of their clinical placement in 2008 and the staff were re-educated regarding the model and thanked for their support of the students.

The resources

The SWIM clinic was based within the antenatal clinic, which had the additional benefit of access to medical staff which enabled the student to consult and refer if required. All resources and equipment used already existed within the facility. This included, pinnard, doppler, sphygmomanometer, examination bed, antenatal notes and access to a computer for data entry and laboratory results. Clinic room 1 in the antenatal clinic was made available exclusively for the

SWIM clinic every Friday between 7am -4.30pm. There were 6 antenatal appointment visits each lasting 40 minutes and 2 antenatal Booking appointments each lasting 90 minutes. The structure of appointment times in the SWIM clinic is seen in Table 11.

Table 11: Structure of appointment times in the SWIM clinic (Pseudonyms used).

Time	Name & Mrn	Gestation
08.30	Mary Jones	39/40
09.10	Patricia Raven	28/40
09.50	Yin (Mary) Lee	22/40
Morning tea		
10.50	Priya Rampersad	41/40
11.30	Colleen Duffy	36/40
12.10	Miyu Smythe	22/40
Lunch		
13.30	Lee Alexander	Booking appointment 14/40
15.00	Niloofa Amina	Booking appointment 18/40

This room was personalised by the student midwives in each year group at their own cost. This included inspirational statements, banners with the SWIM logo and photographs of the women, babies and students. This provided a positive environment for both families and students.

Costs and Budget considerations

The SWIM clinic was considered to be cost neutral in this organisation and there was no additional budget for this model. Neither the CME nor CMC were paid from the cost centres of the maternity unit, but from the Division of Women's and Children's Health. These facilitators had a clinical component to their role therefore it sat well within their position description to supervise the SWIM clinic. However, the limited availability of the educator to the rest of the maternity unit on SWIM clinic days could be considered a cost. The equipment was cost neutral as it already existed in the organisation. An innovations scholarship of $10,000 had been obtained from NaMO which was used to support the clinical education hours of the CME on SWIM clinic days and also

gave it a focus to succeed. The cost that was not measured was that of the student midwives' time. The student attended the SWIM clinic in a paid capacity and if women presented in labour during working hours a SWIM student midwife was always rostered to the Birthing Unit. If a woman was admitted in any capacity, be it antenatal or postnatal, there was a student midwife in the SWIM team rostered to that area. When women were admitted in labour outside of rostered hours, the student midwife attended in her own time. There was an understanding that this was a requirement of their clinical experience, however it was a cost and challenge to the student midwife. There was no financial cost or inconvenience for parking at Hornsby Hospital.

Educating the staff

The facilitators provided a comprehensive in-service education program to inform all staff about the model to be implemented (Sim & Gilroy 2008b). This education included the midwifery, medical, administration and allied health members of the maternity service. At the commencement of their employment as a graduate diploma in midwifery student in this facility, the new student midwives' were introduced to their model (Appendix 4). Initial recruitment of women for the first roll-out of SWIM, was from the antenatal Booking Clinic, with the women first accessing the SWIM clinic in April (Table 3). Once the clinic was established, the students themselves had the ability and confidence to recruit women into the model. Each woman was offered an opportunity to evaluate SWIM at the completion of their care (Appendix 5). The student midwives also completed an evaluation at the completion of their clinical midwifery education (Appendix 6).

It was imperative to the success of the model that everyone in the organisation had an understanding of the role of the SWIM midwife. The student midwives could only come in, if they knew that the women had been admitted to the maternity unit. That could only be achieved if the core midwives called them. It was important that the core midwives were educated, involved and it did not add to their workload. In-service education was given to all midwifery staff regarding the CoMCE and the SWIM model, a SWIM sticker was placed on the women's notes and antenatal card and a laminated instruction was placed in

the women's notes. In the Birthing Unit and ward a notice similar to figure 5 was placed prominently with the name and number of the student on call. Both the student midwives and the core midwives were informed that the core staff were required to place one call to the student midwife and then the students took the responsibility for attendance.

Figure 5: Information poster in maternity to remind core midwives to call the SWIM students.

The student midwives were permitted to provide intrapartum care for the woman for 12 hours (Sim & Gilroy 2006). This was potentially limiting as the student had to consider both her/his employed role i.e. when the next employed shift would commence and the commitment to care for the SWIM woman during labour and birth; if the student was called to care for the woman out of rostered hours. The data indicates that although this was perceived as a potential risk, practically it was not experienced as a challenge. This may be due to the rostering of a SWIM student permanently in the Birthing Unit and also the students communicated and worked as a team to ensure continuity of care for the women. The benefit of working in a small student midwifery group practice

was the ability to know one another's shift patterns and responsibilities and in many cases share the care of each woman.

Student rosters and on call

The educator prepared a roster for the student midwives 12 months clinical education (example Table 4). This roster provided equal access to the SWIM clinic to each student midwife. Student midwives not rostered to the clinic on a particular day were welcome to attend the clinic if their rostered clinical area was quiet or they were not rostered to work that day. At all times, one student midwife was rostered to Birthing Unit, one to the Friday SWIM clinic and one to the ward which provided care for both post and antenatal women. The intention was that if a SWIM woman was admitted to the hospital during their rostered hours, a SWIM student would be available in that area to provide continuity of care. Out of rostered hours, the SWIM students organised their own on call system, which they adapted to their needs.

The CME and CMC were available and supervised all clinics, but were not on call for births, however were always available for assistance and advice if requested. As this model cared for 32 -40 women through the continuum, commitment to this clinic was a major priority for the CME and CMC. Each antenatal appointment was 40 mins which fostered an unhurried supportive learning environment for the students and relaxed supportive care environment for the women.

The roster in Table 12 is an example of how students organised their on call with assistance from the educator. The student rostered that week in the Birthing Unit would generally be first on call, with the second on call working in postnatal ward with the third student on call that weekend. This system enabled the student midwives to have periods when they were not on-call. The students were given the responsibility to change the on call as required to their needs, but the rostering to clinical areas remained the responsibility of the educator. The students would also provide some postnatal care in the maternity unit and often chose to do so on a day off. Home visiting was rare due to the students employed status which limited flexibility; however follow up phone calls in the

postnatal period was the norm. The intention of rostering in this manner was that if a woman should require care in any area in maternity service, one of her students would be rostered in that area to care for her. This would minimise her number of care givers and ideally provide continuity of care to the woman.

Table 12: Student Midwives sample roster indicating equity of clinical placements and on call with legend.

Sample Roster Student Midwives		March		April		May		June		July	
	Student	Fortnight 1	Fortnight 2	Fortnight 1	Fortnight 2	Fortnight 1	Fortnight 2	Fortnight 1	Fortnight 2	Fortnight 1	Fortnight 2
1	Student 1	1	1	we	we	2	2	1	1	we	we
2	Student 2	2	2	1	1	we	we	2	2	1	1
3	Student 3	we	we	2	2	1	1	we	we	2	2

Birthing Unit	Ward	SWIM
First on call	1	
Second on call	2	
Weekend on call	we	

In the early stages of program development the on call system was structured by the educator. As the group gained cohesion and awareness of one another's needs, the on-call was managed and arranged by the students themselves. The student midwives took into account the family and social needs of the group and also the balance of how often individual members came into care for women out of rostered hours. One priority was to roster the student midwives in a manner, that there was no adverse impact to the organisation as these were employed students and as such were part of the general workforce with rostered shifts to complete. The major priority was to provide the students with a relevant, supportive and innovative CoMCE which would be achievable as the foundation of their midwifery education.

Formulating evaluations to address priorities

The Needs Analysis (Appendix 1) highlighted the fact that previous students had a negative experience in the antenatal clinic; therefore the focus was to provide a positive learning environment in a student clinic to enable the students to meet their needs and become confident and competent midwives. A major priority was to create a robust model which was clear in its intentions and simple to administer.

- *Three student midwives will care for four women birthing per month in a Continuity of care model*
- *Student midwives will be supervised by named facilitators.*
- *There will be equity in access to the clinic for student midwives*
- *There will be a robust and equitable on call system*
- *There will be a student midwife rostered in antenatal, clinic and postnatal, to increase the opportunity of continuity of care for women in all areas.*
- *Student midwives will be called by core midwives when the woman presents in the antenatal period or in labour.(Sim & Gilroy 2008a)*

The sample roster Table 12 illustrates how the student midwives were given equitable access to the birthing unit, SWIM clinic and the postnatal/antenatal ward. The special care nursery was adjacent to the ward and if a SWIM baby needed to be admitted there, the manager supported the students' ability to provide this care. Continuity of care was the focus and how this was achieved would be evaluated.

Evaluation of this model was approached from several perspectives. This model was submitted as a Quality Improvement project and an evaluation was submitted at the completion of one year (Appendix 2). The program developers created an evaluation form for both women and students during program planning (Appendix 5 & 6). Women were debriefed by the student midwives following the birth of their babies, given an evaluation form at the completion of their journey with SWIM which they could return anonymously. The evaluations were satisfaction surveys evaluating the experience of both groups of

stakeholders in the SWIM program. These evaluations were also linked to the objectives of the program. The results of these evaluations are provided in Chapter 5.

Further evaluation of the program objectives involved review of the student midwives Follow Through experience portfolios (Appendix 9). These portfolios contained the number of women for whom they provided continuity of care, the number of hours spent per women and a reflection on all aspects of her care. In all cases the student midwives provided continuity of care for between 32 – 40 women per year in the shared SWIM program.

All antenatal visits were entered into the Obstetrix data base including the names of the students and facilitators providing each occasion of care. This was an instrument to provide evidence of student supervision in the clinic and an additional resource to track the student providing care and attending women during intrapartum and postpartum events. The Obstetrix data is not part of this case study. The educators also developed a spread sheet to track the antenatal visits, labour, birth and postnatal care provided to the SWIM women by the student midwives (Appendix 9).

Evaluation was an essential component of this model. A measure of satisfaction was obtained for the women's and students evaluations; continuity was tracked by the Obstetrix data base, the students portfolio and the facilitators spread sheet and student supervision was tracked by auditing the women's medical records and Obstetrix database. There is evidence that informal evaluation of SWIM was a continuous aspect of the program and that the program was adapted to needs of the members as required.

Inviting the Women to join SWIM

Recruitment of the women correlated with the commencement of the new student midwives in March. At the initial booking appointment the women were offered team midwives clinic, midwives clinic and what was then called the Friday student midwives clinic (later named SWIM). Women who expressed an interest in the student midwives clinic, were provided with the university information pamphlet on what was then called the 'follow through' experience,

signed a consent form and were informed that they could withdraw at any time (Appendix 8a & 8b). A 'Welcome to SWIM' information leaflet was provided to each woman (Appendix 7). Once the student midwives were confident they started to invite their own women into the program. Four women were booked to birth per month and the student midwives were allocated equitably to the clinic. This constituted six antenatal visits and two booking in visits per clinic (Table 4). Many previous SWIM women returned for subsequent babies and several had three babies through the model (Gilroy et al. 2012). There were a number of months when there were more women requesting to join SWIM than there was capacity in the model. In the period of time 2007-2011 which is the focus of this case study, no women withdrew from SWIM.

Tracking the woman's journey and data collection

A recommendation from the Maternity Services Review clinical redesign (Nicholl & Adams 2005) was to increase continuity of care for low risk women in HKH. There had been an increase in the number of women presenting to the service at HKH and as such there was a number of low risk women being seen by numerous caregivers depending on the availability of the practitioner (Appendix 2). One program objective was that a group of women would receive continuity of care and that these women would have known caregivers during the pregnancy. To achieve this objective a map of the women's journey through pregnancy was developed, with the intention of streamlining the care given. As mentioned previously, there was in place a team midwives program, but no MGP when SWIM was implemented, therefore Figure 6, illustrates the journey following booking and notes review, for women accessing care through the SWIM program, Team Midwives, Midwives Clinics and Doctors Clinics. The intention was that women would be offered all options at their booking appointment and following notes review that women (if 'normal risk') would access the care of her choosing.

By mapping the plan of a woman's journey it was possible to visualise each step of her journey and how it related to the organisation as a whole. It also assisted the organisation to re-evaluate the service and how it provided care to all women.

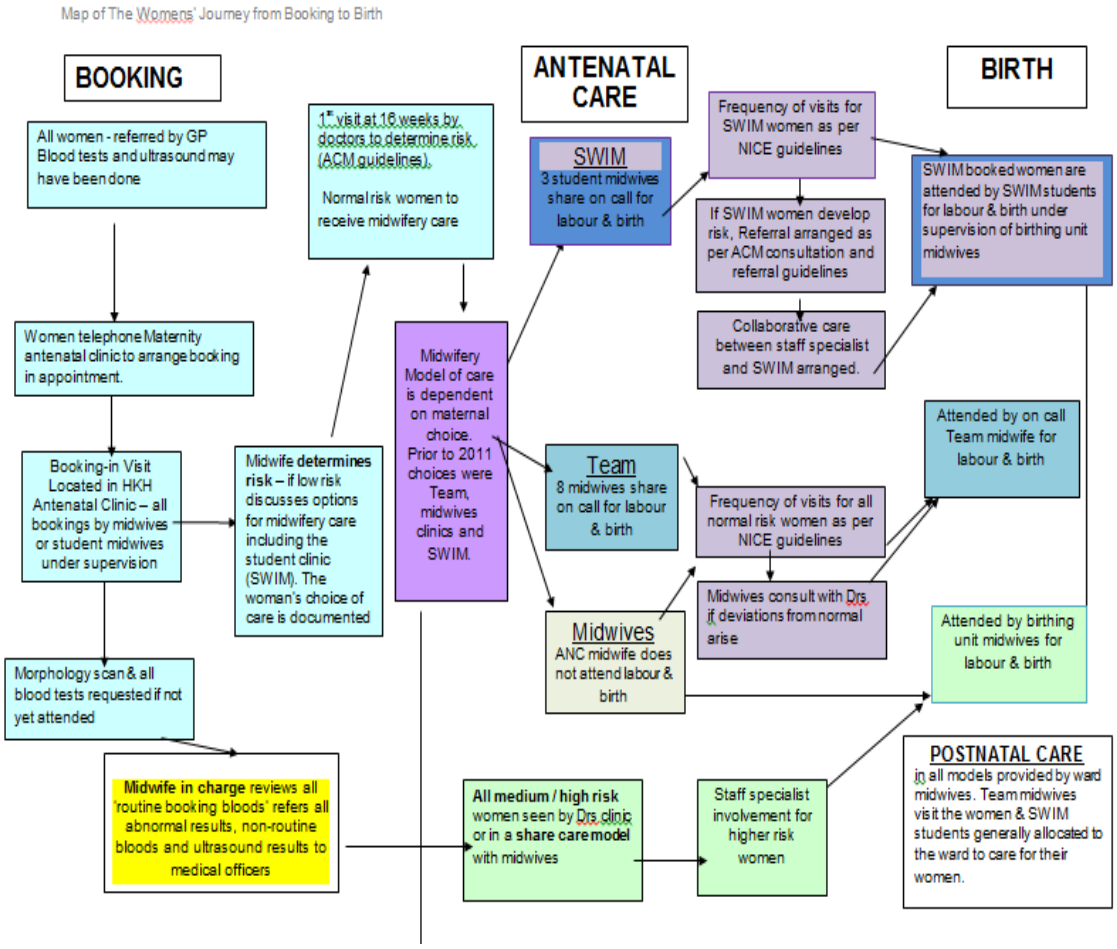


Figure 6: Map of the Woman's journey at Hornsby Maternity in 2007

Once the model was established and SWIM women were only accessing care with a SWIM student and educator, tracking her journey was easier to achieve. All antenatal appointments for the entire pregnancy were made at booking which enabled women to plan their lives in relation to their care. The student midwives met weekly and discussed each woman's care so there was consistency in advice and approach. All documentation was entered into the antenatal records and the obstetrix data base. If a woman needed to access additional care e.g. CTG, the student would follow the woman and attend with her. Most consultations with the medical team took place in the SWIM clinic, therefore the women stayed in their familiar environment. The students learned to refer and consult in a supportive environment. Appendix 9 illustrates how labour and birth attendance, support and outcome were tracked on a

spreadsheet by the educator and could also be accessed in Obstetrix. Postnatal care was tracked by postnatal care plans and Continuity of care portfolios.

Anticipated Student learning and the Continuity of care portfolio

This CoMCE model was not only a vehicle to fulfil the continuity of care needs for midwifery registration but was intended to be the foundation of clinical midwifery education. The 'Follow through' or CoMCE portfolio was used as reflective journey. It also tracked the number of women the student 'followed through' and the number of hours of care through the continuum provided by the student midwife. These portfolios were reviewed regularly by the educator and a summary compiled at the end of each clinical year. In all cases from 2007-2011 each student provided care through the continuum to an average of 32 women (Appendix 9). Swim was an effective framework for student midwives to gain the CoMCE for midwifery registration. Although this was a crucial element of this model, the intention was this would scaffold the learning process for students to assist their midwifery journey.

The initial anticipated learning was based primarily on antenatal care using the ACM consultation and referral guidelines and NICE guidelines (ACM 2008; National Institute for Clinical Excellence 2003). An anticipated learning cycle was developed by the CME in order to provide an educational framework. The facilitators approach was to model 'best practice'. The teaching, modelling and learning process was incremental, dependent on student needs and abilities. The theory was to scaffold the learning process to assist the student midwives to move comfortably from novice to expert. The CME or CMC would demonstrate care and then the student would perform the same. As the student midwife became more confident, the facilitator would sit quietly in the room, the student would conduct all care and answer all questions only to be guided by the facilitator if information given was incorrect or input was requested. All abdominal palpations would be confirmed by the facilitator, the relationship encouraged was that between the student midwives and the women. The facilitator directed the student midwife when the woman's condition deviated from the norm; or consultation or referral was required otherwise the student

with guidance provided all care. The figure below demonstrates the cycle of learning which was planned for the commencement of this model and indicates the anticipated student midwife learning, not purely clinical, but in all areas of midwifery practice.

Figure 7: Anticipated learning cycle for the SWIM student midwives (Gilroy 2008).

The SWIM clinic was the initi al learning environment. Within this environment the facilitators taught and modelled continuity of midwifery care. The student midwives learned to communicate professionally with the women, the facilitators, the multidisciplinary team and each other. Clinical skills were demonstrated by the facilitators and taught in a positive non-confrontational environment. The NICE guidelines for antenatal care were the students guide and a SWIM information folder was developed with step by step guides to practice (National Institute for Clinical Excellence 2003). The students collected and prepared the notes for each clinic and learned to document in the clinical notes and electronically and the facilitator countersigned each occasion of care. The ACM guidelines for consultation and referral (ACM 2008) were a valuable resource to assist student to know when it was appropriate to consult or refer to

their medical colleagues. The students learned about complexity from the women, the facilitators and the medical team. Learning to collaborate was a key component in the instruction of students and learning to trust and work with the multidisciplinary team in order to provide safe continuity of care for the women. The students were learning about evidence based practice at university and were provided with a supportive environment to discuss and demonstrate it in this educational model. The students were encouraged to reflect on their practice and develop a professional identity and sense of responsibility for the women in their care. Practicing ethically involved a higher level of thinking and was discussed within the clinic and in the student group. Ultimately the students were learning to care for women through their journey from pregnancy to the postpartum period within a student midwifery group practice where sharing and communication was essential.

The students assisted in creating a SWIM identity (Figure 8). The logo and name were created at the end of 2007. The name evokes the student midwives and women on a journey together. The waves depict the colours of blue (boy), pink (girl), green (education) and purple for women and midwifery. This logo was placed on all documents, certificates and gifts for women. Each baby was presented with a certificate as thanks for participation in the program. The SWIM ‘moodle’ depicts the words women used in their evaluations.

Figure 8: The SWIM logo was used as an identifier in the woman’s medical records.

The student midwives fulfilled their requirements for the CoMCE through SWIM and had the opportunity to learn and gain professional skills though the

anticipated learning cycle. The student perceptions of this can be seen in the student's evaluations presented in Chapter 5 section 4.

Celebrations and communicating results

Communicating initial results with the professional body was achieved in maternity forums and conferences. SWIM commenced at the beginning of 2007 and was presented to the Midwifery Educators' Forum at UTS in November 2007. The presentation was received with enthusiasm. The feedback was presented in an email from Rachel Smith UTS lecturer saying;

> *Here are some comments from the evaluations today, I think you were hit!'* **(Smith 2007)**

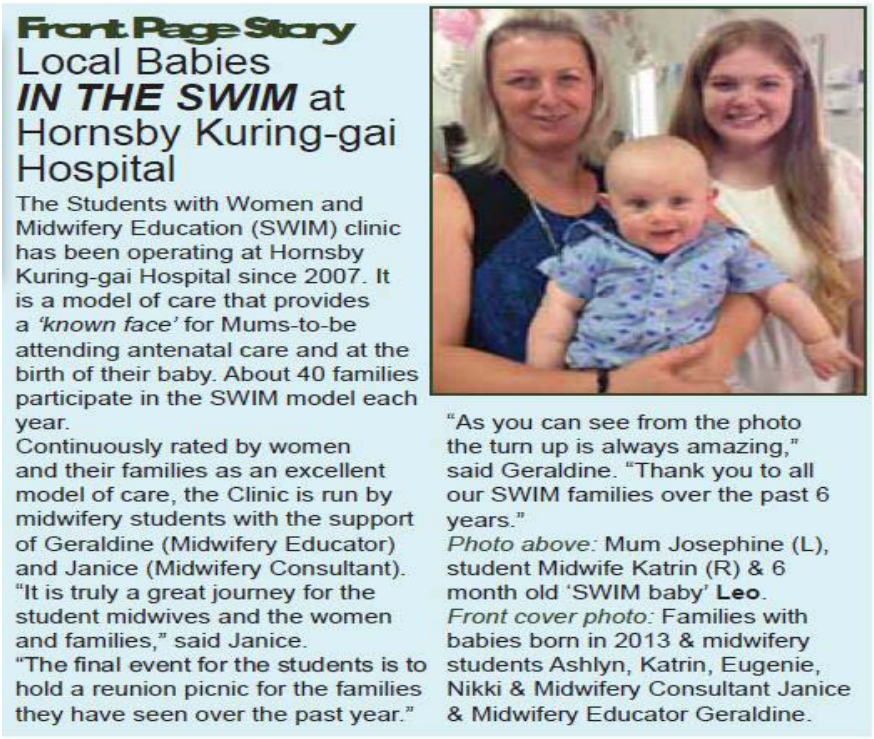
Table 13: Feedback from Midwifery Educators Forum November 2007 (Smith 2007)

Feedback To UTS From Midwifery Educators About The SWIM Presentation
'sink or swim -really got a lot out of it, may be able to use it',
'sink or swim - a very interesting presentation',
'excellent to hear how Hornsby has implemented the swim with me - inspiring to do it at all hospitals',
'sink or swim - fantastic, can't wait to see how we can integrate their ideas',
'swim with me was the highlight of the day'

These comments illustrate that midwifery educators perceived this model to be one that would assist their student midwives achieve their CoMCE in their maternity units.

The development of the SWIM program and the initial findings were presented at the NaMO Innovations in Models of Care Showcase in 2008 (Gilroy 2008) where the findings were enthusiastically received. In November 2008 the facilitators' presented SWIM at the Womens' Hospitals Australasia conference; 'Minding your P's & Q's' Partnering professionally (Sim & Gilroy 2008b). This presentation illustrated how SWIM and the multidisciplinary team collaborated to ensure safe care for the women in the service. In 2012 the facilitators presented at 'Midwives fit for the future' ACM midwifery conference (Gilroy &

Sim 2012), published in Midwifery Matters (Gilroy et al. 2012) and then presented at the Women's and Children's Academic day at Royal North Shore Hospital later that same year (Gilroy 2012). The facilitators received feedback from these presentations that maternity units were keen to adapt a similar model in their facilities. Presenting findings to members of the profession, maternity stakeholders and at conferences was considered relevant as was being visible in the local community. Communicating results to the community occurred in February 2014 when the local newspaper 'The Bush Telegraph" had this photograph on the front page shown in Figure 9.



Front Page Story

Local Babies ***IN THE SWIM*** at Hornsby Kuring-gai Hospital

The Students with Women and Midwifery Education (SWIM) clinic has been operating at Hornsby Kuring-gai Hospital since 2007. It is a model of care that provides a *'known face'* for Mums-to-be attending antenatal care and at the birth of their baby. About 40 families participate in the SWIM model each year.

Continuously rated by women and their families as an excellent model of care, the Clinic is run by midwifery students with the support of Geraldine (Midwifery Educator) and Janice (Midwifery Consultant).

"It is truly a great journey for the student midwives and the women and families," said Janice.

"The final event for the students is to hold a reunion picnic for the families they have seen over the past year."

"As you can see from the photo the turn up is always amazing," said Geraldine. "Thank you to all our SWIM families over the past 6 years."

Photo above: Mum Josephine (L), student Midwife Katrin (R) & 6 month old 'SWIM baby' **Leo**.

Front cover photo: Families with babies born in 2013 & midwifery students Ashlyn, Katrin, Eugenie, Nikki & Midwifery Consultant Janice & Midwifery Educator Geraldine.

Figure 9: SWIM was featured on the front page of the local newspaper (Combe 2014).

At the completion of the student midwives' clinical midwifery education and following the birth of their final baby through SWIM, a final picnic in a local park celebrated everyone's journey to which all the families were invited. Between 80% - 90% of the families attended the SWIM picnic each year. Regular communication to all stakeholders both professionally and the local community was considered to be an essential element to ensure the sustainability of SWIM and keep all key people abreast of any changes.

CHAPTER SUMMARY

This Chapter has presented an overview of the documents connected with this model .It has given the reader an insight into the processes involved in planning and implementing the SWIM program. The Interactive model of program planning has provided a framework to describe the development and operation of the SWIM program (Caffarella 2002). Program documentation has been accessed and insider researcher knowledge used to describe the process of this models implementation. The context has been described and the needs analysis addressed. Building a solid base of support involved acknowledging the needs of all stakeholders and collaborating with the student clinic proposal. Gaining a NaMO scholarship was instrumental in gaining support, assisted the development of the model financially and provided an opportunity to present the initial 12 months findings in a professional forum. Accessing a venue for the clinic and using existing resources was supported by the clinic MUM and the model was considered to be cost neutral. The student rosters and on call system has been described and illustrated. Women and student satisfaction surveys were developed in order to assess if the model met the needs of the women and student midwives. Women were invited to join SWIM and were provided with a university brochure explaining the CoMCE aims and a welcome letter developed by the hospital explaining the models objectives. The women's journey were tracked by notes review and a template created by the program developers. The student midwives continuity of care portfolios tracked the women's journey, demonstrated a learning journey for the students and was a reflective tool for midwifery growth. The anticipated learning journey developed by the CME has been illustrated, this focussed on clinical, professional, ethical and communication skills central to the role of a midwife. The students created an identity by assisting to develop a name, logo, banners, photo album and singlets all with the SWIM logo. The model was celebrated by the students and families with a picnic at the completion of each year. This model has been presented at three conferences and in 2014 it was published on the front page of the local community paper. The following chapter begins the presentation of the findings from the stakeholders' perspectives, from the evaluation documentation collected from the women and student midwives.

CHAPTER FIVE: RESULTS OF WOMEN'S AND STUDENT MIDWIVES' EVALUATION SURVEYS 2007-2011

INTRODUCTION

As detailed in the background to the study, a recommendation from the Hornsby Hospital Maternity Services Review clinical redesign committee was to increase continuity of care for low risk women. This led to the 2007 student midwife clinic (Sim & Gilroy 2006) proposal and the Quality Improvement Project (Appendix 2). The organisation hypothesised that this model would result in a group of women receiving continuity of care and having known care givers during pregnancy. One way of measuring the effectiveness of this model was to develop a self-administered Women's Satisfaction Survey (see Appendix xx) to determine women's perception of their experience. The following chapter details the findings from the survey, beginning with the quantitative responses to closed questions. An invitation to also provide written comment on their experience was enthusiastically taken up with every woman who returned a survey providing comments. These were thematically analysed revealing seven themes which are explored in detail in the second part of the chapter as they provide important insights into the women's experiences.

RESULTS OF THE WOMEN'S EVALUATIONS 2007-2011

Between 2007 and 2011, 150 women participated in SWIM and were provided with a copy of the Women's Satisfaction Survey. The majority of women returned their evaluations resulting in a 96% (n=145) response rate. Responses to questions one and two revealed that of these women 68 were primiparous and 77 were multiparous. Of the 77 women who had birthed previously, 55% had experienced midwifery-led care and 45% were in a medical model of care.

Question 3 measured how confident the women felt that their concerns and questions were addressed during their visits to the SWIM clinic. Figure 10

reveals that most women across the five evaluation periods (2007-2011) either Strongly Agreed or Agreed with this statement.

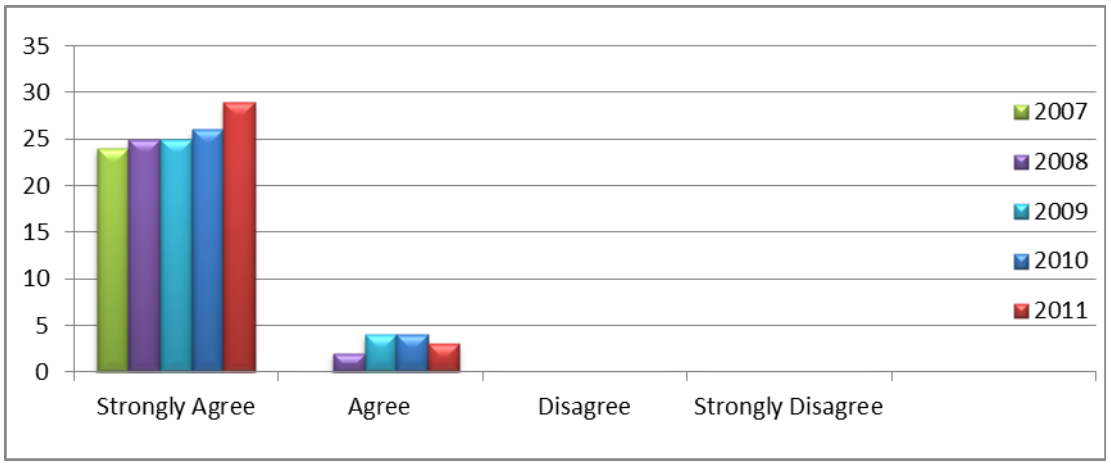


Figure 10: Responses to the statement 'I felt confident that my concerns and questions were addressed in the SWIM clinic'.

A further item (question 6) asked women to consider whether seeing a small group of student midwives had been beneficial for them during their pregnancy. This item resulted in an even larger proportion of women responding that they Strongly Agreed with this statement as revealed in Figure 11.

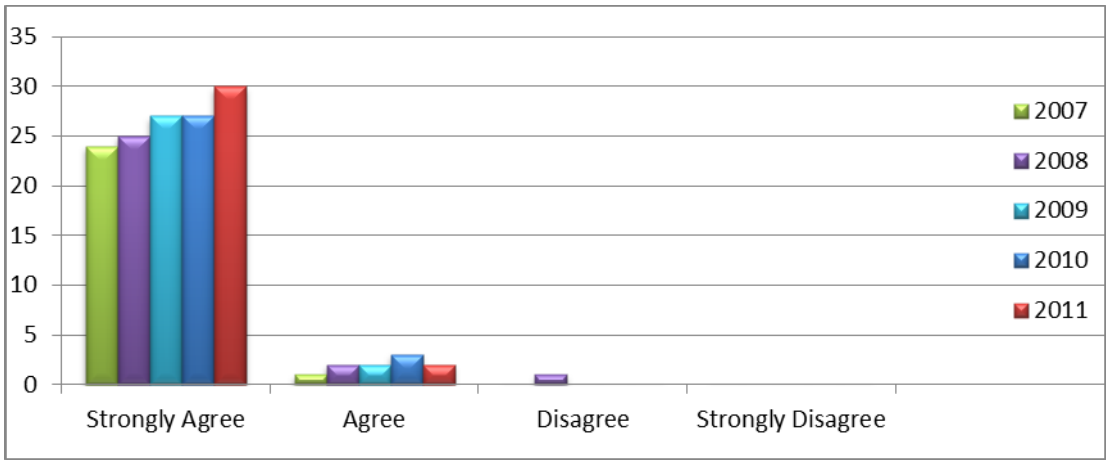


Figure 11: Responses to the statement 'Seeing a small group of student midwives during my pregnancy has been beneficial for me'.

In Question 7 the women's overall satisfaction was rated highly at 96% in the excellent range with 4% stating that they had experienced very good care.

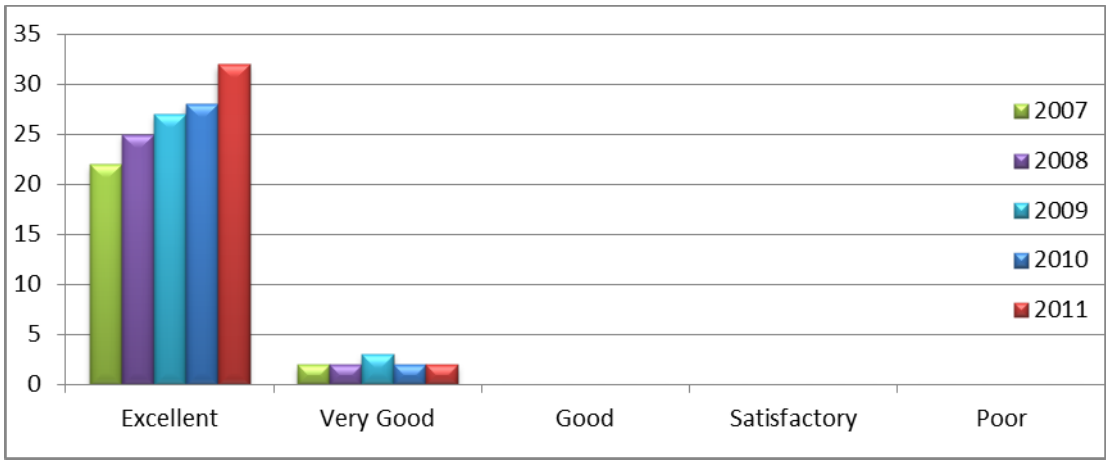


Figure 12: Rating of overall satisfaction with care.

Questions 8 &9 related specifically to the continuity of care aspect of the model. During labour and birth 97% of women had contact and care from a SWIM team student midwife or midwives whom they had met in the antenatal period, however 3% (n= 4) did not. On two of these occasions the midwives did not call the student and on the other two occasions the women birthed soon after arrival at the Birthing Unit so the SWIM midwife did not have time to attend the woman. It is highly likely that 100% of women had contact and care from their team in the postnatal period however one questionnaire had no response to this answer.

Synopsis of survey quantitative questions

The survey indicated that the majority of women who participated in SWIM between 2007 and 2011 stated that they have benefitted from the model of care, their questions have been addressed and they have received care from their SWIM team through the continuum of pregnancy, labour and birth and the postpartum period. This analysis indicates that the model has fulfilled the requirement of the Maternity Services Review for the maternity unit to provide a continuity of care model to women who access the service. The women were invited to make additional comments on their survey and the majority did. The analysis of these comments is explored in the next section entitled thematic analysis of the women's evaluations 2007-2011.

Analysis of the women's evaluations 2007-2011

This section presents the findings of the open-ended question inviting comments from the women. All women who completed the survey provided comments and in total there were 138 comments from the 129 women who returned a survey. The following seven themes emerged from the women's comments and are illustrated in Figure 12 below and in the excerpts from the survey responses. The major themes that arose from these comments were; Relationships; Continuity; Confident and Secure; Support; Gratitude; Beyond Normal Care and Learning and sharing Knowledge. Figure 13 depicts how the major theme of relationship connects all of the experiences of the women.

Figure 13: Thematic Analysis of Women's Comments 2007-2011.

All of the themes contained elements of a focus on the relationship between the student midwives and the woman, revealed in different ways. The first minor theme describes women's feelings of confidence, together with a sense of security and support throughout their care. The theme of gratitude was evident in how often the women thanked the students for their care. The women appreciated the educational aspect of the model and the learning experienced by both student and mother. The women remarked that the SWIM model was beyond normal care. For some, reflecting on their experience was emotionally moving so that one mother described herself as having tears in her eyes; others either couldn't wait to have another baby to experience that level of care again or wished they could. Even women, for whom birth was not a straightforward normal experience, felt that they had a very positive and supported birth and were grateful to the SWIM team. The description of the themes below highlights how all the themes interconnect with Relationship being the common denominator.

Relationships

The first two themes are related; Relationships and Continuity. Women remarked positively on the benefits they derived from being able to establish a relationship with the student midwives who would become a familiar face in labour and birth. As one mother wrote;

> *Building a strong relationship with the SWIM team was highly beneficial and rewarding. It has been a great journey*.

Or as another put it very simply;

> *It was a more personal, developed relationship.*

It was important for the women that they knew their students and that the students knew about their individual needs. This woman reflected on how important it was to have known student midwives who know you and know your history;

Really good to build up relationship with the [student] midwives and to know that one of them would be there at the birth. Great to see a familiar friendly face who knows you and your history.

Or as other women expressed it;

I loved getting to know a small group of students and midwives. I felt that I knew them and they knew me.

Having the group of people I knew made the process much more friendly and caring and they were all fantastic.

One woman perceived the relationship and knowing the student assisted her when she needed encouragement in labour;

It was especially nice to see the same student midwives during my labour when I needed encouragement. It was beneficial in the sense that it increased my chances of a familiar face during labour

The women experienced that the students were interested in them and genuinely cared about them. The women felt more relaxed in the birthing unit when they knew that one of the students was providing care.

The related theme is Continuity since relationship building is a key component of the continuity of care each woman experienced from this small group of student midwives and their clinical educator.Continuity

The following comments from five of the women reveal how continuity was clearly identified as a key opportunity for developing closeness and establishing relationships of trust. Using language such as ‘loved’ indicates the depth of positive emotion experienced by the women;

I loved the continuity of care and the closeness/relationships built throughout the pregnancy

Great not to have to see a new person each time and allowed a relationship and trust to build up for the birth. Everyone was so nice!

To be able to have continual care through the small group of midwives as it enabled me to be in a relationship with them.

It has made it such a positive experience to have continuity and relationship/trust with the midwives.

This positive experience of a relationship with the students and educators in this continuity of care model leads to the next related theme of how the women felt confident and secure throughout their birthing journey.

Confident and secure

One woman linked the themes of relationship, continuity and sense of security succinctly when she wrote;

> *I think this worked very well; I liked knowing there would be a familiar face at the birth and that the relationship you form gives a sense of security.*

Two other women expressed that by knowing the students it gave them confidence to ask questions, increased their feeling of safety and that it was 'stress free';

> *It was lovely knowing the midwives as it made me more comfortable and easier to feel I could talk to them if any problems I had. I felt I was in safe hands.*
>
> *It's more personal, you feel more confident to ask questions… stress free.*

The enthusiasm of the student midwives and the expertise of the educator increased the confidence and sense of security for many women.

> *Loved the enthusiasm and real concern from the students. Also loved [educators]) expertise and I felt very comfortable and confident under her care.*

Relationships built around continuity of care engender a feeling of security and confidence in the women. They felt that they could trust the students, and that they were in safe hands. Women have expressed how confident and secure

they felt being cared for in the model which is reinforced by the theme of support.

Support

The experience of being supported was acknowledged by the women in the comments;

> *I have felt very supported and well looked after during the whole process so THANKS!*

> *[Student midwives] have all been absolutely wonderful. Their kindness, compassion, patience and genuine care for what they are doing shines through in their support.*

One woman spoke of how 'spoilt' she felt being cared for in this supportive model and another stated how she saw the team like an extension of her family;

> *I felt so well looked after. Actually very spoilt. Everyone was so caring, helpful and supportive.*

> *Thank you so much for everyone's support it was awesome. You're all like my other family.*

This support was experienced in the SWIM clinic, around labour, birth and postnatal period;

> *Appointments felt more enjoyable/social, gave supportive relationships and friendships for my time in birth and maternity*.

> *I feel privileged to have been part of the clinic. I have only praise and positive things to say about the care I received. [Student] who I had most contact with, came in for my labour/birth and provided invaluable support the whole time. My labour was much better because of her presence. I received emotional support from the team which was also necessary for me at times. [Educator] has also been a wealth of knowledge and support.*

Even women for whom the process of labour and birth was not straightforward voiced how much they valued the support of the SWIM team;

> *Although the whole process of labour wasn't going very well, I wanted to naturally have my baby but in the end had to have caesarean birth but I had wonderful support from all the midwives, thanks.*

These comments reinforce the link between support and gratitude. Many women expressed how grateful they felt and wanted to express their thanks and gratitude for a rewarding experience.

Gratitude

The theme of a supportive relationship as a result of continuity of care from the student midwives links with the theme of gratitude. This woman described how grateful she was for the supportive care into the postpartum period;

> *The post-partum care I received from (student) after and during the 'trauma' of a bleed was sensational. It brings tears to my eyes to remember her support, reassurance and nursing confidence. I will be eternally grateful.*

Another wished to express her gratitude for the 'beautiful experience' she had with a water birth;

> *[Student] was amazing, she really helped me push through the pain and thanks to attentive sessions she knew I was trying to avoid too much interference/drugs. She was so supportive when I thought I couldn't go any further. Also thanks to [student] I had a water birth. I hadn't planned to and it was a beautiful experience and I am so grateful.*

Several women used the opportunity of the evaluation to express their gratitude to the student midwives. One woman stated how it was an 'amazing experience';

Overall I feel that the SWIM clinic was an amazing experience. I recommend this model to any mother, even if it's not their first. Thank you, thank you, thank you!

Another wants to do it all again;

Thankyou, thankyou, thankyou. I want to do it all again!

This woman experienced the 'warm' attitude in the SWIM clinic and expressed her thanks to everyone involved in her journey;

We loved the warm atmosphere at the clinic appointments. It was great to see everyone at birth too (visiting and encouraging). [Student] was a wonderful midwife/student/birth coach! Thanks so much to everyone involved!

The theme of Gratitude correlates with how the women perceived that they were part of something special and that they experienced being part of the model as being beyond normal care.

Beyond normal care

The women stated that they believed that they had experienced care which was beyond normal care;

Everyone in the team was knowledgeable, professional but also caring and supportive well beyond just normal care. Sorry to have delivered quickly for anyone to come. Thanks heaps.

Two other women believed that the care they received was 'world class';

I've had one baby with SWIM and plan to have another soon. My sister has come from Europe to have her babies through SWIM too. We think there is no other care like it in the world. The team is exceptional and go over and beyond our expectations. Our baby was born early and we were cared for in birthing, nursery and postnatal by our team. We are made to feel special.

I cannot give enough praise to the SWIM ladies. The care that I received was world class! It was also satisfying to know that I helped those girls learn. [Educator] and her team rock! I can't wait to have another baby.

Women also described the students' care as 'unbelievable...amazing' and stated they took more care and time;

I felt the [student] midwives took more care and time to deal with all the issues a new baby brings, not only for the changes in your body but for the changes in your environment.

I really loved the care; all the girls were amazing I would do it again if I could.

Best model of care for low risk women! The students were unbelievable – better than the fully qualified midwives.

The women have described an experience where they felt they received beyond normal care from the student midwives and educators. This experience of beyond normal care is linked to their understanding that the model is an educational model associated with the final theme of learning and knowledge.

Learning and sharing knowledge

The women acknowledged and valued the fact that they were cared for by student midwives with the support and facilitation of clinical midwifery educator and midwifery consultant. The theme of learning and sharing knowledge is expressed by one woman who 'loved' learning about her pregnancy in an educational context;

[I] got to know everyone so well, an amazing team with wonderful professional manner. Also loved learning about pregnancy via an educational context.

Many of the women expressed how they believed that they learned more about their own pregnancy as they felt they learned alongside the student midwives;

The more info, advice the better! As the team were learning and perfecting their skills as midwives, I was benefitting from the knowledge shared.

Very positive great to have continuity of care team. Also having things explained to students meant they were explained to me too. Whole team were lovely thanks!

I also felt I learned a little more about pregnancy and labour by observing the teaching between midwife and student. It was also very reassuring to have a Nurse Educator attend to me. VIP treatment!

It was nice to have [student] at the birth of our baby. Midwives are very special people and anything to assist in training is beneficial. As a patient I feel like I also learnt a lot more as things were explained between student/midwife.

Some of the women really enjoyed the aspect of helping the students in their journey to become midwives;

Loved it, felt like you belonged and it was nice to feel like you benefited them as well in their studies. It's a fantastic program highly recommend it to any expectant parents.

I think the students did an excellent job and I was extremely happy with the care I received from them and wish them all the very best in the future in their studies and beyond. Very helpful midwife [educator], lots of valuable advice and suggestions. To the swim team, you are all rocks.

Overall the themes are summed up by these statements;

Thank you for such a lovely journey with this pregnancy and being such great advocates in what we wanted during this pregnancy and birth. I

think this is a great model of care and would be more than happy to provide any support/feedback in the future.

It was the best experience of my life and I couldn't have done it without the help of the SWIM team. [Student] was absolutely fantastic and if I have her as my midwife for my next baby (oh yes) I would be over the moon. Thank you to [students] who will no doubt be great at what they do as much as [student] as they are all so loving and caring and provide 5 star service at all times. This is no doubt due to the great teachers they have in [educators].

CHAPTER SUMMARY

There were 135 women who participated in SWIM in this five year period, with 129 evaluations returned (96%).Of these women 55 were primiparous, 74 were multiparous. Of the women who had birthed previously 55% had midwifery care and 45% were in a medical model. The final analysis of the Women's Satisfaction Survey is that the majority of women who participated in SWIM between 2007 and 2011 stated that they benefitted from the model of care, their questions have been addressed, and they have received care from their SWIM team through the continuum of pregnancy, labour and birth and the postpartum period. The thematic analysis points to the importance of a strong relationship between the students and the women. Relationship is the major theme which links all other themes depicted in Figure 12. Continuity of care combined with a supportive relationship increased confidence and the feelings of security in these women. Women stated that they experienced beyond normal care and expressed joy and gratitude to the SWIM team for their care. Women acknowledged that this is a student model which involves learning and sharing knowledge. Women appeared to value helping the students to achieve their goals and valued the commitment of the student midwives to support and care for them through their journey.

RESULTS OF THE STUDENT MIDWIVES SATISFACTION SURVEY 2007-2011

All student midwives completing their clinical midwifery education and exiting the SWIM program were invited to complete an evaluation of the SWIM experience (see Appendix 6). 14 out of 15 of these new midwives returned their evaluations [93%]. One student midwife was male and the remaining 14 were female. The age range was 22- 32 yrs. The evaluation period for my study was derived from program documentation and included participants who completed the SWIM exit evaluation from 2007-2011.

The evaluations from these exiting students mirrored the questions from the Needs Analysis (Appendix 1). As with the needs analysis there were 7 likert-scaled questions with answers ranging from strongly agree to strongly disagree. The results of this survey were markedly different to the answers from the Needs Analysis in that to all questions the exiting students answered strongly agree.

All responders strongly agreed that they felt they were regularly given opportunities to provide antenatal care to women in the antenatal period; all felt supported in the clinic; all strongly agreed that sufficient education was given to learn, maintain and update their skills; all felt confident to refer; felt their workload was appropriate and felt that the student midwife clinic had been valuable to their acquisition of midwifery skills. The exiting student midwives from this model were also offered the opportunity to comment further on any aspect of the model and their antenatal experience. The central theme was a perception of ownership of SWIM by the students, this linked to a theme of ‘supervised not constrained’; valuing the group practice; confident to consult and refer to doctors; beyond normal midwifery education; valuing women’s feedback and our SWIM. These comments were analysed using thematic analysis as described.

Analysis of the comments made in the student evaluations of their experience of SWIM

Every respondent provided rich comments about their experience which were thematically analysed. The overarching theme was that of Ownership of SWIM by the student midwives. The central theme connects with the minor themes of Being Supervised not Constrained; Valuing the Group Practice; Confident to Consult and Refer to Doctors; experiencing Beyond Normal Midwifery Education; Valuing Women's' feedback and Our SWIM.

The student midwives sense of ownership and overall connection with the model was a strong theme throughout all their comments as seen below in Figure 14. This experience of ownership connected all the themes. The first theme to be described is the theme of 'Supervised not constrained'.

Figure 14: Thematic analysis of the student evaluations of their experience with SWIM

Supervised not constrained

The overall theme indicates that the respondents' perception was that they were well supervised and given the freedom to provide care in a supportive but not constrained fashion, hence the theme 'supervised not constrained'. These student midwives described how they perceived their experience in the SWIM clinic to be supportive;

> *Consistent, supervised supervision with educators who 'care' has been inspirational.*

Others described how the educators allowed the student midwife to manage the antenatal visits in a supportive role and were always present for input and advice;

> *They [educators] were great, sitting quietly unless you asked them for input. They treated you as though you were capable and they had confidence in us*

> *The [educator] was always present at all antenatal appointments that were conducted by the student midwives and were able to help answer any questions or provide support when needed, thus I always felt very well supported.*

This respondent describes how she felt that he/she was in the role of the midwife at an early stage in their education and that the focus was on the relationship between the student and woman;

> *Great opportunities to feel like you were in the role of a midwife, quite early on in your training. After initial orientation, you were put in the midwife's role with educator(s) in the room. The focus was you and the woman.*

Whilst the following comment related to the level of supervision being at an appropriate level for the student's knowledge base;

The supervision that was provided was appropriate to where I was with my learning and education.

These comments indicate that these participants felt comfortable, confident and reassured that with appropriate supervision they had the ability to provide safe care;

Stepped into the role quite easily…was surprised how soon I felt comfortable.

Perfect.

The ongoing supervision has been key to increased confidence. It allowed me to work independently knowing [educator] was always there.

I feel I have the knowledge and skills to provide safe [care] to the mothers and babies I care for. It is reassuring to know that support and supervision is available.

This comment from one respondent provided a succinct summary of this theme in that this respondent felt that the students' perception was that while they were supervised by an educator who was always present in the consulting room, the supervisor stayed quietly in the background so that they did not feel constrained in their practice;

Always supervised, but not constrained

These students were given the opportunity to increase their confidence and competence, knowing that an educator was there in a supervisory capacity. The student midwives in this model 'shared' the care of the SWIM women with other student midwives working in the model. The analysis revealed a further theme of 'Valuing the Group Practice';

Valuing the Group Practice

The previous theme described through the student midwives comments, how the student midwives felt supervised and not constrained. It also alluded to how the students did not run this model alone, but within a student group practice with two other student midwives. These two respondents' described how it was beneficial to share with their colleagues;

> *It was great to be able to share the workload with 2 other students.*

> *Felt blessed to have access to this model of care. The opportunity to share with your colleagues has been wonderful.*

These respondents' described how the experience of learning in this model had assisted them to understand that 'ownership' of the women was not a part of the shared group practice model, so they had learnt to share the women in order to meet the women's needs and their own learning needs, had learnt to communicate well and also how to support and be supported by the other students;

> *Know how to share and not be possessive about the women. Learning to communicate with your colleagues (other students) has given me insight into working in other [continuity of care] models*

> *Sharing the workload of the SWIM clinic with 2 other students really helped me during my student year. It was always great to know that you could rely on the support of 2 other students.*

These comments describe the functionality of the team which made the continuity of midwifery care experience achievable, rewarding and built friendships;

> *Very appropriate and do-able because of our very functional team of students.*

Working alongside my student colleagues and educator has been a very rewarding experience. Working as a team has built up great relationships, team work and support and friendships.

This respondent described the sharing experience as a ‘blessing’. The reassurance of being there for one another and the ability to discuss and plan the care of the woman with the team was a positive experience.

Sharing the women has been a blessing. Knowing that we were there for one another (the students) is so reassuring; it means you can discuss the women’s needs and plan for her support during labour and birth.

The comments from the students exiting the SWIM model suggest that they felt supported, reassured and valued the experience of sharing the care of the women with two other students in the model. One student felt ‘blessed’ by this support and saw it as a benefit to the women as they could discuss and plan her care for labour and birth.

Confident to consult and refer to doctors

One element in the Program objectives (Appendix 11) was that student midwives would have an understanding of the ACM guidelines for consultation and referral and know how to apply them. This is examined in the following theme ‘Confident to consult and refer to doctors’.

The students stated that they felt supported to refer women to the medical team;

I feel that I am confident and well equipped to use the ACM guidelines. Whenever any woman’s care deviated from the norm within the SWIM clinic support was given by [educators] to assist me to consult or refer to a doctor regarding a woman’s antenatal care.

It was easy to refer women to other health care professionals such as O&G Dr’s and support was given to assist me to be able to do this.

These students expressed that by collaborating with the medical team, that the student had the opportunity to learn more about complex pregnancies;

> *We always aimed to keep the women in our clinic and we would consult with [staff specialist] about complex women and he would plan the care with us. It helped me to trust the doctors and learn more about complex pregnancy.*
>
> *Having various different types of women in SWIM, ranging from normal to complex, allowed me to familiarise myself with the ACM referral guidelines & also practice following these guidelines.*
>
> *Very useful in learning how to refer and collaborate with the medical team.*

Whereas these brief statements indicate that these students assumed that referral was normal practice and easy to facilitate;

> *I have not had any problems referring to another health care provider.*
>
> *The referral process was clear and always followed*.

The written comments in regard to the referral process mirror the Likert scaled response to question 4 which indicated that these students understood the referral pathways and felt supported to follow them. It also indicates that the students did feel that by consulting with the medical team that they could share the woman's care and learn more about complex pregnancies. In summary, consultation and referral is expressed to be a positive, normal process for the SWIM students with the opportunity to collaborate and learn from their medical colleagues. In many ways these students expressed that their perception of clinical education in this model was beyond normal midwifery education; a theme that is examined in the next section.

Beyond normal midwifery education

The theme explored here is the student midwives' perception that the clinical experience they gained in the SWIM model was beyond normal midwifery education. Student midwives discuss their clinical experience within the

university environment with student midwives who are in a variety of contexts and hospital environments. In her thesis ‘Placements with women; not institutions’ Gray (2010) states in her key findings;

> The follow-through experience provides midwifery students with unique and important learning opportunities that they would not experience in standard clinical placements alone (Gray 2010, p. 249).

One student midwife expressed her appreciation of the SWIM clinic being part of their rostered hours and not something they had to do in their own time. This student also expressed how she had discovered from discussions with friends at university that the students in other hospitals do not have this opportunity. The word ‘lucky’ was commonly expressed by these students;

> *We have been lucky to have this opportunity on a rostered working day. Most students elsewhere have a difficult time. We are envied.*

> *I think we are the luckiest students that UTS has. We had easy access to our ‘follow though’ women without getting exhausted. This was a gift.*

> *I felt so lucky to have had SWIM.*

This student acknowledged that support of the educator is important to the students and that this model gave the student midwives ‘undivided attention’ one day a week, which this student did not believe occurred in other hospitals;

> *Many students in other hospitals have little to no contact with their educator. We had undivided attention one full day a week. This support has been crucial to the success of SWIM.*

Whilst this student saw the clinic as the highlight of the week;

> *The SWIM clinic was the highlight of my week! Made me feel like a midwife!*

The aim of the SWIM clinic was the midwifery educational focus which this student perceived to have been achieved at a very high level;

Because of SWIM our antenatal education was at a very high level.

Fulfilling the Continuity of Midwifery Care Experience also known as the follow-through experience was a major objective of the SWIM model. Providing access to a continuity of care model, similar to midwifery group practice exclusively for student midwives was also an aim. These students stated that they;

Managed to have enough points of contact for all women and wrote up thoroughly the number required. It was excellent to be doing the SWIM clinic as a form of group practice and sharing the care of the women

I have loved my year as a student midwife in Hornsby. Working in SWIM & the follow through experience has been wonderful experience. I would love to work in a continuity of care model.

The exiting student midwives who provided comments to this survey have indicated that they believed their experience was beyond normal clinical midwifery education. It was their understanding following discussion with peers in other hospitals that other students did not have access to their own model of care and that student midwives in other facilities had challenges recruiting women and attending their visits. The model appeared to provide student midwives, access to an identified small number of women, in their own clinic, within rostered hours, and which fulfilled the requirements of the follow through experience. It also provided a high level of antenatal education, uninterrupted access to the educator, satisfied students who felt lucky to be part of a model that they loved, who believed they were integrated into a continuity of care model. In summary they believed what they experienced was 'beyond normal midwifery education'. This was supported by how valuable the SWIM women's feedback was to the student midwives.

Valuing women's feedback

All women were given the opportunity to debrief their experience in the postnatal period and the majority completed a women's satisfaction survey

(Appendix) discussed previously. At the completion of each year the student midwives were allowed access to the summary of women's de-identified evaluations and verbal feedback was given to the students at the SWIM picnic. This was something the student midwives cherished;

> *The feedback from the evaluations inspired us. It indicated that the women valued our care.*

The student midwives message from the feedback was that women valued continuity of care, building a professional trusting relationship with the students and the opportunity to discuss and plan for their labour and birth;

> *I believe that women who were provided care by the students in the SWIM clinic 100% valued the continuity of care provided them. I believed the women valued not having to tell their story to a different midwife at each visit and enjoyed building a professional relationship with the student midwives.*
>
> *I think one of the most important things the women valued was being able to explain to the student midwives what they wanted and didn't want and what they expected for their labour and birth, and being able to achieve these things during their labour and birth.*

This student felt that women showed how much they valued this relationship and it was evidenced in their letters and also the well-attended picnic;

> *I definitely feel the women value the continuity of care provided to them. They send letters, photos, cards & it's evidenced in their evaluations. They also all come to the picnic.*

The student midwives valued the opportunity the women had to give feedback and the content of that feedback. These students perception is that the women valued continuity of care, because they did not have to explain their stories to many people, they could discuss and plan their labour and birth and could form professional, trusting relationships with the students. The student also felt that the evaluations, cards and picnic attendance gave women and their families the opportunity to feedback and that positive feedback was inspirational to the

student midwives. These students' statements' suggested a sense of ownership of their SWIM model.

Our SWIM clinic

A strong theme that was illustrated throughout the students' comments within all the themes was a sense of ownership of the SWIM model and acknowledgement that this is a learning experience as noted by this student;

> *A full student clinic each week was fantastic. All our own women; all know we are students, well supported. The solid base of our midwifery experience!*

And this student comment suggests that the students feel the educator supports them in their model;

> *Our model always has [educator] present. We are never unsupported.*

This comment indicates how the women and students are on a learning journey together and there is a positive energy in the SWIM clinic as a result of this;

> *The women and we learn together. There is great energy in the clinic.*

The student midwives use the term 'our clinic' and are motivated to provide consistent continuity of care to their women as seen by this students comment;

> *Our clinic has only our women in it. This is a perfect opportunity to provide consistent continuity of care to our women.*

The terminology used by these exiting students relates strongly to their personal connection to the model. Our SWIM is a sentiment which repeats throughout the data. This sense of ownership of the model and a sense of protection of the women and the model is the central theme which connects the other themes reflecting the student midwives experience of SWIM.

CHAPTER SUMMARY

The student midwives experience in the five year period from 2007 – 2011 were the group examined. From the initial questions on the evaluation, all responders strongly agreed that they felt they were regularly given opportunities to provide antenatal care to women in the antenatal period; all felt supported in the clinic; all strongly agreed that sufficient education was given to learn, maintain and update their skills; all felt confident to refer; felt workload was appropriate and felt that the student midwife clinic had been valuable to their acquisition of midwifery skills. The exiting student midwives from this model were also offered the opportunity to comment further on any aspect of the model and their antenatal experience. These comments were analysed using thematic analysis as described.

The overwhelming theme was that of Ownership of SWIM by the student midwives. This central theme connects with the students experience of being Supervised not Constrained; the Valuing the Group Practice; being Confident to Consult and Refer to Doctors; experiencing Beyond Normal Midwifery Education; Valuing the Womens' feedback and Our SWIM.. The richness of the comments has given an overall description of the student midwives perspective of their SWIM model of care in this five year period. These findings were part of the evaluation of the SWIM model in the program documentation (Gilroy 2012). In chapters four and five I have described the planning, implementation and some evaluation of the SWIM program. Cafarellas' (2002) model emphasises the importance of the people at the heart of the process and the importance of context. Some insider researcher knowledge has been used to guide these chapters which are also in keeping with case studies. An integral part of the documentation is the 2007-2011 evaluations from the women and student midwives who experienced SWIM. The women described relationships as being a core ingredient in this model. They felt they experienced continuity of care, felt confident and secure and well supported. The women expressed gratitude, believed they had experienced beyond normal midwifery care and enjoyed learning and sharing with the student midwives. The joy the women experienced helping the students is a key finding in this case study. The student

midwives stated that they felt supervised and not constrained; valued one another in the group practice and were confident to consult and refer. The student midwives believed they experienced beyond normal midwifery education; strongly valued feedback from the women and expressed a sense of belonging and ownership of SWIM. In the next chapter I present the findings from the interviews and focus group with key stakeholders.

CHAPTER SIX: FINDINGS FROM FOCUS GROUP AND INTERVIEW DATA

INTRODUCTION

Chapters 4 and 5 explored the SWIM program in relation to program documentation, this included the needs analysis and the women's and student midwives' evaluations. This chapter presents the results of the transitional midwives focus group; the midwifery manager's face to face interviews and the facilitators' interviews. They will be individually explored in three sections and then summarised.

SECTION 1: THE MIDWIVES FOCUS GROUP

In order to gain a deeper understanding of the SWIM experience, we approached the previous SWIM students at the completion of their transitional midwifery year and invited them to be part of a focus group. The transitional midwifery year is the first year of midwifery practice following registration as a midwife[4]. As these midwives were no longer part of SWIM, they could look back and reflect on their experience. This opportunity for reflection may provide further insights into the impact of SWIM which is the research focus for this descriptive case study. The themes expressed were: Transitioning from Student to Midwife, Valuing the Sharing in the Group Practice, Valuing Learning with Women, Easily fulfilling the CoMCE for midwifery registration, Inspiring Confidence by Giving Respect and A Perfect Model Celebrated with Respect; all centring on the common theme of Our SWIM.

The answers to the initial question to ascertain the midwives' understanding about SWIM prior to commencing midwifery were varied. Information about the model was on the university and local health district website and students were given written information at commencement of their clinical. Three out of four had read the information, but expressed that until they actually experienced working in the model it was difficult to imagine how the experience would be to

[4] Transitional Midwife is a newly qualified midwife in an educationally supported role in a maternity service. The transitional midwives in this case study had almost completed their transitional year. These transitional midwives had been educated through SWIM for their CoMCE.

learn through this model. Understanding the requirements of the follow-through or CoMCE was not concretised until they commenced their clinical midwifery.

> *It [the information] was very brief and it said that as a student it was required of us to be part of a student group that has four women per month as a caseload of women, which I didn't know what that meant. But you know, I quickly figured it out but that was what I understood.*

The transitional midwives were able to conceptualise the information that was given now that they had journeyed through the model and viewed it as a mini MGP and the focus on continuity of care as described by this midwife.

> *When I met you for my interview I think you explained it to me sort like a mini MGP which is what I came away with. That we shared responsibility for a group of women and you were very focussed on the continuity of care aspect and that was what I came away with more than anything*.

The midwive's responses indicated that although they may have received information about SWIM prior to commencing their clinical midwifery education, it was difficult for them to conceptualise what that actually meant. They were at that stage of their journey still trying to understand the concept of continuity of care and the follow-through or CoMCE. The midwives also stated that it did not take long for them to grasp the concept that it was like a mini MGP.

The second trigger question enquiring about their journey through the model and how it impacted on their student year successfully opened up the discussion. The discussion led to a number of themes the first of which was the journey of transitioning from student to midwife. These themes are illustrated in Figure 15.

Figure 15: Themes from the Transitional Midwives Focus Group.

Transitioning From Student to Midwife

One major aim of clinical midwifery education is to prepare the student midwife to be a confident, competent midwife in clinical practice. The midwives in the focus group felt positively about how SWIM had prepared them for midwifery practice as this midwife expressed;

> *I think it [the SWIM experience] helps you make that step, which was a huge step for me from student to midwife.*

This midwife described the SWIM experience as giving her major assistance (a 'leg-up') in her transition from student to midwife;

That it just gives you a bit of a leg-up on that I think, quite a big leg-up because I think it [SWIM] helps you practising, pretending to be a midwife for that whole year.

This midwife described how learning through SWIM had given her time to explore all aspects of midwifery care including the physical and psychosocial issues. The opportunity of working in this model had given her the opportunity to draw on this experience to now care for women in a time poor environment;

[As a midwife] you can kind of draw on your past experience because you had enough time in [SWIM] in our student year to get into the physical and psychosocial issues, whereas now [as midwives] we don't.

These two midwives describe how learning in the SWIM model has given them the skills, confidence, competence and time management skills to effectively run antenatal clinics now they are midwives;

I think it prepared us really well, like a few times as a new midwife I was in thrown in the deep end with like 10 minutes to spare saying "You're doing a midwives clinic this afternoon. Quick, go, there's your files" [If I had not previously had SWIM] I would have been absolutely panic stricken. I would have just said 'no'. But now you'd kind of go 'All right, I can do it".

This opinion was reinforced by this midwife who stated;

I think it gives you an incredible grounding in antenatal care, which talking to other student midwives [in other maternity units] they didn't have and as a result coming out as a midwife has given me a lot of confidence in time management and in, just in actually running a real clinic because you have been practicing for a year.

Learning through SWIM and the graduation to increased responsibility as skills grew, enhanced the understanding of midwifery accountability and responsibility with this midwife. This midwife also reflected on her own time management skills and organisational skills and her ability to take on more responsibility

> *[Learning in the SWIM model] taught me time management and organising everything and being ultimately responsible, I think that you maybe take on more responsibility through it.*

The experience of how much this midwife believed they had all learned in a relatively short period of time is demonstrated in this statement;

> *I think I was quite amazed at how far we had all come in a year, looking back at how quickly it went.*

The comments from these midwives demonstrate their experience that SWIM had prepared them for clinical practice as midwives. All focus group participants expressed their transition of practising or pretending to be a midwife in their student year, to the reality of being a midwife. They stated that they felt they had a "leg-up", could relate knowledge learned to present circumstances, understood time management and organisational skills and also the level of accountability and responsibility required as a registered midwife.

There was a sense of loss in the statements made by the midwives in their description of leaving SWIM as they transitioned from student to midwife. There is a mixture of relief from some midwives that they were no longer on call for SWIM women during labour and birth which was stressful to some midwives but not others;

> *I must say I don't miss being on call. That was good at the time but now I'm away I enjoy not being on call as well.*

This midwife appreciated no longer being on call, but enjoyed the continuity of care experience and would have liked that to continue for longer;

> *I had enough of being on-call. But I could have kept going with continuity of care style job for a lot longer. I enjoyed it.*

This midwife did not mind being on call because she did not feel she was alone as it was shared by the students. However, she did miss being part of something 'precious' like SWIM and how she felt valued and valuable;

Yeah. I feel the same. I miss belonging to something precious like SWIM. I didn't mind being on call, maybe because we shared it. I felt valued and valuable. Does that sound right?

The experience of these midwives was that it was an amazing chapter in their lives, where they worked with women and their student colleagues and there was a certain importance associated with that which made them feel valued;

It was like you felt, important is not the right word but, valued.

I have certainly found since being a midwife what I have missed the most, is knowing the women antenatally because you just don't unless you have your own clinic to do that.

It was great, an amazing chapter in my life and I miss it.

The midwives in this focus group described their experience as student midwives in SWIM as something they valued in an environment where they felt valued. They describe the on call experience as something most of them no longer miss, however being part of a model they considered precious where they worked with one another and women was an element that they did miss. The opportunity for these midwives to reflect on the SWIM experience revealed a group wistfulness of a happy chapter in their lives. One of the elements that the midwives experienced as rewarding as students in SWIM was the ability to work together.

Valuing the Sharing With Other Students

A strong theme in this data set was that of how much these midwives appreciated one another when they were part of SWIM. All midwives said what they enjoyed most and now miss most is the ability to work together. They became friends, supported one another, met regularly and communicated comprehensively about the care and plans for the women in SWIM;

We were a really good team and also I think that showed to the women that we were a good team and there was no conflict or struggle or

anything between any of us and I think that really worked for our relationships with each other and with the women.

This midwife described how discussing the care of a woman with a student at the same level gave her a new perspective on the situation and provided her with support;

I think another benefit is having the other students there that you can talk to about that particular woman or something that happened. You know, there was someone else there on the same level as you looking through similar eyes to be able to help you with that and provide you with support.

And this midwife felt all the students were comfortable enough in the relationship to help one another without the risk of embarrassment;

We didn't feel embarrassed to say, help each other.

The other student midwives were just wonderful which was very lucky I think. It is a special group, a good group, a great group.

These midwives spoke fondly of the relationship they had with one another. Their connection with SWIM bound them in a professional, supportive way. They felt safe to ask questions, empowered to assist one another in the group, enabled to collaborate and discuss the care of the women in a supportive environment. The midwives believed that their successful, non-confrontational relationship with each other was evident to the women and ultimately was beneficial to their care. This valued relationship between members of the student group, engendered a positive relationship with the women and they valued the experience of learning and sharing knowledge with the women in SWIM.

Valuing Learning with Women

The SWIM model was an educational model and women who chose this as their model of care knew that and as such the students could experience

learning with the women. This midwife experienced confidence in sharing research findings that as a student she had learned at university. It gave her an opportunity to bridge the gap between university and clinical environments and to share her knowledge to inform and benefit the women;

> *What I liked was that you could incorporate what you'd learned at Uni. You could say with confidence to women as you went "research shows that the use of water in labour and birth…" and stuff. It gave you a forum to use that knowledge.*

This student expressed her experience that the women and students were equal, learning together and sharing knowledge. There was no power disparity;

> *They knew you were a student very clearly so you could say "oh, at Uni this week we learned about X.". We all learned and so they would feel not that we were so high above them and that we were learning almost with them.*

This was reaffirmed by this midwife who said;

> *Yes, I agree with that totally.*

This midwife felt comfortable embracing the role of a student in front of the women, which is difficult for student midwives who are also registered nurses. As the women know they are student midwives there was no embarrassment confirming her findings with the educator as that was an expectation of the model. There was no expectation from the women that the student had all the knowledge and as such the student did not pretend to be something i.e. a midwife, that she was not;

> *And as [midwife] says, the women knew we were students so if you said 'I don't know, I've got to ask [educator] to confirm it' they didn't look shocked, they knew. We weren't pretending to be something we weren't. I liked that part.*

The growing in knowledge, confidence and competence over a period of time was expressed by this midwife. She explained how in the early SWIM clinics she did not feel the confidence to answer questions posed by the women and deferred to the educator, but as her experience increased as did her confidence and knowledge and ability to provide the care;

> *I think also that it was really good to see that when you were doing blocks in clinic to see how much you developed and actually learned from one block to the next. You might have gone through a time where you didn't answer any of those questions and left that for [the educator] but then you found in the next block you actually had the confidence and the knowledge to keep adding to people's questions and anything they had.*

The midwives expressed that they felt free to learn and share knowledge together with the women. SWIM gave them a safe forum to voice what they had learned at university especially regarding evidence based practice and to share this knowledge without judgement. The acknowledgement that they were student midwives in a learning environment gave them the confidence to ask questions and given time their knowledge, confidence and competence grew. As this model initially was a low risk entry model, women who developed complexities in their pregnancies continued to be cared for in the model and the appropriate care was brought to the SWIM clinic rather than the women being sent to the doctors clinic. As a result the women were supported and protected in the model and continued to receive continuity of care and the student midwives benefitted by learning about complex pregnancies.

These midwives in the focus group discussed their experience as having more access to women with complex pregnancies and learning about these at the same time as the women. They described the situation of sharing more women in this model than if they were case loading their own continuity of care women. The result of this sharing or collaboration gave them the opportunity to get to know and care for a more diverse range of women, some with complexity in their pregnancy and not only women with a 'normal' pregnancy;

I think you had exposure to many more women, so to many more complexities potentially than you would get if you were just case loading your own women.

This midwife acknowledged the collaborative component of the SWIM clinic;

I feel we definitely had a wider range of women we saw and we knew quite a lot about each of them and their various complexities. I think that was a real benefit because you were able to caseload so many more women through a collaborative clinic.

This midwife appreciated the additional length of appointment time available in the SWIM clinic to address both the physical and psychosocial challenges that some women face in their pregnancies. She also enjoyed building a relationship with some of the colourful characters;

I think it was good that our appointment times were 40 minutes as well. It gave you almost double the amount of time to get into those complexities whether they were physical or psychosocial and I think for me personally, getting to know those women, lots of colourful characters well.

This midwife described how learning in this model gave her insight into caring for women with psychosocial issues once she became a midwife. She was able to reflect on how women may be feeling because of her experience caring for women in SWIM;

Dealing with a variety of psychosocial issues was a benefit, so now you can go 'oh, that's how I dealt with X in SWIM because she really explained to me how she was feeling; maybe she's feeling like that.

The midwives in the focus group expressed how they valued the opportunity to learn with the women in SWIM and to share with them the knowledge that they gained through their midwifery education. The diversity of women who accessed care through the SWIM model was considered to be of benefit to the

midwives in this focus group. They expressed that by seeing a greater number of women in a collaborative model of care, than they would have seen if they case loaded their own women, gave them the opportunity to learn more about complex pregnancy. These midwives also expressed that they benefited from getting to know these women, some of whom were colourful characters and others who were willing to share their feelings particularly around psychosocial issues. The midwives when they were students in SWIM described how they had time to address these issues in a learning environment as the clinic appointment times were longer than the average antenatal clinic time. The breadth of their learning experience encompassed both the normal and complex pregnancy.

Easily Fulfilling the CoMCE Requirements for Midwifery Registration

When these midwives were asked if SWIM provided them with the continuity of midwifery care experience to fulfil the requirements for midwifery registration their answer was an emphatic yes. They stated that they absolutely had more than enough women for their continuity of care experience;

> *More than enough: absolutely. Possibly double.*

Interestingly, this midwife did not see the need to focus on numbers to the extent she was unsure of the numbers required for the CoMCE but was more focussed on the experience of providing continuity of care;

> *[The important experience was] the continuity with the women, you know, with that many women in your student year you are supposed to follow through 15 or 30 or whatever, but to actually be able to be across a lot more people was great.*

These midwives were aware that student midwives in other facilities had found this aspect of their clinical midwifery to be a challenge;

> *Definitely listening to other students we had such a better year than other hospitals which is a huge advantage over all the other students I think with the [SWIM] clinic.*

In fact one midwife who transferred from another facility as a student and therefore joined the SWIM team when it was established expressed some anxiety about gaining 'points of contact' which is a requirement for the CoMCE. She felt that she needed to be at each visit even when she was not allocated to SWIM on that day;

> *To get our point of contact, we had to get into the room and say hello but sometimes it was just a bit awkward if we were on the ward and it was busy or in Birthing Unit trying to look after a woman in labour and you had to run around to SWIM, which was what we wanted to do.*

The other midwives did not express any concern regarding the need for points of contact, but more about the knowledge of the core midwives in relation to their role. Two of the midwives expressed that a challenge was the ability of the hospital midwives to understand the role of the student midwife when they came in for the SWIM women in labour;

> *[It took time] getting all the other staff on board and understanding our role.*

And another stated;

> *One of the challenges was getting everyone to understand our role in labour and birth.*

The midwives were concerned that the core midwives, particularly after hours may not call them in a timely manner when the SWIM women presented in labour. Whereas this midwife since registering as a midwife had gained an appreciation of the complexity of calling the student midwife at the right time when she said;

> *Having said that though, I now know firsthand how hard it is, because I had some other students subsequently that I had to ring and I felt so bad because I rang her when I thought it was appropriate, but actually I don't know whether she made it.*

This was echoed by this midwife who stated;

I think that it is hard to know when to call as well.

Ensuring all stakeholders had an understanding of the requirements of the CoMCE appeared to be a challenge, however this did not appear to have a negative impact on the students' ability to fulfil their CoMCE requirements for midwifery registration. The midwives in the focus group stated that they had 'more than enough' women to care for in the model than was required for midwifery registration. One student was unconcerned regarding the numbers and was more concerned with the experience of providing continuity of care to women. One midwife did express concerns around gaining points of contact, whereas the others concerns were more focussed on the core midwives understanding regarding the student role around labour and birth. As new midwives they also had a better understanding of the complexity of calling student midwives in a timely manner for their CoMCE women in labour.

Inspiring Confidence by Giving Respect

The theme that arose from these statements described the participants' experience of not being constrained in the SWIM clinic but given the opportunity to develop as a midwife under supervision. This experience of being given 'a long string' inspired confidence in this midwife and she felt she was supervised and supported but not hovered over;

> *We were given a long string to see how you would go on your own as well. You were not hovered over to see how you were going either; given the confidence that you can do this and you would be okay with everything, but then if we weren't we had the support if we needed it as well. I think it really set you up to have confidence in what you were doing.*

This midwife described her experience as being given positive reinforcement from the educator that she was doing well and by being 'given the scope early' allowed her to have the confidence to be herself;

The biggest benefit to me I think is because we were given the scope early, or [educator] told us we were doing well, you felt able when you might not have with other midwives or if you were alone, to actually be yourself.

The positive reinforcement theme is reiterated by this midwife who felt that she was not held back or obstructed by the educator and that she was able to develop her own style under supervision;

I think that was the biggest benefit I got because it was like 'you're good at this, you can do this' and I felt 'actually I'm going to give it a red hot crack '. I didn't feel in anyway hamstrung and [educator] never gave us the feeling that we were stupid or didn't know anything or we should just shut-up and follow the party line. I think that was a real benefit.

The experience of being in the midwife's seat and conducting the SWIM clinic was liberating for this midwife. This increased her confidence as a student and enhanced her expectation that the educator was the quiet supervisor in the room;

[I liked] not having to sit there and listen to some Registered Midwife do the talking. [Running the SWIM clinic] pushed you to the fore, which meant you had to be confident with women, which meant that the facilitators had to be quiet, which [they] were, which was a very good thing.

This midwife also experienced being in the midwife's seat as empowering and she felt safe in the knowledge that the educator would not embarrass her in front of the women, but respectfully discuss issues privately. This was perceived as a gift to this midwife;

It gave us confidence in the fact that we were on the money and if we weren't [the educator] would say something quietly later, not in front of the women. That was a gift. But I think that just having to be at the front of it that was good.

The midwives in this focus group described their experience in the SWIM clinic as being given the opportunity to be themselves and learn in a safe environment. They felt they had been given a ‘long string’ and felt the quiet supervisor enabled them to feel ‘you’re good at this, you can do this’ which inspired them to think ‘actually I’m going to give it a red hot crack’. The quiet educator in the room empowered them to take the lead in the antenatal visits in the safe knowledge that they would be respectfully guided but not embarrassed. The overall experience was they gained competence as a result of being given the opportunity to grow by the facilitators in a respectful environment. The word respect was also used in the next theme entitled ‘a perfect model celebrated with respect’.

A Perfect Model Celebrated with Respect

The midwives described SWIM as the opportunity to experience an ideal purpose built model. This midwife calls it a ‘perfect model’, but also states that the existence of this model, highlights deficits in other areas of maternity services where care was not always evidence based;

> *I think too it was also a sort of perfect model. So you have the latest research, the latest knowledge, we were new students and we knew the latest evidence and then you were disappointed when you went to other areas where that was not occurring. I guess it highly suggests deficits in the other areas potentially. You’d get there and you’d learn by examples and may not have any evidence based, so that’s a backhanded compliment to SWIM.*

The antenatal care aspect of SWIM contributed to the ‘huge’ part of learning to be a midwife in this midwife’s experience. She experienced a ‘wonderful year’;

> *For me I thought it was a wonderful year. I really think that a huge part of learning to be a midwife is the antenatal care that you provide and for me SWIM was a lot about antenatal care.*

And this midwife expressed wistfulness about how she missed being part of SWIM;

> *I really miss the model and being with the women and working with these guys and just, I don't know, it wasn't like 'well you're just another midwife doing what we all do'. It seemed perfect.*

An annual picnic in a local park was arranged by the completing student midwives to celebrate the completion of their clinical midwifery education. The purpose of this picnic was to invite all the SWIM families to thank them for their contribution to growing future midwives. This midwife described how enjoyable it was to see the families again and that the SWIM picnic celebration completed this experience with the right respect;

> *I thought it was an appropriate length of time and I like the fact that we celebrated it with a picnic. That felt good and that felt like we gave it the right respect and it was nice to see all the women again because we would never have done that otherwise and it was nice to see where they were at and how they felt. It was nice that they felt so strongly about us. They brought their mother's, their husband's, their friends, whoever they could rally really to bring. Yes, it was good.*

The midwives in the focus group described their experience of SWIM being a perfect model, which may have highlighted deficits in other areas of midwifery. There was an element of 'loss' expressed, but also an realisation that it was a chapter in their lives, which ran for an appropriate length of time and was celebrated respectfully with a family picnic. The midwives were impressed by the realisation that the women and their families felt 'so strongly' about them that they brought their extended family to the picnic.

SECTION SUMMARY

The midwives in the focus group appeared to speak freely about their relationship with and journey through the SWIM program. They related to SWIM as a friend that had supported them through their midwifery education. They described how they transitioned from student to midwife; how they valued the

sharing with other students in the group practice and valued learning with the women in SWIM. They believed that the model had assisted them to easily fulfil the requirements of the CoMCE for midwifery registration and that this achievement was facilitated by the educators who inspired confidence in them by giving them respect. They felt that the SWIM program was of an appropriate length and that it was a perfect model celebrated with respect with a picnic of all the families who had journeyed with them through that year. The next section of this chapter explores the midwifery managers' perception of SWIM.

SECTION 2: RESULTS OF THE MANAGERS' INTERVIEWS

Two managers from the organisation were interviewed for the Case Study to explore their understanding of the SWIM model of care and the impact on their role and the impact on the maternity organisation. Manager 1 was the current Midwifery Unit Manager in the facility and had been in role for three years. This manager had not been in the organisation when SWIM was implemented. Manager 2 was the Divisional Manager of Women, Children and Family Health at the onset of this model and was the executive sponsor who accepted the proposal. At interview he was the Deputy Director of Nursing and Midwifery at this metropolitan hospital. In order to maintain the anonymity of the managers who are easily identifiable within the organisation, no quotes will be ascribed to individuals. The analysis of the interviews with the two managers revealed four major themes. These themes are Workforce, Supervision and Learning, Student Experience and the Organisation's Perspective.

Four Major themes and related subthemes

Within each major theme of Workforce, Supervision and Learning, Student Experience and the Organisation's Perspective, a number of sub themes were identified. The theme of Workforce contains the subthemes of: impact on staffing, organisational activity and staff retention. The theme of Supervision and Learning contains the subthemes of: supervision, registration requirements and student education. The Student Experience theme contains the subthemes of: happy & supported students and time to reflect. The final theme of

Organisational Perspective includes the subthemes of: pride & innovation, sustainable & portable and benefits to all in the organisation. Figure 16 illustrates these findings and their relationships. Each theme is discussed in detail with illustrative quotes from the managers' interviews.

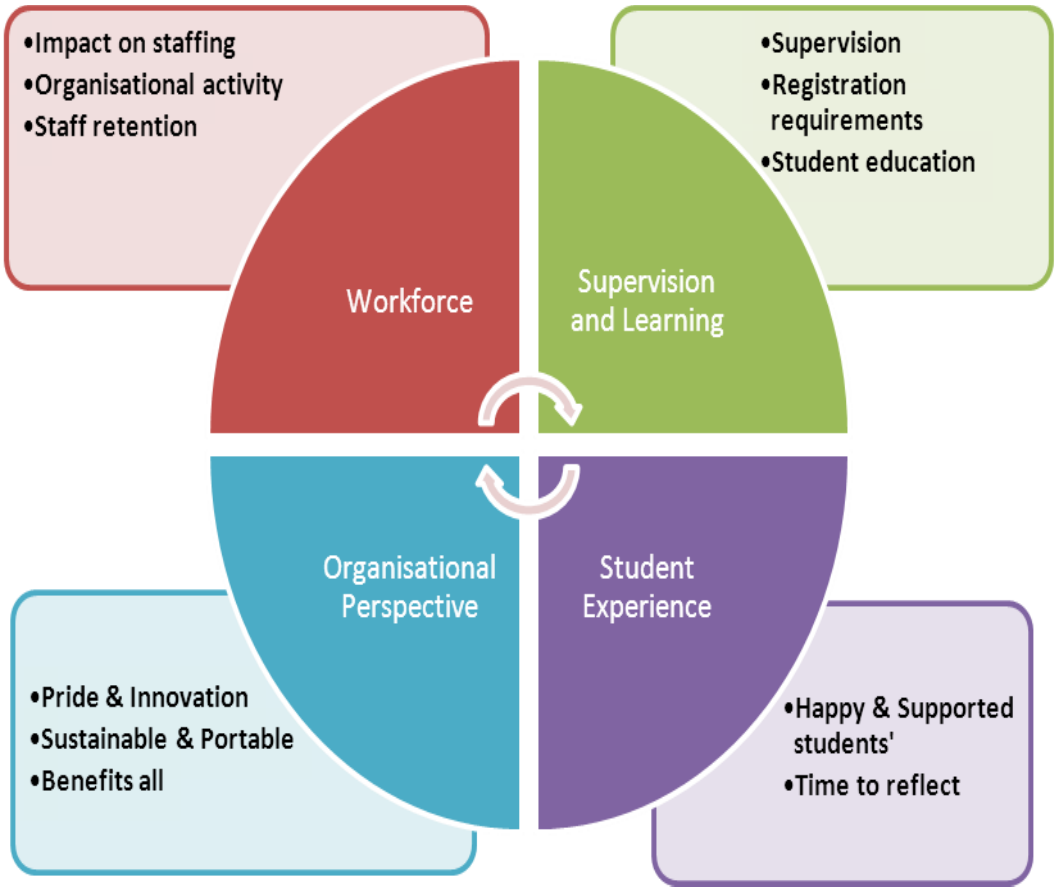


Figure 16: Thematic Analysis of the Management Interviews

Workforce

The major theme of 'Workforce' contained three minor themes of 'impact on staffing'; 'organisational activity' and 'staff retention' which are all major concerns of managers. Each subtheme is illustrated in the following section.

Impact on Staffing

In order for a new model to be accepted by an organisation, the managers asserted that it was important that any new model 'fits' within the organisational context. Their aim was for no negative impact on staffing or the creation of workforce discontent and ideally to provide benefits to the organisation. The

data suggested that the managers' major responsibility was to the smooth running of the maternity unit, safe levels of staffing and a commitment to students. One manager emphasised that the employed student midwives had a joint responsibility to their SWIM women as well as to the organisation;

> *They have an understanding when they come in to birth their [SWIM] women that there is a responsibility to their [other] work as well as a responsibility to their women*.

The educator arranged the shift rotation to ensure that there was always a student midwife from the SWIM team allocated to each area in Maternity unit. Therefore during rostered paid hours there was always a student in the birthing unit, ward and SWIM clinic. This ensured equity in rotation, availability of the SWIM student already rostered in that area to care for their women and the ability for each SWIM student to care for their women. Out of rostered hours the SWIM students arranged an on call system which they shared. Generally the student who was first on call would have a current rotation to the birthing unit; however this was negotiable depending on student needs. When the first on call was the current birthing unit student rotation, this ensured that the student could continue the care if her rostered shift commenced and therefore enabled greater continuity for the women. A major consideration was that students could only provide care for a maximum of 12 hours. This was particularly relevant if a woman was admitted and birthed overnight and the student shift was to commence in the morning. This was managed by the second on call being available to come in to the birthing unit and take over care in a timely fashion, so as not to compromise either the students' rostered responsibilities or her commitment to the woman. Effective communication and mutual respect was the key to this success. In the five years described in this case study; no student exceeded the 12 hours of care; all students attended their rostered shifts and the handover between students has been smooth.

What the manager was making clear in this statement is that although the manager understands that the students have a commitment to their SWIM women, there is an expectation that the students still complete their rostered shift work. The manager is also stating that the students have demonstrated

that they understand this commitment to both SWIM and the organisational needs.

Organisational Activity

As stated above the students' clinical rotation was managed by the educator. This relieved the manager from the additional responsibility of rostering the students in order to ensure they fulfilled their clinical education requirements. As stated below;

> *…it is easier for me to manage this model as the students are already allocated to do a clinic.*

This manager is stating that the students' placement with the SWIM clinic does not adversely affect her staffing numbers;

> …*for the employed students [the students allocation to the SWIM clinic] doesn't have a large impact on staffing numbers which unfortunately is what we have to look at*.

This manager is also expressing a feeling of regret that her major role is to focus on staffing and less on supporting innovative care models and the student experience. Although her focus is on organisational activity she is cognisant of the needs of the students and is relieved that the educator or CMC are supporting the student midwives;

> *If you are purely looking at the [staffing] numbers you know that either the educator or the CMC will be there supporting [the students] as they [Educator or CMC] are not part of the [staffing] numbers.*

Neither the educator nor the CMC are paid from the cost centres of the midwifery unit managers in this facility therefore the educator is cost neutral in their budget. The manager has expressed that she is also relieved that the educators are working with the students whilst providing care for the women and support for the students which makes care safer.

Another impact on the organisation was raised by one Manager who viewed the implementation of the model as an opportunity to review how antenatal services as a whole were run within the organisation;

It actually triggered us to look at the activity within the antenatal clinic, looking at 'is there any way we can modify the way we run clinic?

As a result of the planning for the SWIM clinic, the manager took the opportunity to review how the rooms in the antenatal clinic were utilised. This review assisted in reconfiguring both medical and midwifery clinics to best utilise the resources and streamline organisational activity.

Staff Retention

The following two statements show how managers felt that the model had a positive impact on staff retention;

Student midwives have been retained, so it is also a retainment strategy so I think that it's easier for me as the … manager because I know we've got a good retainment strategy in relation to midwives.

This manager has expressed a belief that as the student midwives enjoy and value this aspect of their clinical education experience, they may request to continue to work in the organisation once they are registered as midwives. There is evidence that this has occurred in that 11 out of 12 students have requested to stay at Hornsby Hospital and the remaining one moved to work in a rural environment;

That means we are actually attracting future midwives and other established midwives. It's not only an opportunity for Hornsby [hospital] I think it's an opportunity for all maternity units.

In fact the data suggested that the existence of the model was perceived as beneficial to the manager as the students were already allocated a patient load and were being well supported to provide safe care. The managers also perceived that the model acted as a staff retention strategy. The next major theme which was discussed by the managers was the importance of student supervision and learning.

Supervision and Learning

With the development of the SWIM program, the proposal stated that student midwives would be fully supervised in this model. The SWIM evaluation data has shown that either the educator or CMC supervised 97% of SWIM clinics between 2007 and 2011 and a senior midwife supervised the final 3%.The themes that arose from both managers interviews indicated the importance of supervision and that in their opinion the students were well supervised in this model;

> *Women enrolled in the model are well cared for because they are always cared for by a student under direct supervision of [educator or CMC], which I think that when running a student model is something that you have to be aware of.*

The manager felt safe in the knowledge the student midwives' practice is safe because the educator or CMC is always there with them. The manager was reassured that this model comes with inbuilt safety and risk management which is provided by the direct involvement of the educators and is not her primary responsibility. The themes that arose from the interview emphasised the importance of the supervision of students;

> *One of the challenges is the reality of having that consistency of that supervision because I think it's important when they are doing the SWIM clinic, that there is someone there to supervise.*

The fact that there was consistent supervision by the educator and CMC has ensured continuity of care and decreased conflicting advice for either the student or the women;

> *It's in relation to having a named midwife, in this case a student midwife with supervision from the clinical midwifery educator and the CMC at the time that this first started.*

The managers' impression is that the students are supervised for all care which means they work one on one with the educator. The ability to fulfil the

requirements of the NMB for midwifery registration was also a focus identified as a subtheme of Supervision and Learning.

Meeting Registration Requirements

One of the main instigators for development of this model was to streamline the process for students to fulfil the requirements of the Continuity of Midwifery Care Experience for midwifery registration. The managers revealed that in their opinion this has been successful;

> *The opportunities I guess is that the students are well cared for, able to meet their criteria, forever expanding in an easy model. Well, I suppose it's a complex model but once its embedded in the system it's an easy model that you are not worried about 'are the students not going to meet their criteria', 'are we going to get them the right amount of numbers?*
>
> *Allows them to get their follow-throughs; in a model that is manageable within a unit of this size quite well.*
>
> *This model allows those number crunching [student registration requirements] to happen very simply and very easily and that's a great thing, so that is a huge benefit.*

The data suggests that the midwifery unit manager felt confident that once this model was embedded in the organisation that this was an easy model to manage and enabled the student midwives to fulfil their requirements for midwifery registration. By calling it an easy model, the manager believed that it sat in the same category as midwifery group practice and was now the established norm within the organisation. As facilitating the model was the responsibility of the educator, it was easier for the manager to manage from a staffing perspective as the students' were allocated to the model; it was easier for them to access women for their continuity of care experience requirements. Another important consideration identified as a subtheme was whether this model effectively educated the students.

Student Education

One manager felt that there was a holistic approach to the students' learning and that the student midwives were;

> *… Well educated and well-rounded … would be my first perception of the model from a holistic point of view.*

This managers' perception is that the model assists the students' learning in a sustainable way and is not constricted by a limited time frame as s/he reveals in these comments;

> *Some other models people have used; there is a time frame to them. 'So you know, you would say 'after three weeks you should be good at this so we'll leave you by yourself', well that never happens in this model.*
>
> *Learning in this model will impact on a new midwife's practice quite significantly from the fact that learning in this model allows them to learn more at a rate that they feel comfortable with rather than a rate that we feel comfortable with … there is always someone in this model to support them.*

The SWIM model supports the student midwives throughout their entire 12 month clinical education experience. The opinions expressed by the managers were that some other student midwifery experiences in other maternity units, offer limited time to learn in a supported supervised environment. The impression is that the supervision and learning in this model is not the norm elsewhere. The student experience from the management perspective is the next theme to be addressed.

Student Experience

The student experience was a major theme found in the data. The data revealed that the managers believed students, who feel safe, cared for and supported have a more rewarding experience and are more likely to be open to learn. It appears that from the manager's perspective that both the students and women are nurtured in this model. This theme has two subthemes of 'happy and supported students' and 'time to reflect' which are illustrated below.

Happy and Supported Students

One manager stated that that the ability for the students to work together in a group was a more satisfying experience and increased their level of support;

> *They [students] learn to work in a group which is important as well because it's not a one on one simple model for the fact that there is a group is good.*

Three student midwives in the SWIM model 'shared' the care of the women through the continuum, which gave them the opportunity to discuss the care, share the experience and also the on-call arrangements. The managers described how this support is a positive feature of the student journey;

> *Information that comes back from the students who have been in this model, all of them are happy and satisfied and there [are] very few parts of training and practice that all people will be happy and satisfied with.*
>
> *The opportunities I guess is that the students are well cared for.*
>
> *So I guess that it looks at the ability for people to learn and feel safe, and that will impact on the outcomes [for women care for by] midwives because if you feel safe in a model and safe in a learning space then you are more able to meet your full potential.*

The data revealed that from their experience the managers believe that the student midwives in the SWIM model are happy, well cared for and feel well supported in a safe model where they are able to meet their full potential.

Time to Reflect

The opportunity for reflection and value of reflection on practice was a further subtheme identified;

> *There is always room for reflecting on anything that has occurred, whether it is good or positive or whether there is variance or an unexpected outcome there is always a support system which is actually good when you are reflecting on your practice*.

The student midwives had the opportunity to meet after each SWIM clinic to discuss the care and plans for birth of their women. This time was used to discuss women who had recently birthed and reflect on this experience. This communication was vital as it ensured that if one of the students were rostered elsewhere and not available to attend the clinic, that they felt informed and connected. These meetings were valuable for building relationships with one another in addition to planning the care for their SWIM women;

> *I'm hoping that once they have finished their time … they will use those tools that they have learnt when they are actually reflecting on their practice when they actually become a full-fledged midwife. So they actually think ok when I was a student midwife this is how we dealt with this situation, these are the people; these are the tools we use.*

This manager described how s/he believed the SWIM model gave the student midwives the opportunity and time for reflection on both events and practice. That this opportunity to reflect in an educational model will assist them in their decision making when they qualify as midwives. The data suggests that if a student feels safe, supported and cared for they are more likely to reflect on their practice and fulfil their full potential. The Organisational perspective was the final theme revealed from the management interviews.

Organisational Perspective

The final theme revealed that from an organisational perspective there was an element of pride in being part of something considered to be innovative, sustainable and portable which benefits the women, organisation, students and staff. This theme contained three subthemes of 'pride and Innovation', 'portable and sustainable' and 'benefits all' which are detailed below.

Pride & Innovation

Throughout the interview the managers frequently expressed how proud they were to be associated with such a positive innovation. The management journey is often focussed on workforce issues and the will to support innovative practice. In fact one manager felt that SWIM was a joyful thing**;**

That's a really joyous thing to be part of.

And that the model was innovative;

> *I would like to add that I think this has been good for Hornsby in the fact that we are able to be viewed as innovative and it is innovative practice and it's only with innovation that you will get change.*

One manager had been instrumental in accepting the educators' proposal to commence the SWIM model and as such had a feeling of pride and even ownership of this innovation. Hornsby Hospital had won a Nurses and Midwifery Models of Care Innovation Scholarship in 2007/8, of which the management were proud. The Educator and CMC had also presented the model at the Womens & Childrens Hospitals Australasia Conference in 2008 and the Australian College of Midwives [Queensland] in 2012 which increased the profile of Hornsby Hospital.

Portable and Sustainable

The SWIM model had been successfully integrated into the organisation for more than five years when the managers were interviewed. The managers stated that one of the benefits was portability and sustainability;

> *It's a portable model you know, if other hospitals could actually implement the same process I think it would be beneficial for both women and the maternity services or the midwifery workforce in relation to that. So it's a portable model that can easily be adopted and implemented in the ward providing they have the support and the process and they don't modify it as it's the modification that sometimes affects the outcomes.*

Another similar sized metropolitan hospital had contacted the Hornsby Hospital educator for advice in setting up a clinic in 2009/10. Although their model is not identical, it does assist the students to fulfil their registration requirements. The ability for many maternity units to assist students to fulfil the continuity of midwifery care experience requirements' has been complex and as such the educator had had requests for assistance from six separate hospitals.

And also its sustainability;

> *It's been going for [more than] five years now…something to be proud of.*

One of the anticipated outcomes from the Quality Improvement proposal (Appendix) was that the model would be sustainable which to date has been achieved and it is embedded in the organisational culture. The final subtheme from the organisational perspective is that the SWIM model is beneficial to all stakeholders in the organisation.

Benefits All

In these two statements there is an acknowledgement that there is a benefit to women in this continuity of care model and SWIM has the ability to promote a culture that birth is normal;

> *I think for the women it is another model of care that they can actually access wherein they are actually supported in their journey from antenatal to postnatal and having that known midwife, known person that they can ring, and will have that committed support so I think for the women that's the benefit for them, that someone is going to care for me throughout my entire pregnancy.*
>
> *It will have embedded a culture that birth is a normal process so there will be an advocate for women*.

The final statement from the perspective of the managers is how SWIM has the ability to benefit all;

> *So I guess it offers both an organisation benefit and opportunity and as well as benefiting the student midwives and as well as the midwifery staff and the women, so you are hitting three levels there in relation to benefits and opportunities*.

SECTION SUMMARY

The managers described their understanding of and impact of the SWIM model on their role under four major themes. Within each major theme of Workforce,

Supervision and Learning, Student Experience and the Organisation's Perspective, a number of sub themes were identified. The theme of Workforce contained the subthemes of: impact on staffing, organisational activity and staff retention. The theme of Supervision and Learning contained the subthemes of: supervision, registration requirements and student education. The Student Experience theme contained the subthemes of: happy & supported students and time to reflect. The final theme of Organisational Perspective included the subthemes of: pride & innovation, sustainable & portable and benefits to all in the organisation. Figure 11 illustrates these findings and their relationships. Each theme was discussed in detail with illustrative quotes from the managers' interviews.

The overall impression from these themes is that the managers perceived that the SWIM model was beneficial to all in the organisation. That is did not have a negative impact on staffing and that they were reassured that the students were supervised. They perceived that the model fulfilled the educational requirements of the students and that the students enjoyed their experience which in turn led to staff retention. The outstanding impression was that of pride, a belief that the maternity unit was innovative and the model was portable and sustainable. The final section in this chapter explores the facilitators' experience of SWIM.

SECTION 3: RESULTS OF THE FACILITATORS INTERVIEWS

The facilitation of the SWIM model was provided by the Clinical Midwifery Consultant and the Clinical Midwifery Educator. Both were interviewed separately and their perspectives are addressed under the topics (themes) below.

As the primary researcher and also a facilitator of this model I was interviewed. I had an awareness of my closeness to the data and have acknowledged this previously when addressing reflexivity. Case study methodology requires obtaining data from all perspectives and sources. This chapter will address the interview data obtaining the facilitator perspective. The major themes are challenge, commitment and support; benefits for the facilitator; growth of student midwives and progression planning as seen in Figure 17.

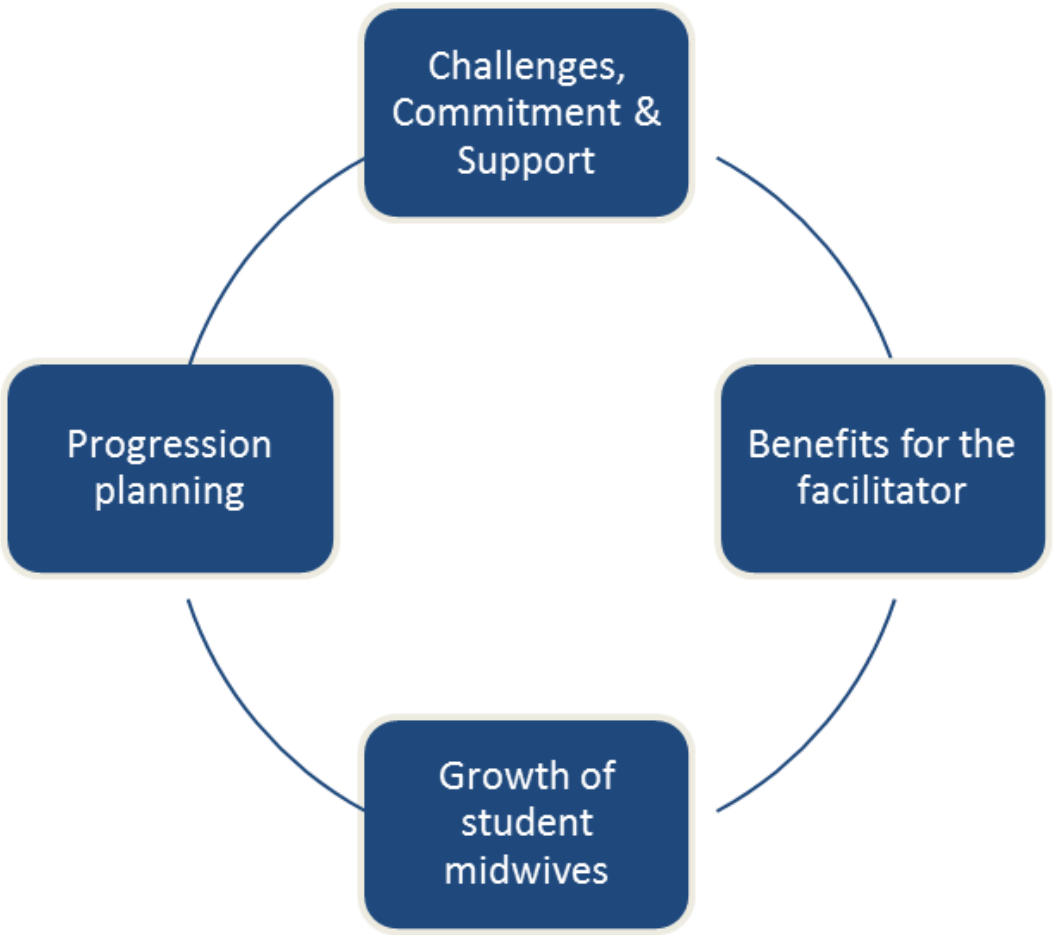


Figure 17: Themes arising from the Facilitators' interviews.

Challenges, Commitment & Support

The SWIM model was commenced in 2007 and the facilitator comments below describe the context and organisational environment that existed prior to its implementation. The comments suggest that the facilitators perceived that the organisation was not providing a satisfactory antenatal experience for student midwives or fulfilling their clinical requirements for midwifery education. There appeared to have been some initial resistance from management, a lack of understanding as to the need for a student midwifery continuity of care model and some concerns regarding the commitment of the facilitators to support the model. The challenges of implementing this model are described by the facilitators and also the commitment required.

This facilitator described how student midwives had not been provided with appropriate clinical midwifery experience in the antenatal clinic environment prior to the implementation of SWIM and how these student midwives had been considered workforce;

> *Prior to the commencement of the model [facilitator] and I had been trying to implement something like that. We'd been aware that there had been needs for our midwifery students who had been getting very little antenatal care with antenatal women and were virtually being used as staff members in their clinic rotation to assist with doctors clinic to do blood pressures and do all of those things that we as midwives do not consider to be midwifery care. So students' getting the experience of continuity of care in a midwives clinic was virtually non-existent prior to the development of this model.*

This facilitator described how getting a commitment or 'buy in' from management was difficult to achieve and that this was a major challenge to its implementation;

> *The other challenges were buy in from management. Because it was something new there was an element of the management system struggling to understand why the need was there and what the benefits*

of this would be and in the initial stages we were definitely not encouraged to commence this model.

This perception was reinforced by this facilitator who did not feel supported by management;

There were many challenges; we had many frustrations developing this model. I didn't think it was particularly innovative but unfortunately management really wasn't on our side to start with.

There was also a perception that the students would get too much attention in this model;

There were midwives who thought that these [students] were probably being nurtured a bit too much.

This facilitator describes how the change of senior manager opened the door to an efficient roll out of the model and that by being persistent and overcoming these challenges, the model was created;

Our initial proposal was rejected…Then a new divisional manager was employed in the Division (Women's and Children's Health) and [Facilitator] and I presented to him our proposal and immediately he said yes [Facilitator] and I ran with the whole model. We educated all staff, involved all stakeholders and started. Most of the work & planning had been done prior to that. So those were the challenges, but then once we had overcome those challenges the actual running of the clinic and the actual whole concept of continuity of care is just midwifery so in that way, the development was a bit of the challenge but the actual running of the model has been very normal, natural & rewarding.

The creation and maintenance of the model involved commitment and the perception was that the facilitators would have a lack of commitment to the model. One facilitator described an email in response to the initial proposal;

I'll never forget the email from the NUM that said as a mother with small children I might not always be reliable to facilitate the clinic. Thankfully by

[facilitator] and I supporting one another there has never been a lack of supervision of SWIM.

The facilitator commitment was described as a concern for management and a challenge to the facilitators;

When we first set off it was a bit challenging and we had some negative feedback that we wouldn't support this model for long enough.

The managers needed assistance to understand that the facilitators would fulfil this commitment during the antenatal period for the SWIM clinic;

It was about the commitment and getting the institution to understand that we had a commitment to this model and we would fulfil our criteria which was being with those students each week.

It was not the facilitators' intention to be on call for labour and birth as that was the domain of the student midwives:

Our commitment was to the antenatal care and overseeing the model, but not to the birth or postnatal period. If we were on site for the labour, birth or postnatal, we would say hello if appropriate, but not to take over care. Our educational roles are not conducive to maintaining all the requirements of a 40 births [per annum] MGP model as we have so many other challenges and so many other roles to fulfil. This was also not our intention as the crucial relationship is between the student midwives and the women and her family.

The facilitators stated that they had evidence of the sustainability of this model and their commitment to it, in that in the five year period described between them they had facilitated most of the clinics;

Over those five years, [Facilitator] and I were the lead midwives in 97% plus of the particular clinic appointments. This was possible because we [facilitators] supported one another. So from that perspective it was a great commitment, however it was a commitment from my perspective that I actually thought was really valuable.

The commitment and challenge of implementing the SWIM model was considered to be worthwhile as this facilitator reflected that students exiting the model are confident midwives;

> *However, I think that challenge has been well and truly been met now because the [students] being confident, comfortable and definitely good midwives.*

The facilitators described how there were many challenges initially obtaining management support for the implementation of SWIM. The management reservations appeared to be primarily around the need, the vision and the commitment from the facilitators. Once there was management support the model was swiftly implemented and the sustainability of the model plus the commitment and support of the facilitators had been evidenced over a five year period.

Benefits for the facilitator

The challenges and commitment described in the previous paragraph are just one aspect of the facilitators' experience. The beneficial experiences described by the facilitators were three fold; they valued working with students and with women and being part of a continuity of care model which in turn kept them clinically relevant; they appreciated working in partnership with one another and bringing a cohesive approach to midwifery education and were cognisant of the fact that they had facilitated the development of a model of care which fulfilled the CoMCE requirements for student midwives.

One of the major benefits expressed by both facilitators was the opportunity to work with students and women;

> *As an educator it meant that I was working with the students' one on one or in small groups. Being the only educator in the facility, working individually with students within the rest of the maternity unit was not always achievable. So I was able to look at how the students practiced within all areas of care to be able to do their assessments through this*

model and as an educator I found it a really good way to model best practice and to also spend time with students.

This facilitator loved having the ability to be part of a continuity of care model;

The benefits are great for me; I know having some clinical input into women during their process of antenatal care, which is great. I love the fact we've got a clinic that I am involved with as well.

The ability to be part of this student midwifery group practice was considered beneficial to this facilitator as she maintained her clinical skills and professional relevance;

So from my perspective it was great to be able to be a part of a small group practice where you were actually able to provide continuity of care, keep up clinically and be relevant.

The facilitators also describe the personal and professional satisfaction they received by being involved in the SWIM model and state it was exhilarating, rewarding and valuable;

I found the experience really exhilarating in many ways.

Over this 5 year period, we're now well into the sixth year of having this model, I personally have found it excellent. It has been a rewarding and valuable experience.

An integral component of this model was the support that the two facilitators gave to one another in order to maintain supervision and support to the students and the women. This resulted in the development of trust relationships with one another and with the students. The facilitators describe that in their experience the different educational approaches of each facilitator, benefitted both the students and the women;

We were able to build up trust relationships and working with [facilitator] was fantastic, because we were able to bring different skills, knowledge and perspective for the students to learn.

Definitely it has helped with the relationship with the students, each of the students are different, the way [Facilitator] teaches is different from the way I teach. It gives me some respect of their learning curve but gives them some idea of how we work as a team and how we may have different opinions, but in fact the women usually gain from having input from a few people.

One of the major drivers for the development of the SWIM model was to assist the student midwives to fulfil the requirements of the CoMCE for midwifery registration. As stated before the number of women the students were required to provide continuity of care for increased over the period of time analysed. The facilitators developed this model to embed this in the organisation and make this requirement rewarding and achievable for the student midwives.

This facilitator expressed that the student midwives had all fulfilled this requirement;

So in every occasion over that period of time, all of the students were able to provide continuity of care to a greater number of women than was actual requirement for registration.

The student midwives provided care for all women in the model and as a group organised a rotational on call roster for labour and birth. As explained by this facilitator;

The student had provided continuity of care for all of the SWIM women but the ones they had written up for their portfolio were the ones that they had spent the majority of their time with, had a particular relationship or learning experience with and were actually present for the birth.

However, they wrote all the women in their portfolio and retrospectively nominated 20 women for whom they had provided the majority of their care. This facilitator suggests that the evaluations from the women indicated that they were provided continuity of care from all three students;

So they wrote them all up but the ones that were actually the ones they would put through for registration were the ones they had provided more

care for and in every case, as far as the women were concerned that they had had continuity of care from all of the student midwives.

This facilitator expressed the belief that the students effectively fulfil their requirements and that other organisations would have liked to have a model which assisted the student midwives to gain this CoMCE;

I think we were often the envy of other universities and hospitals because these students get their follow through experiences. Definitely they fulfil their requirements and I'm very happy to sign them off at the end of the day.

The facilitators of this model considered that they personally and professionally benefitted by their association with SWIM. Primarily it kept them clinically relevant and gave them an opportunity to be part of a continuity of care model and access to student midwives; they appreciated working in partnership with one another and providing different perspectives to antenatal care and they also felt that they had facilitated the development of a continuity of care model for student midwives and women which fulfilled the CoMCE requirement for midwifery registration. An additional aspect that interested the facilitators was that they assisted in the growth of student midwives.

The growth of student midwives

One of the areas described by the facilitators was observing and assisting in the growth of student midwives. There was an emphasis on the student midwives having good role models from two like-minded lead clinicians who modelled best practice;

The benefits are self-explanatory; the [students] get good role models for their antenatal care from senior clinicians who are like minded.

This was reiterated by the second facilitator;

The other benefits I believe for the students is that they are getting consistent information from lead clinicians, myself and [facilitator], who

are consistently there so therefore they have a fairly well-grounded perception of how to be midwives.

The facilitators would role model antenatal care, evidence based practice and communication skills and then encouraged the student midwife to be the lead carer with the support of the facilitator;

[Facilitator] and I would be the lead clinicians, not be in the room at the same time, we might pop in and say hello but there would only be one lead midwife who is in the room and that particular midwife after a couple of sessions with the student, would put the student in the midwives chair and just guide very much how the clinic would be run, add information where appropriate and use it very much as an educational opportunity for both the mother, the families and the students themselves.

This facilitators experience was that the student midwives gained confidence as a result of being given the responsibility early. This demonstrated a sense of commitment or ownership of the model;

The students rose to the challenge very quickly they ran the clinic very competently they would pull all of the notes, arrange any tests, decide issues that needed discussion, appropriately consult with the doctors and they would collaborate well. They were always supported by myself and [Facilitator] so they always felt that there was somebody there who they could rely on and as a result they became confident and competent very early on in the piece.

The facilitators saw their role as supervisors of the student midwives, ensuring the students embedded their knowledge in normal risk midwifery and gain the ability to care for women with more complex needs;

They have always been supervised for their entire clinic experience and all their abdominal palpations and their decision have been assessed and confirmed. So from that opportunity they got to see women who were more complex as well not just the women who entered the model with low risk.

As the students developed their own individual abilities in antenatal care, they also had the additional challenge of learning to work as a group to provide optimal continuity of care for the women. This led to each group developing strengths which would enable the group to function effectively and support its members;

> *As in many group scenarios creativity, leadership and organisational qualities of the students come to the fore. They were well guided throughout the model and they worked very much as a team. This in itself is a challenge for the students. [The students were] learning how to work together as opposed to just individually.*

They also learned to support one another and arrange their on call equitably taking into consideration the circumstances of the group members.

> *The [students] are very thoughtful for each other, sometimes if somebody has less time they may manage their on call differently;*

The facilitators expressed the fact that they had seen five groups of students complete their SWIM experience and by observing this, they were confident in their abilities and impressed how they grow into midwives;

> *Watching now five sets of students grow and how they come out the other end confident in the antenatal clinic, and I am confident in the way they teach their antenatal clinic and they are comfortable running a clinic by themselves.*
>
> *There had been a difference in confidence and approach to midwifery practice with these new midwives who practice more holistically and without fear. Many of whom had moved on to Midwifery Group Practice models.*
>
> *I have seen the difference in these new midwives, how they can work and how they are so much more holistic. They are not afraid to move around, they're not reticent to go to the clinic because they will be running a clinic by themselves. Definitely, some of these midwives have*

gone onto happily join [midwifery] group practice and are very successful in that way.

Hornsby Hospital was not always in a position to employ their new graduate midwives due to lack of availability of midwifery positions. The facilitators were contacted annually regarding availability of these midwives for employment. There was a perception that the student midwives who graduate from this model were well educated as many hospitals chose to employ them as midwives as expressed by this facilitator;

In every case we have seen excellent midwives leave this model, and there has also been competition from other hospitals to employ our new midwives so from that perspective we believe that the model is perceived within the area and within other hospitals as an appropriate model to be educated through. Like many things in life...you get out what you put in!

Although this model could be perceived to be a strategy to retain midwives, this facilitator states that her focus was broader and her aim was to assist the development of inspirational midwives of the future;

The model could be seen as a staff retention strategy from a management perspective; however my focus has been to assist in the growth of relevant, well rounded, competent, confident and inspirational midwives of the future; midwives who can communicate, collaborate, value continuity of care and always place the needs of the women and the family as the central focus.

Every 12 months a new group of student midwives entered the SWIM program and the facilitators observed and assisted in the growth and development of these future midwives. The students learned from and were supervised by two lead clinicians who although they had differing approaches, brought cohesiveness to the team. The student midwives learned to provide continuity of care to their women, but also to work together as a group, supporting both the women and each other. It was perceived by the facilitators that these students grew into excellent midwives, who felt competent and confident to work in all areas including Midwifery Group Practice. Although this model could

be used as a staff retention strategy, there were not always midwifery positions available in this facility, however all the local hospitals annually requested for these new midwives to apply for positions in their facility as transitional midwives. This was perceived as evidence by the facilitators that these student midwives were considered to be well educated and that the model fulfilled the requirements for their clinical education. One facilitator expressed that her aim was to assist in the development of inspirational midwives for the future.

As previously mentioned each course was 12 months and towards the completion of each year there was a need for smooth progression into the next group of student midwives and women as discussed below.

Progression planning

The clinical component of the Graduate Diploma in Midwifery in this facility was 12 months. There was no overlap of one cohort of students to the next i.e. one group of student midwives contract would end one day prior to commencement of the next. There was the potential for a breakdown in continuity of care if progression planning was not addressed. The facilitators in this program commented on how this was managed.

The progression from one student group to the next was managed primarily by one of the facilitators as described below. She also perceived that she was also part of that progression in that she too was introduced to the new students and women in the model;

> *The succession planning is mainly up to the educator. I probably picked up a few of the pieces of the staff changing over at times, but I often was introduced myself and came through with the staff.*

This facilitator describes how the plan was for a lead-in and lead-out time within the models planning for student consolidation and to ensure women in the model received their continuity of care;

> *So we tended to have 4 women birthing for 10 months of the year and maybe towards the end, not having women birth in the last two months of*

their clinical placement. The aim was to consolidate the experience for the current students and ensure continuity of care for the current women.

The statement below describes how the completing student midwives would continue the clinic and recruit new women for the students who were yet to commence. The students appeared to value the concept of continuity of care and a desire to assist new students;

The SWIM clinic would still be running because new midwifery students would be commencing and we would be inviting new women into the model on their behalf. The women and their families are our first priority and the students are aware of that. So initially we were fairly strict that the progression planning was managed smoothly. The [current] students appeared to be really keen to keep up the continuity because they considered it to be valuable.

One element that appeared to assist in the progression planning from one cohort of the student midwives to the next, involved inviting the incoming cohort of students to the clinic prior to their commencement to get some insight into how the model was run. As described below, the incoming students were also invited to the SWIM picnic facilitated by the outgoing students where the previous SWIM families were invited to celebrate their journey. The comment below indicates that this approach was considered to be successful;

So we would introduce the new students midwives who were not yet employed within the model, they would come to our SWIM picnic, they would get to meet some of the women there .They would also be offered the opportunity to come in prior to actually starting their role to help them understand how the clinic worked and maybe even have a face to face contact with some of the women without providing any care. So it's seemed to have worked well and the outgoing students would be starting to teach the incoming students, and from that perspective it seems to have worked quite well in all areas.

This progression had the potential to be a challenge as the outgoing students had a sense of ownership of the model as seen in the student chapter and

transitional midwives chapter. The facilitators had also built relationships with the outgoing students and building new relationships with new group of student midwives created further challenges. This facilitator described how she too was aware of her need to end her relationship with the student in the model and develop new relationships with the new students and that this was getting easier each year. There is also an acknowledgement that effective progression planning assisted the students to withdraw both professionally and personally from the women and their families;

> *Every year it gets easier I think to sever some relationships with some of the students and develop other relationships and it's probably helped in many ways to help the students disconnect professionally and personally from the women.*

The importance of progression planning could not be underestimated from the perspective of the facilitators. The women and their families are the centre of the care and in order to provide continuity of care the women need to 'know' their student midwives. It was inappropriate for the women to be cared for by student midwives from both cohorts, therefore a lead-in and lead-out model was developed. This approach appeared to be successful in that the outgoing student midwives had time to disconnect professionally and personally from the women and this was celebrated by a SWIM picnic.

The incoming student midwives were welcomed through an invitation to the SWIM picnic, which gave them some insight into how the families experience the model and the value that it held for them. The incoming students had an invitation to visit the clinic, prior to their commencement in the organisation and receive a hand over from the outgoing students which assisted in the smooth transition between student groups.

The facilitators' experience of this transition is also important as there was acknowledgement that they too are affected by the transition and change of students. This is a subject that could be investigated further.

SECTION SUMMARY

Four major themes arose from the facilitators' interview data. The facilitators' were the educator and clinical midwifery consultant who were the midwifery supervisors for the SWIM program. The facilitators' spoke about challenges, commitment and support; the benefits to them as facilitators; observing and contributing to the growth of student midwives and organising the progression or succession planning from one group of midwives to the next.

CHAPTER SUMMARY

This chapter has explored through a focus group and face to face interviews the stakeholders' experiences of SWIM. This range of perspectives provides a holistic view from the key stakeholders. The data indicates that SWIM met the needs of the stakeholders; that they were proud of and developed ownership of the model and that a degree of mutual support was foundation of its sustainability. The final chapter will incorporate a discussion, synthesise the findings and make recommendations for the future.

CHAPTER SEVEN: THE SYNTHESIS OF FINDINGS, DISCUSSION AND CONCLUSION

This chapter presents a synthesis of the findings of this descriptive case study. While the reader is cautioned that case studies by definition are not generalisable as they are bound by context, many of the findings of case studies may be transferable to other contexts. Maternity services and education providers might consider the description and findings of this case study as a guide or impetus to assist them to develop a similar model of CoMCE for all midwifery students, acknowledging that there are particular challenges for employed Graduate Diploma of Midwifery students. Within this chapter I will use a process of 'abduction', commonly used in case studies, which is defined as "using the best explanation for the facts collected" (Thomas 2011). The process of abduction is used as a technique to synthesise the many findings of the case study. Although evaluation was not a focus of this case study the synthesis considers whether the aims and assumptions of the SWIM model were addressed. This is followed by further synthesis through the lens of the concept of a circle of support that is proposed as a unifying construct. The chapter concludes by exploring the limitations of this case study and by making recommendations for maternity services and midwifery educators who may want to set up a similar model in their setting; recommendations that have arisen from the analysis of this case study and are underpinned by Change Management Theory.

INTRODUCTION

Addressing the objectives and assumptions of SWIM is an important aspect in this discussion. When the SWIM program was planned and implemented there were certain objectives which were considered a focus in establishing this model of care. The main aim was to address the needs of all stakeholders in the maternity service. Through using the interactive model of program planning as a structure and reviewing the documentation, the case study revealed that this aim was well addressed. Table 14 provides an overview of the SWIM objectives together with a brief description of how each objective was met. It is apparent that these six objectives played an important role in guiding the implementation

of SWIM and in establishing benchmarks against which the project could be measured.

Table 14: Summary of how the SWIM program addressed he Program objectives

Stated objectives	Objectives Addressed
Three student midwives will care for four women birthing per month in a Continuity of care model called SWIM	In order to ensure continuity of care 4 women were booked per month for 10 months of the year. The exception was February and March as this coincided with the completion of one student group and commencement of another ** (Chapter 4. 2).
Student midwives will be supervised by named facilitators.	The named facilitators(CMC&CME) supervised 97% of all clinics in the five year period with a senior midwife facilitating the remaining 3% (Sim & Gilroy 2008a) (Chapter 4. 2).
There will be equity in access to the SWIM clinic for student midwives	The student roster created by the educator provided equity of access to the SWIM clinic and this roster was supported by management in all areas of the maternity service to which the students were rostered (Chapter 4.3).
There will be a robust and equitable on call system	The initial on call system was organised by the educator and as the SWIM team developed independence, they arranged their own on call system (Chapter 4.3).
There will be a student midwife rostered in antenatal, clinic and postnatal, to increase the opportunity of continuity of care for women in all areas in rostered hours	The full roster (the full clinical midwifery rotations) addressed the requirement for a SWIM student to be allocated to each area of maternity service, thus increasing access and care for SWIM women (Chapter4. 3).
Student midwives will be called by core midwives when the woman presents antenatally or in labour	Following initial education to the core midwives, the SWIM students were informed when women presented in labour, but not always when women presented in the antenatal period (Chapter 4.3).

** Indicates in which chapter of the thesis supporting data is presented.

In line with the case study methodology multiple data sources were examined to explore assumptions relating to the SWIM model and its ability to assist

students to fulfil the CoMCE requirements for registration, and provide women with continuity of care. As revealed in the preceding chapters, the data from a range of documents related to SWIM including the student midwives CoMCE diaries, Obstetrix database, key stakeholder interviews and focus group provided rich sources of information to address these assumptions as indicated in the summary Table 15 below:

Table 15: Summary of how the SWIM program addressed the assumptions governing the set up and implementation of the program

Assumptions	Assumptions addressed
SWIM will fulfil the CoMCE requirements of the ANMC for midwifery registration.	The SWIM model adequately provided the opportunity for the ANMC CoMCE requirements to be met. The data indicated that a greater number of women than required were cared for by each student in this model (Chapter 4. 6).
SWIM will provide continuity of care for women at Hornsby Hospital.	Continuity of care was the core focus of this model and the data indicated that on all occasions the women received and also perceived they had received continuity of midwifery care (Chapter 4.5 & 4.6).
SWIM will provide a sustainable model of CoMCE at Hornsby Hospital.	SWIM has been a robust and sustainable model of care for student midwives and women for seven years and is embedded in the organisation (Chapter 5).
All maternity unit stakeholders will have an understanding of the SWIM program.	Managers, student midwives, facilitators, transitional midwives and women's views were addressed in this data. There is evidence that these stakeholders have a unique understanding of the SWIM program (Chapter 5).

Synthesis of findings: addressing the objectives and assumptions

As summarised in Tables 14 and 15, this case study has demonstrated that the objectives and assumptions of SWIM were addressed. The model has provided continuity of midwifery care for women at Hornsby Hospital, whilst fulfilling the CoMCE for students in this facility. There has been evidence of equity of access to the SWIM clinic, to birthing unit and to postnatal services. The SWIM students were called by core midwives for labour and birth consistently. The

major stakeholders of this model had a rich, unique understanding of SWIM and the model is sustainable and is embedded in the organisation. The experience of the stakeholders associated with SWIM are summarised, synthesised and discussed in the following section.

Addressing the stakeholder's perspectives

Having addressed the objectives and assumptions associated with SWIM, analysing and synthesising the experience of the stakeholders is important in order to understand the impact and sustainability of the model. This section represents a brief summary of these experiences which are then synthesised and discussed in the final section of the chapter.

The women's experiences

Analysis of the women's satisfaction surveys revealed that women positively benefitted from the model of care. The thematic analysis pointed to the importance of strong relationships between the students and the women with 'relationship' emerging as the major theme. Continuity of care combined with a supportive relationship increased confidence and the feelings of security in these women. Women stated that they experienced something they described as 'beyond normal care' and expressed joy and gratitude to the SWIM team for their care. Women acknowledged that this was a well-supported, student model of care, which involved learning and sharing knowledge. Importantly, a major finding of this study is that women appeared to value helping the students to achieve their goals and valued the reciprocal commitment of the student midwives to support and care for them through their journey.

The student's experience

The student midwives' surveys revealed the students felt they were well supported and were given many opportunities to provide antenatal care to women with sufficient education to learn, maintain and update their skills. The result was they felt that the SWIM clinic had been invaluable to their acquisition of midwifery skills and they felt confident to refer women when needed. A somewhat surprising and unanticipated finding was that despite the on call

component of SWIM often being completed in their own time, they regarded the workload as appropriate and achievable. This could be because they shared the on call and felt supported. Analysis of the comments provided on their surveys reinforced the quantitative responses and revealed the major theme was that of ownership of SWIM by the students. This central theme connected with the student's experience of being supervised and not constrained; valuing the group practice; being confident to consult and refer to doctors; experiencing 'beyond normal' midwifery education and valuing the women's feedback on their developing skills and contribution to each woman's birth experience. They regarded the CoMCE as the key to the development of their competence and confidence as midwives.

The transitional midwives' experience

The midwives in the focus group appeared to speak freely about their relationship with and journey through the SWIM program. They related to SWIM as a friend that had supported them through their midwifery education. They described how they transitioned from student to midwife; how they valued the sharing with other students in the SWIM group practice and valued learning with the women in SWIM. Only one transitional midwife said that she did not miss being on call, whereas the other midwives stated that being on call was achievable because it was shared between the SWIM team. They believed that the model had assisted them to easily fulfil the requirements of the CoMCE for midwifery registration and that this achievement was facilitated by the educators who inspired confidence in them by giving them respect. They felt that the SWIM program was of an appropriate length and that it was a perfect model, celebrated with a picnic of all the families who had journeyed with them through that year.

The manager's experience

The managers described their understanding of and impact of the SWIM model on their role under four major themes of Workforce, Supervision and Learning, Student Experience and the Organisation's Perspective. The overall impression from these themes was that the managers perceived that the SWIM model was

beneficial to all in the organisation. This may have been the major and ongoing reason that they supported the model, but they also felt supported by the facilitators. They were of the view that SWIM did not negatively impact on staffing and they were confident that the students were well supervised. They perceived that the model fulfilled the educational requirements of the students and that the students enjoyed their experience which in turn led to staff retention. The overwhelming impression was that of pride, a belief that the maternity unit was innovative and the model was portable and sustainable.

The facilitator's experience

Four major themes arose from the facilitators' interview data. The two facilitators' were the CMC and myself (the CME) the insider/outsider in this study. The facilitators' identified benefits they received working in SWIM through observing and contributing to the growth of student midwives and organising the progression or succession planning from one group of midwives to the next. They particularly enjoyed being involved in continuity of care which kept them clinically relevant and invigorated. The CME and CMC had developed and championed the SWIM program and had been the facilitators for more than 5yrs. The unspoken word from the facilitators was the level of commitment required to support. Between them they supervised every SWIM clinic. This time commitment could be perceived as a cost to the organisation as on SWIM clinic days the CME or CMC was not available to the rest of the maternity unit. The CMC and CME however did state that they were supported by one another, the management and the students and also felt supported by the women.

As this overview reveals, all stakeholders expressed that in their experience the model fulfilled the needs of women, students and the organisation. They expressed a sense of ownership of the model and described how they supported and in turn felt supported by the model and all the members associated with it. The question that remains to be explored is, "What is unique about the SWIM program that generated this response? Was it the program or the members within it?" A synthesising theoretical perspective is provided by the idea that a circle of support was created in and around the model. In this

final section of the thesis I present an analysis of the circle of support provided by the model.

CIRCLE OF SUPPORT THAT IS SWIM

The experience of all stakeholders in this model could be described as a circle of support. Circles of support are described in many areas of health care (Corte 2012). A circle is a group of people who come together regularly with a common purpose, who think and talk together, then agree and take actions that will further that purpose. It's based on human relationships, and on the way that a group of people working together can harness their mental and physical resources toward a common end (DeMarasse 2014). This can be described in the case of SWIM as a model that underpins woman centred care as it links together everyone involved. The circle of support revolves around and includes the women who were being cared for through SWIM. The women are on the inside and the outside of the circle of support. The data indicated that continuation of the SWIM program was important to all stakeholders; all described support as the key component and they were motivated towards its success.

The women in SWIM spoke about the overwhelming experience of support that they felt from the student midwives and facilitators but importantly also acknowledged and recognised with a sense of pride that they too supported the students. So the circle continues, each stakeholder member providing and receiving support as illustrated in Figure 18.

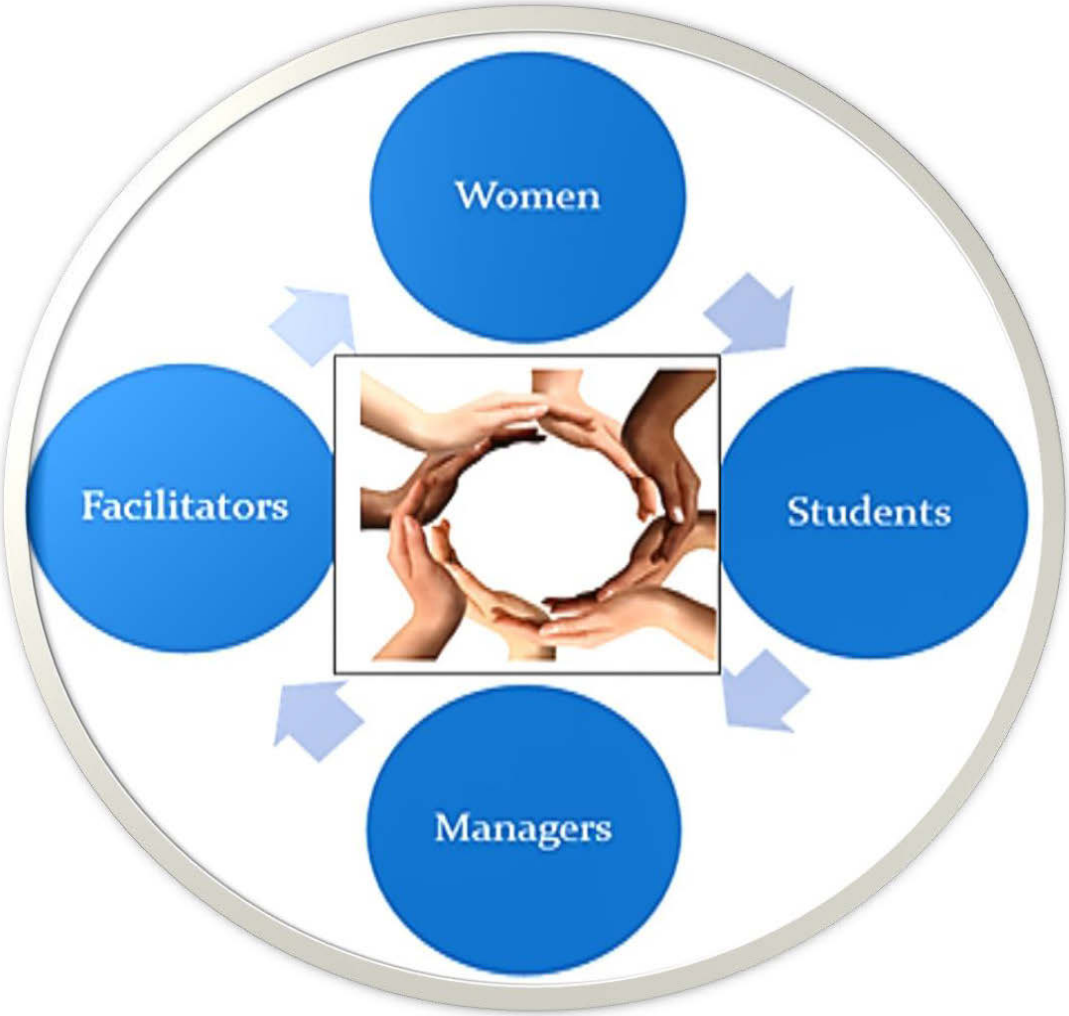


Figure 18: The SWIM Circle of Support, where all stakeholders support one another.

Principles of the SWIM circle of support

There are certain principles that underpin the circle of support, they are; purpose, people, vision, capacity, inclusion, listening, thinking, learning and action (Corte 2013). The first of which is purpose. Circles of support are formed as a result of individuals coming together for a common purpose which in this case was the successful implementation and continuation of SWIM; a continuity of care model for women and students to fulfil the requirements of midwifery registration. The people in the circle of support were instrumental to its protection and each person brought a different skill and perspective. Each member of the circle experienced support in the model, and they in turn supported the model as evidenced in the previous chapters.

A shared vision to aim for the best outcomes for women was important as a focus. The data indicated that the initial vision came from the facilitators and as the model developed the managers embraced the vision, saw its potential and were motivated towards its success. The student midwives vision of the value and uniqueness of SWIM was initially instilled by the facilitators, and then reinforced by previous student midwives' who were educated through the model. Stories from their university colleagues who did not have a SWIM model to assist them with their CoMCE reinforced the value of SWIM to the students. The focus for the women was personal as they were jointly in the centre of the circle as well as supporting its success. Theirs was a vision of continuity of care, building meaningful, supportive relationships in order to have the best outcome for themselves and their baby.

A principle focus of circles of support is the capacity of the model and the inclusion of the people in it (Eade 1997). Capacity looks at the individual strengths of each member and how they contribute. In the case of SWIM, the manager's support was essential to the model as without managerial support the model would not have been sustainable. Within the workings of the model, the facilitators brought different strengths and gifts to both the education of the students and the care of the women. The student midwives brought different personalities, perspectives and strengths. The students met regularly to facilitate the smooth running of the clinic, organise their on call and care for one another's needs within the group. As with many groups, individuals within, adopted certain roles; some organisational, others artistic and some developed leadership. Of greatest importance in this circle was trust, creating an environment where all the members were respected and given the opportunity for honest dialogue. Any potential conflicts were discussed and resolved. Inclusion of all members was a primary focus and working towards the best journey for the women within the model.

An important factor in circles of support is mindful listening and thinking. The opportunity for all members of the circle to have a voice in order to forward its purpose was essential to assist in its direction and the quality of the care given. The data indicated that each new group of student midwives worked together to create a renewed identity of the model whilst retaining its original name.

Supported by the facilitators the students created banners, baby singlets with the SWIM logo and baby 'beanies', photo albums, all created collaboratively by the students in the circle. Women, who were happy to have their photos displayed in an album, signed a corporate photography consent form which was filed in their medical records and a copy in the SWIM folder. Developing a creative expression required each member to mindfully listen to each other's input and collaboratively think of an appropriate representation of their particular group. This collaboration within the model extended to the learning journey. One of the roles of the circle of support, particularly around an educational model of care and the women for whom the care is provided, is openness to learning (Neill & Sanderson 2013).

The SWIM circle of support was based on the principle of learning and the flexibility to safely adapt to the needs of the women and participants in the model. The facilitator's perceived their role as primarily an educational one. As an educational model, both the students and women expressed how the model and the support around the model assisted them on the learning journey. For the students the learning was around midwifery skills, communication skills and adjusting to the differing needs of women and their families. The student midwives expressed that they experienced an empowerment to be themselves, not restricted by the facilitators. This resulted in the students' experience of the facilitators not having 'power over' the students, but sharing of roles and responsibilities within the model. Arguably the facilitators generated 'power to' the students which engendered 'power within', the circle and enhanced the level of commitment and care that the women experienced.

The ultimate goal of the circle of support is action (Falvey et al. 2000). The members of the circle honoured the commitments they made to the women, the model and each other. The managers committed to supporting the model and supported the rostering of students by the educator. The managers were also flexible when the student midwives were called in out of hours and were cognisant of their needs. In seven years there has only been one instance when a SWIM student was not available for the clinic. The facilitators honoured their commitment to supervise the clinic and oversee the SWIM model of care and have been present at over 95% of clinics in seven years. It was extremely

rare for a woman to not attend an antenatal appointment, invariably the women reminded the core midwives to call their SWIM student for the labour and birth and 97% have returned their evaluation forms. This level of commitment from the women was exceptional and indicated that they too valued the model and were motivated towards its success. It is remarkable that a large number of SWIM women returned to have their subsequent babies with SWIM.

Women learning in partnership with students

A major finding from this case study is that the women in the model spoke about the learning they experienced about their pregnancy in the model and described how much they enjoyed learning in partnership with the students. They described how they believed they supported the students in their journey to become midwives, which gave them a sense of pride. They believed the students had access to current midwifery knowledge and appreciated the students sharing this knowledge with them. They trusted their SWIM students. This promoted a radical openness to learning for both women and students which in turn empowered the student midwives to share their knowledge with women in an environment conducive to learning. It could be argued that the facilitators may have been perceived by the women to be the central continuity of care provider. The responses of the women indicate that the women acknowledged and appreciated the facilitators input, yet they valued the relationship with the SWIM students and saw the students as their midwives. In fact in many of the comments made by women in their evaluations, the women often referred to the student as “my midwife” when describing care during their labour and birth. This mutual support between the SWIM students and women appears to be the cornerstone of the relationship.

The responses from all participants in the program described how they supported one another for the common cause which in this case appeared to be the successful implementation and continuation of the SWIM model.

Reflection on my insider- researcher role in this case study

As discussed in Chapter 4, I have a unique position of being involved in the SWIM program. I was involved in the development of this model, I continue to facilitate it and I have been interviewed as part of this case study. There are both advantages and disadvantages of being an insider-researcher, which need to be acknowledged.

There are three key advantages of being an insider-researcher: (a) having a greater understanding of the culture being studied; (b) not altering the flow of social interaction unnaturally; and (c) having an established intimacy which promotes both the telling and the judging of truth (Bonner & Tolhurst 2002). As an employee and educator, my role gave me access to the research participants and the data required for this case study. I did not have to negotiate regular access to the facility as an outsider researcher would need. In many ways my presence was normal in the facility and I was accepted as part of the team.

The challenge of being an insider-researcher is the potential for loss of objectivity. Case studies are strongest when researcher expertise and intuition are maximised, but this raises doubts about their "objectivity"(Hodkinson & Hodkinson 2001). Being close to the case could have the potential for bias; the participants may have credited me with assumed knowledge and the participants may have wanted to please me with their responses. Unluer (2012) describes how an insider-researcher experiences a role duality and must be aware of both roles as stated by Smyth & Holian in Unluer (2012);

> *'To conduct credible insider research, insider-researchers must constitute an explicit awareness of the possible effects of perceived bias on data collection and analysis, respect the ethical issues related to the anonymity of the organization and individual participants and consider and address the issues about the influencing researcher's insider role on coercion, compliance and access to privileged information, at each and every stage of the research' (Smyth & Holian 2008).*

As described in the Research and Design methodology Chapter Four, the role of ethics and reflexivity have been addressed. A descriptive case study was chosen as opposed to an evaluative one for two reasons, firstly a description of this model may assist other organisations to implement a similar program and this case study may add to the body of research regarding CoMCE; secondly the participants were asked to describe their experience and not evaluate the model. Evaluative data has been used from the document data collection, but the interviews themselves were not evaluative. Potentially, if this was purely an evaluative case study, the participants being known to me may have felt compelled to give the model a positive evaluation.

There were a number of strategies I put in place to reduce any challenges that my presence may have had on the case study. Case study research is concerned with human beings and their behaviour, involving a great number of players, each of whom brings to the research process a wide range of perspectives, including the researcher's own perspective. The perspectives of the women and student midwives were obtained from program documentation and surveys. The women and the student midwives surveys were anonymous, with no identifying features. My academic supervisors assisted me with eliciting themes from this data which reduced the possibility of insider-researcher bias. The managers, transitional midwives and facilitator who participated in the interviews and focus group, were given a choice of interviewer to reduce the potential of bias. I did not hold a position of influence over any of the participants. I was interviewed by the Clinical Support Officer (CSO) in maternity in my insider role as facilitator of the model. All interview transcripts were typed by the CSO, who was also 'note taker' at the focus group and currently ensures all data is locked away. My academic supervisors assisted me in eliciting themes from this data.

Throughout this research process I have been cognisant of my position in this research. I have attempted to address any potential bias. My aim was to triangulate the data by studying the case from a variety of perspectives including the documentation surrounding the model and the stakeholders involved. The objective was to present the case and not my opinion of the case.

It is important to acknowledge ones place when conducting research in one's own facility. It is important to address and overcome the disadvantages in order to ensure credible insider research. This case study has used several strategies to eliminate bias and present SWIM to the reader as a model worthy of consideration.

LIMITATIONS AND OPPORTUNITIES

This descriptive case study is based in its own context. It focuses on one organisation and as such cannot be generalised to all midwifery services. This has been a rich description of the development of SWIM, with reference to the steps of its implementation and the perspectives of the stakeholders involved. One perspective not explored is that of the doctors employed in this organisation. Another perspective could have been a second evaluation sent to the families participating in SWIM possibly six weeks postnatally. This may have had a reduced response rate. These are limitations to this case study and would be a future recommendation. This study does not address the needs of the undergraduate Bachelor of Midwifery students. Gray (2010)) has explored this cohort in detail in her thesis. The detailed description and the women and stakeholders perspective in this study may be of value to other maternity units who are struggling to address this educational requirement for their student midwives. SWIM was not set up as a formal change management process. With hindsight knowledge of the theory of organisational change may have facilitated the implementation process of SWIM as it is potentially a useful structure.

RECOMMENDATIONS

The major recommendation arising from this case study is to use a formal change management process when considering setting up a model such as SWIM. Change is the process of moving from the current state to a vision of the future. This transition creates a fear of the unknown, which often causes distress for people. Change Management is about managing this transition from the old position to the new. Introducing new models of care or ways of working requires planning and awareness of the needs of the members and the culture of the organisation. There are many change management theories in the

literature and I have chosen to explore the theory espoused by Jones (2004) Figure 19 describes eight strategies for change management within organisations developed by Jones and colleagues (Jones, Aguirre & Calderone 2004) that are recommended.

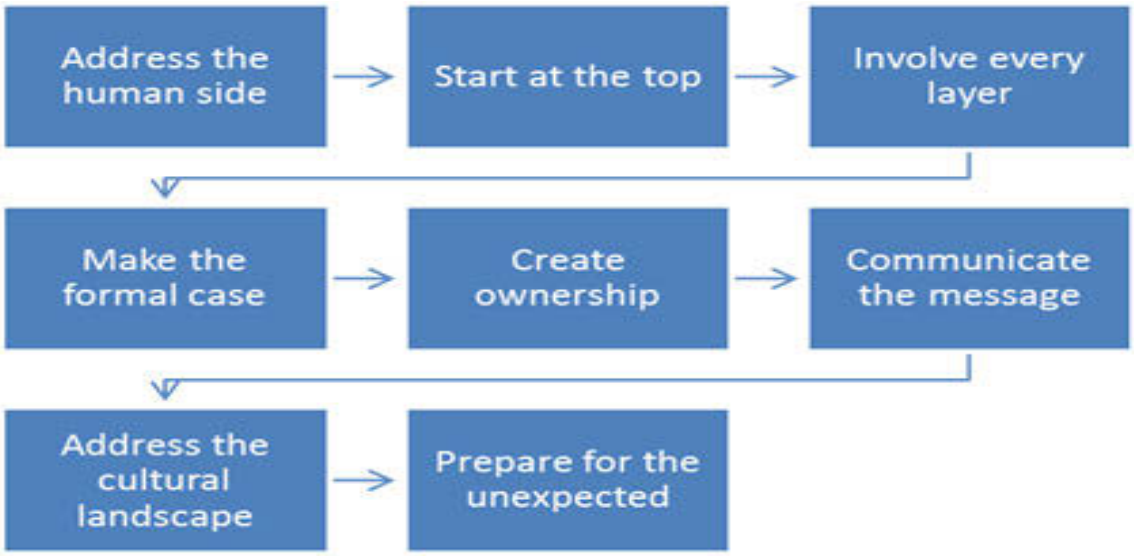


Figure 19: Change management strategies adapted from Jones, Aguirre & Calderone (2004).

Change management theory stresses the need to address the organisation's readiness, its history and capacity for change (Jones, Aguirre & Calderone 2004). This case study described how Hornsby Hospital had the opportunity for change as change was already in progress as the maternity unit was in the process of moving to a new facility; other organisations would need to consider their own capacity for change. According to the specific change management theory espoused by Jones there are steps to follow: the first is to assess the need for change and address the human side of the problem, start at the top and involve every layer of the organisation. In this case the need is for women to have access to continuity of care and for student midwives to access women for their CoMCE. The emphasis is that the change management approach is integrated into every level of program design, all decision making and evaluation. Identifying a leader to champion the change can provide stability and leadership from the top. Involving all stakeholders' managers, doctors, students, midwives and consumers in initial and ongoing discussions can assist in the change process.

The next steps would be to make the formal case, create ownership and communicate the message. The formal case could be in the form of a student midwives' clinic proposal. Creating ownership of the change can take time as stakeholders may be unsure as to how a student midwife model of care may affect them. In this case ownership evolved through a combination of factors depending on the stakeholders' perspectives. Communicating the message can be achieved by educating and informing all stakeholders throughout the process of establishing a model. This can be achieved by providing in service education, creating logos and banners and conference presentations.

Finally, addressing the cultural landscape and preparing for the unexpected is important. Assessing the cultural landscape both locally and professionally is crucial when planning and implementing a new program. Considerations in establishing a student midwife model of care may include; whether the maternity unit is open to change and if change has been successful in the past; the midwifery managers' understanding of the needs of student midwives access to CoMCE; the core midwives understanding of and exposure to continuity of midwifery care; whether there is a learning culture in the organisation and is there a passionate leader to champion the cause. Preparing for the unexpected is a constant awareness process when initiating any change in organisations (Jones, Aguirre & Calderone 2004). By addressing the previous seven steps in Figure 18, the program developer will have minimised unexpected events. The unexpected can be both negative and positive. The unexpected results in SWIM came in the form of the minimal resistance to SWIM once it was implemented. The reason for this may have been that all stakeholders had been involved in the process and another unexpected occurrence was how popular the model became with women, how enthusiastic the midwives were to recommend the model to women and how the model quickly developed its own strong identity. Change management strategies could be a useful tool to assist midwifery organisations to establish a model similar to SWIM which could quickly become embedded in the organisation.

SUMMARY OF THE CASE STUDY

This case study described the process of developing a continuity of midwifery care model for women which equally addressed the needs of postgraduate midwifery students for their CoMCE. This particular group of student midwives had perceived difficulty gaining access to their own model of continuity of care for women, due to their employed status. This case study also addressed certain assumptions and aims of the model. The journey of the women and student midwives through the model was described through the interview and exit evaluation data. The journey of the facilitators and managers was described though face to face interview data and the documentation and archival information associated with the model.

The SWIM program was described though the lens of Caffarella's (2002) model of planning programs for adult learners as this program is also an educational model in clinical practice. This description is contextual. In keeping with case study methodology a case study is bounded in context and cannot be generalised to the general population, however the reader may be able to extrapolate some elements to adapt to their own organisational context. As a result of the facilitators' presentation of this program at various professional forums and conferences there have been several requests for assistance to establish similar models in other maternity services in several states in Australia. Previous SWIM student midwives have assisted in developing a similar model as in the Australian Capital Territory (Sim 2010). Some are organised as student clinics where the students see their own women, others are a venue for student midwives to access, and none to date are based on an MGP philosophy for student midwives in their own model of care.

The perceived difficulty for student midwives to access women for the CoMCE has led to a change in registration requirements for this component in midwifery education throughout Australia (ANMAC 2014). Continuity of midwifery care is considered to be the most effective and satisfying model for well women and should be embedded in midwifery education. It would be a sad loss to midwifery education if the CoMCE was reduced, however achievability within each organisational context must be acknowledged in order for it to be successful.

Ideally, all student midwives, regardless of their midwifery program, employed or supernumerary should be offered the opportunity to easily access a continuity of midwifery educational model specific to their needs.

CONCLUSION

Maternity services are required to provide relevant clinical midwifery experiences to Graduate Diploma of midwifery students who are employed in their organisation. A key requirement of the clinical education is that students are able to 'follow through' a number of women from the beginning of their pregnancy up until 4 weeks after the birth of their baby in order to gain a complete picture of the childbearing experience from the woman's perspective. This model of 'continuity of care' is an evidence based model that has been well established to provide women with the most satisfying maternity care experience with the most favourable outcomes in terms of maternal and perinatal mortality and morbidity. It is therefore the model of care that is most highly regarded in the education curriculum. However few maternity services are organised in this way, therefore few students have access to the model. This case study has described how one maternity service responded to the challenge to provide midwifery students with well supported clinical experiences built around continuity of midwifery care for women. It discussed how a circle of support surrounding this model may have contributed to its perceived success and sustainability. It also considered how organisational changes in both management and the opening of a new facility may also have provided unique opportunities for the SWIM model to be implemented.

This case study describing the SWIM program may contain elements that resonate with others and has the potential to be transferable to other contexts. The purpose of the case study has been to provide a rich description of an example that can be explored by leaders in other maternity services who must grapple with these same issues in both clinical education of student midwives and provision of an evidence based model of maternity care for women.

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Appendix 1: Needs Analysis

Retrospective Student Midwife Satisfaction Survey prior to commencement of Student Midwives Clinic (Needs Analysis)

As part of our ongoing efforts to maintain a high level of midwifery care at HKHS we would like you to complete this survey. We are planning a trial of the new Student Midwives Clinic program. The valuable information gained from your experience prior to the availability of this model, is valuable to our planning for the future. Your responses will help us to improve models of care and provide continuity in the care given to women with uncomplicated pregnancies.

Please circle the most appropriate response.

1. I felt I was regularly given opportunities to provide continuity of care to women in the antenatal period

Strongly Agree Agree Neutral Disagree Strongly Disagree

Comments:

_____

_____

2. I felt supported in the Antenatal Clinic by all staff.

Strongly Agree Agree Neutral Disagree Strongly Disagree

Comments:

_____

_____

3. Sufficient education was provided to learn, maintain and update my skills.

Strongly Agree Agree Neutral Disagree Strongly Disagree

Comments:

_____

_____

4. I feel confident when using the ACMI referral guidelines

Strongly Agree Agree Neutral Disagree Strongly Disagree

Comments:

_____

_____

5. I feel that the student midwife workload in the clinic was at an appropriate level.

Strongly Agree Agree Neutral Disagree Strongly Disagree

Comments:

_____
_____

6. I feel that the student midwife clinic would have been valuable to my acquisition of midwifery skills during my midwifery training..

Strongly Agree Agree Neutral Disagree Strongly Disagree

Comments:

_____
_____

7. I feel that the women would value the continuity of care provided by the student midwives clinic

Strongly Agree Agree Neutral Disagree Strongly Disagree

Comments:

_____
_____

Please comment on the following issues:

Patient load:

_____
_____

Working independently:

_____
_____

The referral process:

_____
_____

Ongoing supervision

_____
_____

Thank you for taking the time to complete this survey. The results will be communicated to you once all surveys have been returned.
Return all completed surveys to Geraldine Gilroy or Janice Sim.

Appendix 2: Quality Improvement Summary

HORNSBY KU-RING-GAI HEALTH SERVICE
QUALITY IMPROVEMENT ACTIVITIES - SUMMARY REPORT

PROJECT # &	Student Midwives Clinic and continuity of care		Does this project have a registration form? Yes
1. Date of Commencement Date of Completion	March 2007 February 2008	2. Contact Person	Geraldine Gilroy / Janice Sim
3. EQuIP Function	Clinical – Continuity of Care Clinical – Access Clinical - Consumer Focus Clinical (x)		
4. Team/Unit/Dept/Section			
Clinical Midwifery Consultant, Clinical Midwifery Educator, 3 Graduate Diploma of Midwifery (UTS) students, Bachelor of Midwifery Student (UTS) , Antenatal Clinic Staff, medical staff for referral			
5. Objective/Purpose			
A recommendation from the Maternity Services Review clinical redesign was to increase continuity of care for low risk women in HKH. There has been an increase in the number of women presenting to the service at HKH and as such there is a number of low risk women being seen by numerous caregivers depending on the availability of the practitioner. We propose to have an antenatal clinic that is staffed by the 3 student midwives under the supervision of the Clinical Midwifery Consultant and the Clinical Midwifery educators. We hypothesise that this model will result in a group of women having more continuity of care during pregnancy. The student midwives will have increased satisfaction with their care model and demonstrate an understanding of the primary health care model. Women will have known caregivers during the pregnancy			
6. Monitoring Method			
Surveys of women and student midwives, needs analysis on previous students. Notes review and birth outcomes collated			
7. Results/Outcomes			
Outcome measures - were 1. Women will have a decrease in the number of caregivers they have during pregnancy. 2. Student midwives will demonstrate confidence in antenatal assessment and referral guidelines by ACMI Significant increase in student midwife satisfaction with education, supervision and support. Increase in confidence using ACMI referral guidelines and antenatal assessment. 24 patient satisfaction surveys (out of 26) returned. Responses included - seeing a small group of midwives was beneficial. – strongly agree - overall satisfaction – excellent - contact or care during labour/ birth - 24 - contact or care postnatally - 22			
8. Recommendations/ Actions			

The clinic now has a name SWIM with ME (Students with Women Innovative Model with Midwifery Education)

This antenatal model of care has been presented at an area forum and at UTS. There has been extreme interest in duplicating this model in other maternity facilities. UTS have an interest in this model of midwifery care.

This model will continue with the next group of students – it will increase the number of women recruited. There will be ongoing evaluation of the model.

Investigate ways to commence small group practices with registered midwives to enable them to increase their continuity of care and allow more women access to a continuity of care model.

Present the model of care at other forums.

9. Review Plan / Follow-up (Time Frame)	

Review – ongoing further evaluation February 2009

10. Comments

This antenatal model of care has been presented at an area forum and at UTS. There has been extreme interest in duplicating this model in other maternity facilities. UTS have an interest in this model of midwifery care.

Received a DOH scholarship for Innovative Models of Care.

Janice Sim

Was this project commenced due to a complaint	No
Was this project commenced due to a RCA	No

PLEASE RETURN REPORT TO QUALITY & SAFETY DEPARTMENT ONCE COMPLETE

Appendix 3: NaMO Innovations workshop

NSW HEALTH

Nursing & Midwifery Office
Innovations Showcase

Thursday 4th December 2008
Dixon Room~ NSW State Library ~ Macquarie Street Sydney

PROGRAM

0830	Registration and coffee
0930	**Welcome** ~ The Modelling Care Project Co-Chairs Dr Vicki Parker (HNEAHS) and Karen Patterson (SESIAHS)
0940	**Psychotherapeutic Relationship Skills** – An education program for Adolescent Mental Health Nursing practice – Julie Ferguson and Greg Clarke, Area Mental Health, Liverpool Hospital
1000	**Targeting Pain:** Early detection and management of pain in older people in the acute care setting – Caroline Phelan, Hunter Integrated Pain Service
1020	**SWIM with ME** – Geraldine Gilroy, Hornsby Hospital
1040	**Protected Engagement** – Fiona Lamont, SESIAHS Mental Health
1100	**Morning Tea**
1120	**Learning to take the pressure down** – Sally Sutherland-Fraser, St Vincent's Hospital
1140	**Introducing a Wound Management Model into clinical practice across all sites within Hunter New England Area Health Service** – Jenny Simpson, Hunter New England Area Heath Services
1200	**The Addiction Medicine Outpatient Clinic** – Soung Lee and Lucinda Scopelliti, Drug Health Services Liverpool & Fairfield Hospitals
1220	**Heart Beads: The creation of a child's journey** – Lexi Dengler, The Children's Hospital Westmead
1240	**The consumer hand held record card for mental health patients** – Scott Brunero and Scott Lamont, Liaison Mental Health nursing Prince of Wales Hospital
1300	**Getting it Right from the Start for Mothers and Babies Project** – Diane Hurt, John Hunter Hospital
1320	**Thank you to presenters** – Vicki Parker and Karen Patterson
1330	**LUNCH**
1415	Break into workshop groups: 1. Evaluation and reporting guidelines 2. Identifying the joys and pitfalls of the projects
1500	**Feedback from workshops**

Appendix 4: Welcome to SWIM for student midwives

What is SWIM?

Students with women innovative model with midwifery education

Congratulations on your decision to apply for midwifery education at Hornsby Hospital. Midwifery is an awe-inspiring profession, where we are privileged to care for women and their families in the continuum from antenatal, birth and the postnatal period. You have the unique opportunity to be involved in and run a small case load with your colleagues. A commitment from the student midwives to this model is essential in order to provide continuity of care for our women and relevant midwifery education training.

BACKGROUND

In January 2007, Hornsby Hospital Maternity Unit, following much consultation, commenced a student midwife led antenatal clinic which progressed into a small midwifery group practice. This continuity of care model received an Innovations Scholarship from the Nurse and Midwifery Office (NaMO) for 2007. It has been continuously evaluated from its inception and the outcomes are exciting.

ANTENATAL CARE

All women at their booking appointment are offered a range of models of care including the student midwives clinic. This clinic is the responsibility of the students and not the Educator/Consultant and they are expected to be at every possible antenatal appointment, birth and postnatal visit. The relationship between student and family often engenders trust and facilitates a positive pregnancy and birth experience. Initially, the students will observe and learn from the educator and will progress to full midwifery care under the supervision of the Educator/Consultant.

SCHEDULE & RESPONSIBILITIES

Each student is rostered on a rotational basis to the clinic. When possible the non rostered students in the team will visit the clinic to ensure the familiarity of the students to the women.

- The students together as a team oversee the care of all the women and the women consent to group continuity of care. There are four women booked to birth each month.
- This student is responsible for preparing notes, sourcing results, ensuring the smooth running of the clinic and appropriately referring.
- Student midwives are on-call for births based on a schedule made with the other students. This may be in addition to paid work hours.
-

ACADEMIC CURRICULUM

This clinic runs under the auspice of a teaching clinic, where the students learn and model 'Best Practice' in a supportive environment. Every experience gained is to be documented in the *Midwifery Practice Portfolio*. From 2012 AHPRA requires that within their midwifery training, a student cares for 20 women within a continuity of care experience. The existence of this clinic will assist you in accessing the women for whom you are caring, which should in turn streamline your midwifery training and optimize your ability to give excellent care. It is anticipated that both yourselves and the families for whom you care, will gain a high level of satisfaction from the experience. This does not prohibit you from caring for additional women in other models of care. It is the Student Midwives responsibility to complete the Learning Objectives, competencies and Midwifery Practice Portfolio designed by the University, the Nurses and Midwives Board and Maternity Unit Educator.

EVALUATION

- Each woman will formally evaluate her experience, in the form of a 'Satisfaction' questionnaire. This is given to them during the postnatal period.
- The Educator/Consultant will analyze data and outcomes and also audit the notes.
- As a student you will formally complete an evaluation of your experience at the completion of your midwifery training. For any further information please contact GG at Hornsby Hospital Maternity unit.

Welcome to midwifery.

Appendix 5: Women's Satisfaction survey

SWIM evaluation for Women

Satisfaction Survey

You have attended the Student Midwife Clinic for your antenatal care. The purpose of this clinic is to increase the continuity of care for women whilst providing a follow through experience for our student midwives. As part of our ongoing efforts to maintain a high level of midwifery care at HKHS we would like you to complete this survey. The valuable information gained from your experience and responses will help us to improve the care we deliver to all of our patients.

Please circle the most appropriate response.

1. Is this your first baby? *Yes / No (If No, please complete question 2)*

2. In my last pregnancy I attended *GP shared care ,Obstetrician, Doctors Clinic ,Midwives Clinic, Team Midwives ,Other*

3. I felt confident that my concerns and questions were addressed during my visits to the midwife clinic.

   Strongly Agree *Agree* *Disagree* *Strongly Disagree*

4. I felt that I received adequate information (verbal and written) to make informed decisions about my treatment and care.

   Strongly Agree *Agree* *Disagree* *Strongly Disagree*

5. Did you know the contact details /phone numbers of the hospital if you had a problem or question before the next scheduled visit?
   Yes *No*
6. Seeing a small group of midwives during my pregnancy visits has been beneficial for me.
   Strongly Agree *Agree* *Disagree* *Strongly Disagree*

   Please comment

   _____

7. My overall satisfaction with the care I have received at the midwife antenatal clinic was
   Poor *Satisfactory……...Good……Very Good…… Excellent…*

8. During the birth I had contact or care from a midwife/student I had met in the clinic
   Yes *contact or care* *No*

9. After the birth I had contact or care from a midwife/student I had met in the clinic.
   Yes *contact or care* *No*

10. I would recommend this model of care to others
    Yes *No*

Please feel free to make comments about your experience

_____

Thank you for taking the time to complete this survey. Please return the completed survey in the envelope provided

Appendix 6: Student midwives satisfaction survey

Student Midwife Satisfaction Survey

As part of our ongoing efforts to maintain a high level of midwifery care at HKHS we would like you to complete this survey. We are continuing with our Student Midwives Clinic program. Your responses will help us to improve models of care and provide continuity in the care given to women with uncomplicated pregnancies.

Please circle the most appropriate response.

1. I felt I was regularly given opportunities to provide continuity of care to women in the antenatal period

Strongly Agree Agree Neutral Disagree Strongly Disagree

Comments

2. I felt supported in the Antenatal Clinic by all staff.

Strongly Agree Agree Neutral Disagree Strongly Disagree

Comments:

---

3. Sufficient education was provided to learn, maintain and update my skills.

Strongly Agree Agree Neutral Disagree Strongly Disagree

Comments:

---

4. I feel confident when using the ACMI referral guidelines

Strongly Agree Agree Neutral Disagree Strongly Disagree

Comments:

---

5. I feel that the student midwife workload in the clinic was at an appropriate level.

Strongly Agree Agree Neutral Disagree Strongly Disagree

Comments:

6. I feel that the student midwife clinic has been valuable to my acquisition of midwifery skills during my midwifery training..

Strongly Agree Agree Neutral Disagree Strongly Disagree

Comments:

7. I feel that the women value the continuity of care provided by the student midwives clinic

Strongly Agree Agree Neutral Disagree Strongly Disagree

Appendix 7: Welcome to SWIM for women

Students with Women Innovative Model with Midwifery Education

Welcome to our midwives clinic.

At Hornsby Hospital as one of your choices for midwifery care, we offer you our SWIM clinic. As part of midwifery training our students provide continuity of care during their pregnancy to a small number of women and we offer you an opportunity to join us. This clinic is run by the student midwives in collaboration with the midwifery educator and clinical consultant. In order to provide quality continuity of care to our women, this clinic runs under the auspice of an educational clinic for student midwives and enhances the relationship between the families and the student.

The commitment to you is to the antenatal period, where you will meet our student midwives, our midwifery educator and clinical consultant. As a small team we care for you and if complications arise, we refer you to the appropriate medical team, but still remain in contact so you continue to receive midwifery support.
Although it is not a guarantee that a student will be with you at the birth of your baby, each of our students rotate through the birthing unit and postnatal ward, which increases your opportunity of continuity of care with them. They also instigate an on call system to increase their availability.

The continuity of care experience is an educational requirement for the registration of midwives and we will provide for you the information brochure and consent form, developed by University of Technology Sydney. What we ask from you is that you complete an evaluation of your experience, so that we can monitor our quality of care and if you wish, add some of your family photos to our album. The aim of current midwifery training is to prepare the students to practice in a variety of models of care including caseloads. We believe that well supervised and supported student midwives will become competent Registered Midwives of the future. By providing continuity of care for you, we aim to decrease the number of midwives that you meet during your pregnancy and enhance your experience.

In January 2007 we launched our inaugural clinic, which continues to be a popular model of care with families and student midwives. It has received excellent evaluations and has won a 2007 Innovations Scholarship for Hornsby from the Nurses and Midwifery Office (NaMO) and been presented at conferences in 2008 and 2012.

Welcome to SWIM.

Appendix 8: UTS Follow Through Brochure (Current)

Appendix 9.1: Monthly Tracking sheet

MONTH: *MARCH 2011* NAME	AGE	GEST @ 1st VISIT	MRN	EDB	G/P	BEST CONTACT	BIRTH	EVAL		POINTS OF CONTACT				
											ANC	L&B	PN	F/U
										JW				
										NP				
										KS				
											ANC	L&B	PN	F/U
										JW				
										NP				
										KS				
											ANC	L&B	PN	F/U
										JW				
										NP				
										KS				
											ANC	L&B	PN	F/U
										JW				
										NP				
										KS				

Each student midwife tracks their points of contact with each woman in SWIM.

ANC= Antenatal

L&B = Labour and birth

PN= Postnatal

F/U = Follow up usually phone calls in the postnatal period up to day 14.

Appendix 9.2: De-identified points of contact summary sheet for one midwifery student in 2011

FOLLOW THROUGH EXPERIENCE: CONTACT SUMMARY

EDB	Woman's MRN	Antenatal contacts	Attended birth	Postnatal contacts	Total contacts
27/03/11	Allison	2	Yes	2	4 +1
12/04/11	Alisa	5		2	7
15/04/11	Michelle	5	Yes	3	8 +1
19/04/11	Barbara	4		2	6
30/04/11	Renata	5	Yes	2	7
08/05/11	Elizabeth	4		4	8
18/05/11	Victoria	4		3	7
21/05/11	Lisa-Maree	5	Yes	2	7
16/06/11	Zahara	2		4	6
21/06/11	Vanessa	6		1	7
02/07/11	Simone	3	Yes	2	5
05/07/11	Miranda	7		-	7
20/07/11	Felicity	4		1	5
22/07/11	Michelle	4	Yes	1	5 +1
27/08/11	Anita	4		3	7
31/08/11	Nuree	3	Yes	2	5 +1
01/09/11	Kylie	5		2	7
08/09/11	Naomi	5	Yes	2	7 +1
22/09/11	Tina	4		1	5
01/10/11	Barbara	3		2	5
02/10/11	Claire	5	Yes	2	7 +1
05/10/11	Katie	4		1	5
04/11/11	Jessica	5		2	7
08/11/11	Jade	5		3	8
10/11/11	Chantal	3		3	6
11/11/11	Kimberley	5	Yes	-	5 +1
24/11/11	Leesa	5		2	7
04/12/11	Emma	4	Yes	2	6 +1
07/12/11	Lina	5		1	6
24/12/11	Belinda	[illegible]	Yes	2	6 +1
19/01/12	Caroline	3	Yes	2	5
23/01/12	Lea	4	Yes	2	6

Appendix 10: Ethics and Site Approval

Health
Northern Sydney
Local Health District

24 August 2012

Ms Geraldine Gilroy
Maternity Unit
Hornsy Ku-Ring-Gai Hospital
Palmerston Road,
Hornsby, 2080, NSW

Dear Ms Gilroy,

1206-202M: *A case study of an integrated model of midwifery clinical education and clinical practice based on continuity of care for women and midwives., Ms Geraldine Gilroy,*

I am pleased to inform you that on the **24 August 2012,** the delegate of the Chief Executive authorised the Site Specific Assessment for the above study on behalf of Northern Sydney Local Health District (NSLHD).

It is noted that the approval covers the following NSW Health site:

- Hornsby Hospital

The documentation included in the approval is as follows:

- NSW LNR SSA Version 2.0 (2011)
- NSW LNR Version 2.0 (2011) dated 17/05/2012
- Masters of Midwifery Candidate. Student Number 94005648
- Meeting with Michael Peregrina and Kathleen Thorpe
- Interview for Midwifery Educator/Consultant
  - Information Sheet and Consent Form, Version 1 dated 17 May 2012.
  - Trigger questions
- Interview for Midwifery Unit Manager
  - Information Sheet and Consent Form, Version 1 dated 17 May 2012.
  - Trigger questions
- Focus Group for Midwives
  - Information Sheet and Consent Form, Version 1 dated 17 May 2012.
  - Trigger questions

At this time, we also remind you that, in order to comply with the *Guidelines for Good Clinical Research Practice (GCRP) in Australia*, and in line with NSLHD HREC policy, the Chief Investigator is responsible to ensure that:

1. ***The HREC is notified of anything that might warrant review of the ethical approval of the project, including unforeseen events that might affect the ethical acceptability of the project.***
2. ***The HREC is notified of all Serious Adverse Events (SAEs) or Serious Unexpected Suspected Adverse Reactions (SUSARs) in accordance with the Serious Adverse Event Reporting Guidelines. Please refer to the Research Office website.***
3. ***Proposed amendments to the research protocol or conduct of the research that may affect the ethical acceptability of the project are submitted to the HREC on an amendment form (including any relevant attachments). For multi-centre studies, the Chief Investigator should submit to the Lead HREC and then send the amendment approval letter to the investigators at each of the sites so that they can notify their Research Governance Officer.***

AURED NEAF REF: ***LNR/12/HAWKE/174***
NSLHD REF NO: 1206-202M,

Research Office
Kolling Building, Level 13
Royal North Shore Hospital
St Leonards NSW 2065
Tel (02) 9926 4566 Fax (02) 9926 6179

Health
Northern Sydney
Local Health District

4. *Proposed changes to the personnel involved in the study are submitted to the HREC on a Change in Personnel Form (accompanied by the investigator's CV where applicable).*
5. *The HREC must be provided with an annual progress report for the study by the 31st October each year. For multi-centre studies the Chief Investigator should submit to the Lead HREC on behalf of all sites. The annual report acknowledgment from the Lead HREC should be submitted to the Research Governance Officer.*
6. *The HREC must be provided with a final report upon completion of the study. For multi-centre studies the Chief Investigator should notify the Lead HREC and the investigators at each site should notify the relevant Research Governance Officer.*
7. *The HREC must be notified, giving reasons if the project is discontinued at a site before the expected date of completion.*

Internet:
http://www.northernsydneyresearch.com.au

Site Authorisation remains valid until the HREC approval associated with this project expires. It is therefore noted that the Ethics approval for this project will expire on 24 August 2017. Should you require an extension an amendment form should be submitted to the approving HREC. Once approved by the Lead HREC you will need to notify the Research Governance Officer.

Yours sincerely,

Production Note:
Signature removed prior to publication.

Susan Siwakoti
Ethics & Governance Officer
RESEARCH OFFICE
NORTHERN SYDNEY CENTRAL COAST HEALTH

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St Leonards NSW 2065
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AURED NEAF REF: *LNR/12/HAWKE/174*
NSLHD REF NO: 1208-202M.

Health
Northern Sydney
Local Health District

11 July 2012

Ms Geraldine Gilroy
Maternity Unit
Hornsy Ku-Ring-Gai Hospital
Palmerston Road
Hornsby, 2080, NSW

Dear **Ms Gilroy,**

Re: LOW RISK /NEGLIGIBLE RISK RESEARCH APPROVAL
1206-182M, (LR)
AURED LNR REF: ***LNR/12/HAWKE/174***
STUDY INVESTIGATORS: ***Ms Geraldine Gilroy,***
STUDY TITLE: ***A case study of an integrated model of midwifery clinical education and clinical practice based on continuity of care for women and midwives.***

Thank you for sending the **Northern Sydney Local Health District (NSLHD) Human Research Ethics Committee (HREC)** a proposal for **Low Risk/ Negligible Risk application** for the above study.

Please be advised that the HREC Executive has reviewed this study and has concluded that the project is qualified as a **Low Risk / Negligible Risk** research project and therefore deemed appropriate for expedited review. Please be advised that your study has now been approved. The approval will be ratified by the Full Committee at the next HREC meeting on 24 July 2012.

The documentation included in the approval is as follows:

- NSW LNR Version 2.0 (2011) dated 17/05/2012.
- Trigger Questions for the Participants. Version 2 dated 25 June 2012.
- Information Sheet and Consent Form, Version 2 dated 25 June 2012 for Student Midwife in 2011.
- Information Sheet and Consent Form, Version 2 dated 25 June 2012 for Midwifery Unit Manager
- Information Sheet and Consent Form, Version 2 dated 25 June 2012 for Educator/Facilitator
- Meeting with Michael Peregrina and Kathleen Thorpe
- Research Plan.
- Interview for Midwifery Educator/Consultant
- Interview for Midwifery Unit Manager
- Focus Group for midwives

It is noted that the approval covers the following NSW Health sites:

- Hornsby-Kur-ring-gai Hospital

It is noted that the study has been assessed by the HREC Executive for ethical and scientific review ONLY and that clearance on the Site Specific aspects of the trial (local sign-off's, legal documentation etc) MUST be obtained from the above listed sites prior to commencement of research. Each site has

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Level 13, Kolling Building
Royal North Shore Hospital
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different requirements; NSW Area Health Service sites require submission and approval of a Site Specific Assessment (SSA) and/or ACCESS Request Form which can be completed at www.ethicsforms.org/au. Please contact the local site for advice on what will be required.

At this time, we also remind you that, in order to comply with the approval of **LOW RISK / NEGLIGIBLE RISK RESEARCH**, in line with NSLHD HREC policy, the Chief Investigator is responsible to ensure that:

1. The HREC is notified of anything that might warrant review of the ethical approval of the project, including unforeseen events that might affect the ethical acceptability of the project.
2. The HREC is notified of all Serious Adverse Events (SAEs) or Serious Unexpected Suspected Adverse Reactions (SUSARs) in accordance with the Serious Adverse Event Reporting Guidelines. Please refer to the Research Office website.
3. Proposed amendments to the research protocol or conduct of the research that may affect the ethical acceptability of the project are submitted to the HREC on an amendment form (including any relevant attachments). For multi-centre studies, the Chief Investigator should submit to the Lead HREC and then send the amendment approval letter to the investigators at each of the sites so that they can notify their Research Governance Officer.
4. Proposed changes to the personnel involved in the study are submitted to the HREC on a Change in Personnel Form (accompanied by the investigator's CV where applicable).
5. The HREC must be provided with an annual progress report for the study by the 31st October each year. For multi-centre studies the Chief Investigator should submit to the Lead HREC on behalf of all sites.
6. The HREC must also be provided with a final report upon completion of the study. For multi-centre studies the Chief Investigator should notify the Lead HREC and the investigators at each site should notify the relevant Research Governance Officer.
7. The HREC must be notified, giving reasons if the project is discontinued at a site before the expected date of completion.

Please refer to the NSLHD Research Office website to access forms such as the amendment form, Annual/Final Report Form, Change in Personnel Form and Serious Adverse Event Guidelines and Forms;

Internet:
www.northernsydneyresearch.com.au

HREC approval is valid for five (5) years from the date of the approval letter. **Your approval will therefore expire on the 11 July 2017. Your first progress report is due on the 31st October 2012.**

Yours sincerely,

Production Note:
Signature removed prior to publication.

Dr Liz Newton
HREC Co-Chairperson
NORTHERN SYDNEY LOCAL HEALTH DISTRICT

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Appendix 11: Student Clinic Proposal

Proposal for student midwife clinics in 2007.

There have been many changes at HKH over the past two years the most relevant of these being the Maternity Review of NSCCAHS. The recommendations from the review were to restructure models of care to reflect increased activity and improved work practices in our new facility.

The recommendations from the review were to increase continuity of midwifery care/carer to 70% of all women. Continuity of care can be achieved in many ways but it involves reviewing the current midwifery led models and increasing these.

There has been an area commitment to support models of care that increase continuity whether this is by group practice, midwifery led models or GP led care.

Midwives are recognised as appropriate carers for women with uncomplicated pregnancies. Many midwives have however, become unfamiliar with changes in the models of antenatal care and are reluctant to work in this model. This further impedes a woman's ability to access the recommended continuity of care model.

RECOMMENDATION

Antenatal care should be provided by a small group of carers with whom the woman feels comfortable. There should be continuity of care throughout the antenatal period. [A]

A system of clear referral paths should be established so that pregnant women who require additional care are managed and treated by the appropriate specialist teams when problems are identified. [D] (NICE clinical guideline 6 2003)

RECOMMENDATION

Midwife and GP-led models of care should be offered for women with an uncomplicated pregnancy. Routine involvement of obstetricians in the care of women with an uncomplicated pregnancy at scheduled times does not appear to improve perinatal outcomes compared with involving obstetricians when complications arise. [A] NICE clinical guideline 6 2003)

The proposal of student midwifery clinics addresses many issues

8. Enabling students to identify and offer care for their 15 follow through women (the UTS requirement)
9. Offering another antenatal clinic that offers continuity of care for women with uncomplicated pregnancies.
10. Providing a venue for the educators/ midwives to support and educate students in real clinical situations.

11. Educating staff about ACMI referral guidelines and support correct referral procedures.
12. Mentoring staff who have an identified skill deficit in antenatal care provision and supervision and education of novice staff.
13. The aim is to move forward with the philosophy of continuity of care models with beginning practitioners and mentoring and supporting practitioners who are unsure or reluctant to embrace this model of care.

RECOMMENDATION

Provide support and training for staff undertaking change and developing new extended roles (pg. 47) Report of the Maternity Services Review (SR1) Northern Sydney Central Coast Area Health

The role of the Educators / CMC / Clinic Co coordinator

- The job description and duties of the educators and clinical consultants clearly identify their duties are for clinical support of registered and student midwives.
- The very nature of their roster code (indirect) means that in normal circumstances they are not counted as part of the daily staffing for clinical work. This does not mean they are not involved clinically however; they have an ability to supervise clinical staff without an effect on the 'staffing numbers'.
- Midwifery educators/consultants have a responsibility to facilitate evidence based practice and support changes that enable this.

RECOMMENDATION

Antenatal care should be readily and easily accessible to all women and should be sensitive tothe needs of individual women and the local community. [C] The environment in which antenatal appointments take place should enable women to discuss sensitive issues such as domestic violence, sexual abuse, psychiatric illness and illicit drug use.

OPERATIONAL ISSUES

1. Selection of women for clinic – these will be selected either at the student midwife booking sessions in the afternoon or be nominated from other bookings that month.
2. Four 4 women will be booked per month (between April and December 2007) – for example the women booked with an EDB in April will be selected from the low risk population already in an antenatal clinic commencing their visits at approximately 34 – 36 weeks.
3. Ceasing the clinic – the last women accepted will have an EDB of late December which allows the students' time to follow through all women by mid-

January. This will ensure they have completed their follow through by the end of their placement.

4. Risk factors – these women will be selected as per low risk criteria from ACMI guidelines. Women will remain in the clinics if they remain low risk. Transfer to a medical clinic will happen if the woman develops risk factors during pregnancy.
5. Initial Supervision – as proposed in the model there will be supervision by the clinical midwifery educator or the clinical midwifery consultant. This will be for the antenatal visits
6. Ongoing Supervision - .this clinic runs under the auspice of an educational clinic for students and therefore will be overseen by the educators/ clinical consultant. As the students develop skills and become more confident with their assessment and planning the clinical educator / clinical midwifery consultant will be in a supervisory role but will be easily accessible for questions and will review notes at the end of the clinic.
7. Mentoring – it is a goal to do some 'succession planning' for other midwifery staff. As such it is envisaged the educators/ clinical consultant can provide a mentoring role for staff interested in progressing their skills in education.
8. Staffing – the purpose of the clinic is to educate students in the continuity of care model. This clinic is an 'educational clinic' and as such shall be staffed by the student midwives as part of their antenatal placement.

FURTHER PLANNING

The concept of midwives being allocated to a group of women can be expanded to enable more women to have continuity of carer in their antenatal period.

Provision of care for four women per month involves a commitment of approximately 2 hours per week. Practising midwives who are not rostered to a 'midwives clinic' but have an interest in providing some antenatal care for development of skills or personal / professional development can be given an opportunity to have their own caseload. The responsibility for arranging the visits and ongoing care shall be that of the midwife. Flexibility is the key to this arrangement – a midwife rostered on to a ward may utilise the 2 hour overlap between morning and afternoon shift etc.

Whilst this is a new concept at HKH this would be an excellent way to increase midwifery led clinics, increase continuity of care and provide an experience for midwives that is more holistic and in keeping with the goals of the Maternity Review.

Appendix 12: Participants information sheet and consent form

INFORMATION SHEET AND CONSENT FORM

A case study of an integrated model of midwifery clinical education and clinical practice based on continuity of care for women and midwives: SWIM with ME

Invitation to participate in an interview

You are invited to participate in a research study into the SWIM midwifery education program at Hornsby Hospital.

The study is being conducted by:

Geraldine Gilroy. Masters of Midwifery (Hons) Research student (RN RM, Grad Dip Nursing Management, Grad Dip Adult Education.)

Professor Maralyn Foureur (PhD), Faculty of Nursing, Midwifery and Health at UTS as Principal Supervisor.

Joanne Gray (PhD) Faculty of Nursing, Midwifery and Health at UTS as Supervisor.

Before you decide whether or not you wish to participate in this study, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish.

1. **'What is the purpose of this study?'**

   The purpose of this case study is to provide an in depth description of a model of midwifery clinical education: SWIM, a continuity of care model for Graduate Diploma of Midwifery students. Describing the model will enable other midwifery units who are grappling with these issues, to examine whether the model (as described) is applicable to their organisation.

2. **'Why have I been invited to participate in this study?'**

   You are eligible to participate in this study because you have been involved in the SWIM program as a midwifery unit manager.

3. **'What if I don't want to take part in this study or if I want to withdraw later?'**

   Participation in this study is voluntary. It is completely up to you whether or not you participate.
   If you wish to withdraw from the study once it has started, you can do so at any time without having to give a reason.

4. **'What does this study involve?'**

   If you agree to participate in this study, you will be asked to sign the Participant Consent Form. The research involves a semi-structured face to face interview. This study will be conducted over one hour at a time and place which is convenient for you. The trigger questions will be supplied in a timely fashion to assist you with the process.

5. **'Are there risks to me in taking part in this study?'**

   There are no foreseeable risks to you taking part in the study.

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6 **'Will I benefit from the study?'**

   Although you may not personally benefit, the planned outcome of this particular research is to gain a richer understanding of the students' journey through SWIM now they are qualified as midwives, any impacts on the organisation and insight into the women's journey. The goal is to provide a report of the experiences of the key stakeholders and an outline of the process used to plan and implement a program called SWIM. Describing the model will enable other midwifery units who are grappling with these issues, to examine whether the model (as described) is applicable to their organisation.

7 **'Will taking part in this study cost me anything, and will I be paid?**

   Participation in this study will not cost you anything. Afternoon tea will be provided.

8. **'How will my confidentiality be protected?'**

   Any identifiable information that is collected about you in connection with this study will remain confidential and will be disclosed only with your permission, or except as required by law. Only the researchers named above will have access to your details and results that will be held securely at Hornsby Hospital.

9. ‘What happens with the results?

If you give us your permission by signing the consent document, we plan to publish the results in a Masters of Midwifery thesis at UTS; relevant professional journals such as Women and Birth and Nursing education journals and also present the results at Australian College of Midwives Conference.

In any publication, information will be provided in such a way that you cannot be identified. Results of the study will be provided to you, if you wish.

10. ‘What should I do if I want to discuss this study further before I decide?’

When you have read this information, the researcher Geraldine Gilroy will discuss it with you and any queries you may have. If you would like to know more at any stage, please do not hesitate to contact her on 94779506.

11. ‘Who should I contact if I have concerns about the conduct of this study?’

This study has been approved by the Northern Sydney Coast HREC of Northern Sydney and Central Coast Local Health Districts (NSLHD & CCLHD). Any person with concerns or complaints about the conduct of this study should contact the Research Office who is nominated to receive complaints from research participants. You should contact them on 02 9926 8106 and quote **AU/6/736D011**.

Thank you for taking the time to consider this study.
If you wish to take part in it, please sign the attached consent form.
This information sheet is for you to keep.

Appendix 13: Consent and revocation of consent

A case study of an integrated model of midwifery clinical education and clinical practice

based on continuity of care for women and midwives: SWIM with ME

1. I,.....
of.....
agree to participate as a subject in the study described in the participant information statement set out above.

2. I acknowledge that I have read the participant information statement, which explains why I have been selected, the aims of the study and the nature and the possible risks of the investigation, and the statement has been explained to me to my satisfaction.

3. Before signing this consent form, I have been given the opportunity of asking any questions relating to any possible physical and mental harm I might suffer as a result of my participation and I have received satisfactory answers.

4. I understand that I can withdraw from the study at any time without prejudice to my relationship to the researcher, Hornsby Hospital or University of Technology Sydney.

5. I agree that research data gathered from the results of the study may be published, provided that I cannot be identified.

6. I understand that if I have any questions relating to my participation in this research, I may contact Geraldine Gilroy on 94779506 who will be happy to answer them.

7. I acknowledge receipt of a copy of this Consent Form and the Participant Information Statement.

Complaints may be directed to Kathleen Thorpe (DONM)

Signature of subject	Please PRINT name	Date

Signature of investigator	Please PRINT name	Date

REVOCATION OF CONSENT

I hereby wish to **WITHDRAW** my consent to participate in the study described above and understand that such withdrawal **WILL NOT** jeopardise any treatment or my relationship with the the researcher, Hornsby Hospital or University of Technology Sydney.

Signature Date

Please PRINT Name

The section for Revocation of Consent should be forwarded to

Geraldine Gilroy
Maternity Unit
Hornsby Hospital
PalmestonRd
Hornsby NSW 2007

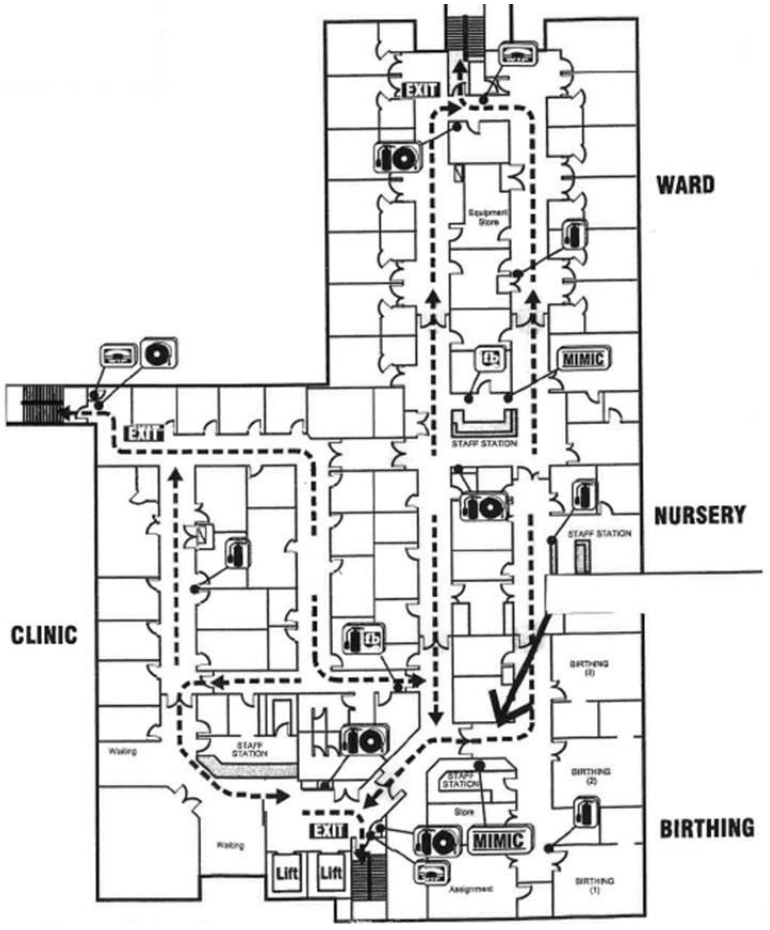
Appendix 14: Structure of the SWIM program

The structure of the SWIM model

Woman accesses care through SWIM booking at 10 -14 weeks. Only SWIM women access the SWIM clinic. The CME or CMC is supervising at all times.

She is welcomed to SWIM usually by meeting all three student midwives. Each women is informed about the CoMCE and offered and alternate person to contact if she wishes to withdraw from the model. A laminated SWIM logo is inserted prominently in her medical records and a sticker on her antenatal card. The woman continues all care in the SWIM clinic and if consultation or referral is required this takes place in the SWIM clinic. If the woman requires an ultrasound or CTG the student accompanies the woman to the place of care.

The three students rotate through the SWIM clinic. Only one student is the primary carer per clinic day, however the student team visit if their work activities permit, or if they are on a rostered day off. The physical layout of the maternity unit as seen below facilitates this access to all areas in maternity.



A SWIM student is rostered to the Birthing Unit, SWIM clinic and maternity ward during working hours which increases the availability of continuity of care for the woman should she be admitted. The SWIM students organise medical records, access tests results, discuss and collaborate to provide woman centred individualised care to each woman.

For labour and birth the students organise an on call system, which usually involves a first and second on call. The contact details of the first on call students is displayed in Birthing Unit. The students balance this on call system taking into consideration the needs of the women and the individual students' needs. For example, if one woman appears to have received more care from a particular student then that student generally makes herself more available for her labour and birth. It would not be unusual for the second on call to be available for the 'receive' and therefore also be present for the birth. As there are four women birthing per month, this generally gives equity of access to births and CoMCE.

As one student is rostered to the Birthing Unit and one to the maternity ward, this facilitates care provision during working hours and does not compromise staffing. Out of rostered hours the students visit the women on the maternity ward and provide care under the supervision of a midwife. They rarely provide home visiting.

Appendix 9.2 demonstrates one SWIM students 'points of contact' with the SWIM women in 2011. The number of points of contact here exceed the midwifery registration requirements.

Towards the end of the current SWIM students' clinical midwifery education, they recruit women into SWIM for the student midwives who will commence after them. The intention of this transition is that women receive continuity of care by their primary carers. As such no women are booked to birth in the last two weeks of the students currently in the role and for the first four weeks of the new students commencing. The new student midwives have usually met the SWIM woman prior to commencing when they are orientated to the role by the outgoing student midwives.