

GUIDE TO TEACHING, LEARNING AND ASSESSMENT FOR MIDWIFERY PRECEPTORS AND STUDENT MIDWIVES

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TEACHING AND LEARNING

1. INTRODUCTION TO THE ROLES OF PRECEPTORS AND STUDENT MIDWIVES

1.1 Introduction to the Guide

This Guide was developed as a result of the experiences of preceptors and students in the initial years of the Midwifery Education Program (MEP). Through preceptor workshops, student and faculty meetings, and evaluations, we have collected information about effective teaching techniques and evaluation benchmarks. Students have given us feedback about students' needs for support for their learning, their need to be introduced to skills in a timely way, their need to be guided and given the opportunity to demonstrate skills and to be assessed fairly, to a consistent standard. The Suggestions for Learning and Teaching Sections reflect suggestions shared with us by many preceptors and students.

The Guide is intended to be a 'living resource' which will continue to evolve each year as preceptors and students give input about their needs, what works and what doesn't work in order to teach and learn midwifery. Your suggestions for further development of the Guide are welcome.

The Guide is focused primarily on supporting preceptors; however, we hope it will also be helpful to students.

Respect for the importance of hands on learning and a belief in the importance of midwifery as a community-based profession has led Ontario's Midwifery Education Program to place students with midwives in the community for the majority of time they spend in the MEP.

Midwifery preceptors have an important and lasting influence on student midwives. Preceptors welcome students into the community of midwifery. A student's views and understanding of midwifery issues, her practice as a student and later as a midwife will reflect what they see, hear, and learn with their preceptor. The preceptor helps the student to apply and test academic learning, teaches clinical skills, and assesses the student's competence.

Midwives have generously responded to the Midwifery Education Program's need for clinical placements since June of 1994, six months after legal recognition of midwifery in Ontario. Since that time, the demand for clinical placements has increased considerably to correspond with the increase in student enrollment. We believe this integration of teaching and practice contributes to a strong, unified midwifery community.

1.2 Being a Teacher/Practitioner

Becoming a preceptor means adding a new role into clinical practice. Like many clinical teachers in the health professions, some new preceptors may not feel adequately prepared to teach and assess students because they come to clinical teaching through their work as midwives, rather than as teachers. In this respect, midwives are not different from physician teachers and clinical teachers in other professions. Although the roles are different, many of the skills involved in teaching students are related to the skills of being a midwife.

All midwifery preceptors, regardless of their education and teaching experience, need to continually reflect on their practice as teachers as well as midwives. The MEP is committed to addressing the needs of clinical teachers for ongoing education and professional development. This Guide exists as a resource to support preceptors and to keep them connected to the MEP. Preceptor workshops, webinars, website and other forums can be used by preceptors to share skills with each other, and to help all of us continue learning as teachers and assessors. The preceptor information and resources at each site provide further information and networking opportunities. Please send your requests for continuing education topics in writing to the Placement Coordinator. Course tutors are available to preceptors for assistance with teaching challenges throughout the term.

1.3 Roles and Boundaries

Preceptors and student roles and responsibilities are outlined in the materials shared with new preceptors when they certify and the Practice Education Coordinators and in the MEP Policy and Information Handbook contains the most recent MEP policies. Preceptors should be clear about the limitations of their role as clinical teacher and assessor. Sometimes, working with mature students in close proximity for extended hours can diminish boundaries, which may be needed and are hard to re-establish later. It is important for preceptors to be clear about their responsibility to the MEP and to the student; they are teachers and assessors, not friends, counselors or co-workers. Preceptors can respect students as future colleagues, but need to ensure student learning needs are the focus of the student/teacher relationship.

Midwife interactions with students are expected to be in keeping with human rights legislation. Please refer to Appendix C for a summary of human rights and equity information for preceptors.

It must be emphasized that as long as a student is in the MEP, the registered midwife is entirely responsible for client care, whether provided by herself or by a student. For example, if the College of Midwives receives a complaint involving a student, the complaint is processed entirely with the midwife as the caregiver in question. It is important for both preceptors and students to be aware of the preceptor's legal role throughout the Program, even as the student's role changes from providing labour support and monitoring in FUN I to acting completely in the primary role in the **Clerkship**.

1.4 Consistent Evaluation Standards

One of the most common requests to the MEP has been for clearly identified evaluation standards. Preceptors and students want to know what level of competence is satisfactory for clinical skills at the completion of each clinical placement.

Preceptors have worked closely with the MEP to try and ensure consistency in evaluation. We hope the Guide will help to achieve a standard of competence that is consistent across practices. It is important to note, however, that no matter how closely we define levels of competence there is a significant degree of judgment which preceptors and tutors have to exercise in evaluation. This Guide will support preceptors and tutors in making these judgments.

1.5 When to Refer to This Guide

The Guide introduces a framework for evaluating competency at introductory, intermediate and entry to practice levels, and provides examples with clinical competencies. During orientation sessions at the beginning of clinical placements and throughout the placements, preceptors and students can use the Guide to develop learning and teaching plans. Preceptors should refer to the Guide when midterm and final evaluations are done in order to assess the student's level of competence and to further develop learning plans.

2. CLINICAL TEACHING AND EVALUATION

2.1 The Objectives of Clinical Learning

The objectives of clinical learning are the acquisition of clinical skills and the application of student knowledge to practice.

2.2 Clinical Learning Experience Criteria

Clinical learning experiences:

- Must be appropriate for the clinical learning objectives.
- Must be appropriate for the student's level of knowledge and skill.
- Should provide a variety of experiences.
- Must be compatible with the philosophy and theoretical framework of the Midwifery Education Program.
- Should provide for a progressive development of clinical learning.

2.3 Some Myths of Clinical Learning

It helps to be aware of some of the myths about clinical learning in order to be effective in our teaching. Some myths of clinical learning are:

- Being exposed to a situation in the clinical area equals learning.
- If a student is shown something once, they will remember it.
- If a student is told something once, they will remember it.
- If a student has performed the skill a few times, leaves you and comes back the next year, they will know how to perform it.
- If a student is motivated to learn, they will not need many demonstrations.
- If a student has previously been a maternity nurse or a midwife, they will not require much teaching.

2.4 Creating a Supportive Environment

In order to maximize student learning, it is important to provide a supportive learning environment. The preceptor should:

- Demonstrate an empathetic and honest approach to the student.
- Provide clear information about expectations of the student within the practice and the course.
- Provide clinical opportunities and active teaching.
- Provide constructive feedback on an ongoing basis.
- Provide clear and non-judgmental verbal communication.

- Provide ongoing supervision. The degree of supervision should change over time as the student's skills develop.

2.5 Working Collaboratively with Students

Many will have significant previous education and/or life and work experience. Students are expected to take an active role in their learning, to help define their own learning objectives, to continually develop plans for learning and to develop skills at self-assessment. Even though students develop their own learning plans and take considerable responsibility for their own learning, preceptors have a vital teaching role. Quality teaching is critical to the success of student midwives. It affects not only the student's theoretical and technical knowledge but also the student's emotions, values, and behaviour.

For preceptors who previously taught or learned in an informal apprenticeship model, it may be an adjustment to adapt to the formal evaluation process and to the academic responsibilities students have in addition to their clinical role. Preceptors used to a more hierarchical or authoritarian education system may find they need to develop new approaches to working with adult students in a collaborative fashion.

The preceptor's role includes spending time reviewing student's learning plans, and designing appropriate teaching plans that are linked to objectives which both the preceptor and student midwife understand and agree on. These plans should be reviewed at least during the orientation session, at mid-term and at the final evaluation.

Although students evaluate their own performance in clinical placements, the role of the preceptor as evaluator is essential. The preceptor is the clinical evaluator for the MEP and takes responsibility for ensuring that students can competently and consistently perform the skills identified under each course. Furthermore, the preceptor provides appropriate documentation of student competence to the MEP. Even students who are performing well require frequent informal feedback and formal clinical evaluation.

2.6 Learning Styles

Different students have different needs. The same student will have differing needs at different stages of her learning. This is important to keep in mind when there is more than one student in a practice or when a midwife is preceptor for more than one student. Preceptors, like students, have a variety of "styles". Becoming aware

of, and discussing learning and teaching styles, can help preceptors and students to work effectively together.

Appendix B outlines different precepting styles and in what situations to use them. What may seem like issues unrelated to learning, teaching and assessment (conversational styles, sense of humour, energy level) can be very important in terms of enjoying or not enjoying work with another person. Try to find out some of these things about each other, and identify approaches that can maximize enjoyment of your work experience together.

Similarly, orientation to your practice style of labour and birth management (preferences for certain ways of managing 1st, 2nd and 3rd stage) before you and the student are at births together can go a long way towards making a student more confident and more likely to perform well and enjoy working with you.

2.7 Enjoying Working with Students/Challenges of Work with Students

Working with students can bring both challenges and enjoyment to midwifery practices. Students bring energy, new perspectives, interests and resources to a practice. They can contribute current theoretical knowledge, which can help midwives to keep up to date. Students are usually keen to develop their midwifery skills and are appreciative of the teaching, assessment and encouragement provided by preceptors. Students can share the midwives' clinical workload, working as part of the team of care providers.

It can sometimes be difficult for midwives to share the relationships they have with clients. It takes energy and skill to present students to clients, to be teaching and assessing during prenatal appointments, labours, births and postpartum visits. Many preceptors however enjoy the added challenge and complexity of providing good care while teaching. They also enjoy sharing their skills and knowledge, and value the contributions that students bring to the practice.

Preceptors and students both need support from peers. Some practices regularly discuss teaching challenges at practice meetings and brainstorm approaches and solutions. Sharing problems, dilemmas and solutions between preceptors and students is essential to developing critical thinking skills and improving teaching and learning. It is essential that this kind of sharing and discussion be done in a manner that is respectful and maintains confidentiality. Preceptor webinars are another place where peer support and information sharing happen.

2.8 The Client as Teacher

A valuable member of the clinical teaching process is the client. The ability to participate in the teaching process, to question and challenge students and to give feedback about their care comes easily to some clients. For many others, encouragement and suggestions from the precepting midwife help the client to feel comfortable participating in teaching. By involving the client as teacher we make the teaching/learning process transparent, rather than hidden. We also avoid objectifying the client during the teaching process by keeping their experience as the focus. Providing clients with information about the role of students and the MEP can help them to feel more involved. Some practices include information about students in their informed choice package.

Encourage the client to give the student both immediate and retrospective feedback about such things as counseling, history taking, physical assessment, abdominal examination, and internal examination. You can invite the client to reflect on questions such as the following:

Did the student:

- Listen respectfully to my questions and concerns?
- Communicate information effectively?
- Offer choices in a supportive manner?
- Seem confident and competent in clinical skills?
- Help me to feel confident?
- Use touch in a respectful and comforting manner?
- Make clear his/her level of knowledge and involve the preceptor appropriately?
- Clearly value my needs and support my choices?

These kinds of questions can help a client give valuable feedback to a student. Some practices give clients the opportunity to provide written feedback to the student.

2.9 Maintaining Client-Centered Care in a Teaching Practice

Sometimes, practice groups feel that they may have to choose between prioritizing excellent care for clients or prioritizing teaching. Clients may have had bad experiences in the past in a teaching hospital or other setting and feel reluctant to involve students. Preceptors and students need to reassure clients and emphasize their commitment to ensuring that quality of care is not reduced when students are involved. Most teaching practices find care is enhanced for their clients. Clients in a teaching practice should be informed from the outset of care that students will be involved in their care.

After the client has met the student at a couple of appointments, it may be helpful for the midwife to ask the client to voice any concerns they might have about working with a student so that these concerns can be addressed. Regular “check ins” with clients reduce the likelihood of a client feeling disempowered and being unhappy with their care in a teaching practice.

Practice groups are encouraged to review all oral and written input from clients about the role of students in their care and to plan adjustments as necessary. Input about student involvement may also be gleaned from QA client questionnaires and may provide ideas for overall approaches to including students in client care.

2.10 Appropriate Volume of Clinical Experience

The MEP provides guidelines found in both the materials provided to new preceptors, Practice Education Coordinators and the MEP Policy & Information Handbook regarding the number of appointments, the number of births attended, and in some cases the number of times certain skills should be observed, and practiced. It is important for preceptors to be familiar with these requirements and to provide these opportunities for students. Where this is difficult, the preceptor should contact the appropriate course tutor as early as possible to help develop an alternate plan for the student. Both students and preceptors should take responsibility to keep track of whether adequate clinical opportunities are available.

Preceptors may find simulated practice helpful, especially when clinical experiences are limited or a student is having difficulty learning a particular skill. Most clinical skills can be practiced outside of labours, births and prenatal and postpartum appointments with actual clients. Students can be asked by the preceptor to “talk through, then walk through” competencies, first describing in detail how they would perform clinical skills, then acting them out. Often, other students, midwives, friends, family can be “practiced on.” Where appropriate, drawings can be used, miming of hand manoeuvres is helpful and models of the pelvis, torso, fetus, placenta, and cervix can be used to good effect. While simulated model practice situations cannot always replace clinical ones, they help prepare students prior to “real” experience. They are excellent opportunities for teaching and some kinds of assessment and they fill in experience gaps for students when clinical situations are not naturally occurring.

2.11 Active Teaching and Teaching Plans

Preceptors are valued not just for their ability to provide clinical opportunities but also for their skills in actively teaching. This teaching role takes place both during real life situations and during mock situations created especially for active teaching. Even the most self-directed, skilled students benefit from preceptor teaching.

A good first step is to assess a student's level of understanding and skill competence, and then build on that level by increasing the complexity of the knowledge and skills required. This should be done gradually with frequent assessments of the student's progress. Increasing complexity should be demonstrated step by step in order for learning to be efficient. Ask the student to describe what they have just done in order that you may assess whether their learning is correct. Remember, students bring previous learning and socialization to their new role and this can either enhance or hinder their learning.

Just as students benefit from learning plans, preceptors may wish to develop teaching plans. At the beginning of each clinical placement, review the clinical competencies you will be assessing by referring to the clinical evaluation form. Together with the student, estimate how often and in what situations opportunities to perform competencies will likely present themselves.

As experienced practitioners we often use short cuts in our skills, both in physical assessment and in making judgements. We tend to forget that to learn complex skills in a competent fashion we must be taught the specific basic steps of the performance. Two examples of complex skills requiring step-by-step instruction are abdominal palpation and internal examination. The preceptor will need to break down these skills into components in order to explain them to the student.

The preceptor should also consider ways to work with and supplement clinical opportunities. For example, in FUN I when students are first delivering babies, have the student walk and talk through 2nd stage management and the delivery a few times prior to an actual birth. Soon after an actual delivery, have the student review how the labour and birth went as well as what they did with their hands; what went well and what needed improvement. The student needs time to reflect in order to explore previous experiences and gain an understanding of them.

Ask the student to present a brief summary to your practice group about the parent's positions in second stage, or on techniques to avoid lacerations, and to be prepared to answer questions from the midwives. If a student needs practice with hand techniques, a visual method of learning may be helpful. Examples include the use of a doll and pelvis or doll and torso or the numbers on the clock for describing the sagittal future when assessing fetal problems. If the student's

communication with the client in 2nd stage is problematic, you can use role-playing to review the situation and act it out differently until the student learns new communication patterns to try at the next birth.

Students can benefit from the use of layered scenarios for learning about difficult management situations that do not happen frequently. The preceptor can review charts of previous clients with the student. Using a step-by-step approach, the preceptor can describe what happened next and ask the student to suggest what could be done at that point.

These are just a few examples of ways that preceptors provide active teaching. By being more engaged in actively teaching, midwives have a better grasp of student learning needs. Members of the MEP faculty are always available to assist preceptors in developing teaching and evaluation strategies.

2.12 Feedback

Preceptors are involved in an ongoing process of providing feedback to students, which can be written as well as oral. Notes about what was done well or not performed well, taken during clinical interactions, serve as reminders for feedback sessions and provide support to recommended grades.

Ideally constructive feedback is:

- Specific.
- Descriptive and informative.
- Focused on skills and behaviour rather than on the person.
- Appropriate to the student's level in the Program.
- Collegial and involves the student in self-evaluation.

(Adapted from workshop material of University of Toronto, School of Occupational Therapy and Physical Therapy)

Feedback sessions usually work best if the student is encouraged to begin with self-evaluation and identification of learning needs. Preceptors can then compare their assessment with the student's evaluation and plan. Learning and teaching plans can be established out of these discussions. It is important to summarize the discussion, so that both the student and preceptor are clear about the plans and expectations for follow-up.

Consider the timing of feedback. Some feedback is appropriate to give while providing client care. In other situations, a discussion at a later time, away from clients, is necessary.

One of the most important ways a preceptor can assist a student to learn about receiving and integrating feedback is by modeling. Preceptors can acknowledge both clinical and precepting “mistakes” and demonstrate for students the ways in which midwives both seek and integrate feedback from peers and other professionals in day-to-day practice. Practice groups can use practice meetings and peer review sessions to model professional ways to both give and receive feedback.

When offering suggestions for improvement, always strive to be objective. Critique and evaluation must take the form of comment about behaviour or performance, not about the person. Here is an example: “When you were examining Mary’s baby last week, and the client they asked if the baby could be given alcohol to help him to sleep, you rolled your eyes and said loudly: ‘Don’t you know alcohol is not okay for babies?’ The words you used sound punitive and are not appropriate for providing support and information. Eye rolling is a body language signal, which distances you from the client and denotes lack of respect. These are significant communication problems which interfere with your ability to care for the client. Not “You know I’ve just noticed with parents and babies ...well it’s probably just that you’re young and you don’t have children yet... you just seem so insensitive, and I’m not sure you’re going to be able to show the compassion needed to become a midwife.”

Remember to note and provide praise for good clinical performance. Students will benefit from hearing about why their performance is good. For example: “When we were at Kata’s labour last week, you provided excellent labour support helping her to change positions, get in and out of the bath when Kata was having difficulty moving, and taking turns with Kata’s partner giving lower back pressure. Your responses were respectful of Kata and their partner, and you showed a good understanding of which labour support maneuvers would often work in advanced labour.” This is much more helpful than “You know you’re great at labour coaching!” Understanding the rationale behind skills which are clinical strengths is as important to learning as understanding clinical difficulties.

When a student is having difficulty it is particularly important to try teaching the skill a number of different ways, and to document your efforts and the student’s performance. The student’s tutor can act as a resource, suggesting objective phrases that can be used for feedback sessions and on evaluation forms. Whenever problems with clinical performance are present the preceptor should ensure that both the student and tutor are informed about it before meeting together to finalize the evaluation. It is critical that students know early in a placement when they are having problems in performing skills. It should not come as a surprise to the student during formal evaluation sessions.

Assessment is rarely stressful when a student performs well but is almost always stressful when the student is not performing well. As a preceptor in these situations, first make sure you have provided sufficient clinical opportunity for the student to learn and to demonstrate improvement. It may also be helpful to ask other preceptors who have observed the student's work to provide verbal and written feedback to both the student and official preceptor. Talk with the tutor early in the placement to get help if a student is having difficulty or if the student and preceptor disagree or are finding themselves in a conflict.

2.13 Formal Evaluation Process

Each clinical placement provides two opportunities for formal evaluation: one at the middle of the placement ("mid-term evaluation") and one at the end of the placement ("final evaluation"). If learning and teaching plans are well utilized, students and preceptors will be well prepared for the formal process. The student is responsible for providing the preceptor with evaluation forms, for organizing the evaluation sessions and for sending her completed evaluations to the Program.

Each preceptor and student must complete an evaluation form separately before sitting down together. Set aside enough time to formally review the completed forms together. Both student and preceptor must document comments and examples on the form. This should be done before the student and preceptor meet with the course tutor, which may be in person, or by teleconference. Be sure to use concrete examples to illustrate competencies, which have been performed well and those that have not been done adequately.

Some students may benefit from taking longer in the Program and repeating clinical placements. While students rarely welcome this prospect, it may be their best chance to successfully master skills and become a competent practitioner. Do not provide a passing grade to a student whose clinical performance does not demonstrate the level of competence required by the Program. If in doubt, contact the tutor and discuss the situation and your concerns.

3. MEP EXPECTATIONS OF STUDENTS IN CLINICAL PLACEMENTS

The MEP has a workshop to orient students to clinical placements as a regular part of intensive courses, e.g. prior to the **Fundamentals of Midwifery** and **Senior** placements. The following is a summary of the information that is discussed before the first clinical placement.

It is important that students understand the role of the clinical placements in the larger context of midwifery practices providing care for childbearing clients. There are multiple demands on a midwife and the practice in taking on students. The preceptor makes a significant time commitment to assist the student to meet their learning needs. The preceptor's time may not be very flexible and they will expect the student to fit into the already existing rhythm of their midwifery work. The student will need to be available to work within the expectations of the preceptor and the practice group, especially when it comes to scheduling of client appointments. The preceptor is expected to ensure that reflective time is planned to allow review and feedback about clinical learning and that there is time to plan special learning sessions or workshops.

It can be challenging for preceptors to balance the student's and the client's needs. It is crucial that students remember that the focus in midwifery care needs to be on the childbearing client, not the needs of the student. Most clients are willing to have students involved in their care, but that is not why they choose midwifery care. It is important to realize that the preceptor is the legal caregiver, even during the **Clerkship**, and is ultimately responsible for all the care given to the client.

If the student is aware of any potential for conflict of interest, it should be discussed with the tutor. Conflict of interest can arise when there is a previous or present relationship other than student/preceptor or when there is an expectation of a future relationship other than that of student/preceptor. Students can refer to the "MEP's Conflict of Interest" document for further information (Appendix A).

The MEP expects students to be respectful of the opportunity preceptors provide in sharing their clients, their knowledge, their experience, and their time. Being a preceptor, while having its own unique demands, can also be very rewarding. However, much of the reward depends on the attitude of the student. Students can set a positive stage by being open to and enthusiastic about learning opportunities. They should be able to receive feedback and suggestions with a genuine desire to grow and develop in their understanding of midwifery. Students must take responsibility for their learning needs by expressing those needs to preceptors and other midwives in the practice. Students are expected to contribute to the practice by sharing academic resources, by volunteering for local public speaking events, or by making other contributions. These approaches contribute to positive preceptor/student relationships.

3.1 Orientation and Learning Plan

Students should come prepared for their initial orientation session with a copy of the clinical evaluation from their previous placement and a learning plan which details how the students can achieve their learning needs during this placement. Students should give the preceptor the appropriate evaluation forms and review the clinical objectives of the course with the preceptor by reading the evaluation form and incorporating any further learning needs into their plan. The plan will help identify for the student and the preceptor what active roles each can take to accomplish the objectives of the learning plan. If clinical situations do not present themselves during the term, the student should take the initiative to arrange with the preceptor to work together on some role-plays or layered scenarios to accomplish needed learning.

If students have particular requests for the timing of meetings with preceptors, the half day protected study time, and their three days off-call per month, they should discuss these with the preceptor in order to come up with a mutually acceptable plan. Students should also give the preceptor their tutorial schedule, exam dates and off-call study schedule for the term.

3.2 Role of Student

Students are expected to take full responsibility for client care and client relationships in collaboration with the preceptor, in order to experience the full role of primary caregiver. Students need to prepare for client visits in advance. This is often accomplished by arriving early on the clinic day or by staying after the preceding clinic day. Students should read the charts and look up any conditions or medications that they are not familiar with. They may wish to put “post-it-notes” on the chart with suggestions, to be reviewed with the preceptor, of what the student believes needs to be accomplished with each client and what part the student expects to play in the up-coming appointment.

If the student has questions about care that is provided to a client by the preceptor those questions can be discussed when the student and the preceptor are alone. Sometimes students, while working with a number of midwives in a practice group, may become aware of different approaches within the same practice group. In order to address this question, the student should ask the preceptor how the practice group would like questions about different practices addressed. Some practice groups have special times in their meetings when students can address questions about practice protocols and discuss the student’s changing learning needs.

Some midwives enjoy traveling to births and clinic with the student and use that time as an opportunity to plan client care and to debrief. Other midwives prefer to have their travel time as personal reflective time and will expect the student to make her own travel arrangements. Students need to be very flexible and adaptive to the individual approaches of preceptors. It is particularly important to be aware of this need when changing from one practice group or one preceptor to another.

3.3 Professional Behaviour

Exemplary professional behaviour is expected by the MEP and by midwives in the practice groups. Students must arrive on time to clinic, dressed according to the expectations of the practice group in which they are placed. They should expect to be helpful within the practice, assisting with the type of practice jobs that the midwife would do. For example, in some practices the midwives do the chart filing and so would the student. Students should be very respectful of and polite with administrative staff requesting guidance from the preceptor about any special requests the student might have of the staff.

Students experiencing personal or emotional problems should consider accessing student services at the university or approaching their university advisor. If the student has any special needs during the placement (for example for medical appointments) the student should plan them well in advance with the preceptor and take responsibility for informing clients. Students should inform preceptors and tutors of any problems that might affect clinical performance. The preceptor may be sympathetic, but should not be expected to be responsible for problem solving or making accommodations unless requested by the Program.

3.4 Feedback

Being an adult learner has many challenges, especially as a midwifery student. Clinical evaluation is an essential component of the Midwifery Education Program and will assist students in monitoring their progress throughout the clinical courses. Self-evaluation is an important skill and represents the students' ability to reflect and assess their own strengths as well as areas where improvement is needed. It is the preceptor's role to regularly evaluate the student's progress and provide feedback about knowledge, skills, and professional behaviour, in a timely manner.

Some midwifery students, like other adult learners, find they need adjust to being in a student role, particularly to receiving feedback and to participating in evaluation. Ongoing feedback and self-reflection are integral parts of being an accountable health care provider. Feedback and self-reflection sessions should be handled by the student in a professional manner. The MEP expects students to develop the confidence and skill to self-reflect appropriately, to receive feedback graciously and to give feedback to peers, preceptors and tutors respectfully.

From their experiences with students, preceptors have identified the following behaviours as inappropriate during feedback and evaluation sessions: persistent crying, responding to feedback by arguing or blaming others for clinical performances, remaining silent or appearing to agree when you do not understand or agree with the feedback.

It is both acceptable and professional to let your preceptor know that you do not understand or agree with feedback. It also is appropriate to request time to consider and respond to feedback.

If the student disagrees with the preceptor's evaluation or are having trouble integrating feedback they should work with both their preceptor and tutor to find constructive solutions. Preceptors have identified that one of the qualities they most value in a student is the ability self-evaluate and to integrate feedback.

3.5 Problem Resolution

The preceptor/student relationship is a professional relationship, founded on mutual respect and commitment to good communication. Both the student and preceptor may experience stresses due to the unique demands placed upon them.

It is our experience that most problems that arise in clinical placements can be resolved by the preceptor and student within the practice. If this is not successful (or at any time the preceptor evaluates the student's performance to be unsatisfactory) then the student and preceptor must meet with the tutor. The Program tries to avoid setting up situations that may pose a conflict of interest such as when the tutor and preceptor are in the same practice. However, the midwifery community is small and this may not always be possible. Alternate faculty can be involved in evaluation or problem solving in these situations.

The MEP encourages midwives to be aware that the job of being a student can be very stressful. Students must remember that being a preceptor is a very significant time commitment for the midwife and can be much more stressful than working without students. We hope that both student and preceptor will focus on the rewards of working together.

Students should be aware that there is diversity among preceptors and practices. They should be prepared to adapt to different teaching and practice styles with a genuine desire to learn from each experience.

Problems in the clinical setting must be identified early by both preceptor and student and addressed according to the following chart:

- **Identify problem**
- **Document it**
- **Student and Preceptor discuss problem**
 - **Do they agree?**
 - **Yes – Plan together and resolve**
 - **No – Refer problem to tutor**
- **When to refer problem to tutor:**
 - **If preceptor and student do not agree**
 - **If problem is not resolvable**
 - **If problem is recurring**
 - **If problem is serious (could affect whether student passes the course)**

4. **DEFINING ‘SATISFACTORY’**

4.1 Midwifery Education Program Levels of Clinical Competence For Student Midwives

A guiding framework for the evaluation of clinical competence has been developed which describes three levels of competence. Each skill will be described under the following headings: Learning Opportunities, Program Competency Requirements, Suggestions for Learning and Teaching, and Describing the Levels of Competence.

In the Guide to Teaching, Learning and Assessment, major clinical skills are identified. The first section heading under each skill is LEARNING OPPORTUNITIES. This section identifies when the skill is first introduced to the student, and when the student should have opportunity to practice the skill and be evaluated by the preceptor. The Program expects that preceptors will facilitate adequate opportunities for learning. We expect students to take responsibility for developing relationships with preceptors and clients that will maximize their learning opportunities.

This section provides guidance about the volume of clinical learning opportunities the Program considers necessary for students and what degree of monitoring and supervision by the preceptor is needed. The course tutor must be notified as soon as possible if there are issues in a placement which will result in inadequate clinical learning opportunities.

The second section heading for each competency is PROGRAM COMPETENCY REQUIREMENTS. In this section, the Program’s expected level of clinical performance for students is described clearly. For example, at midterm of the **Fundamentals of Midwifery I** clinical placement, the student should have

demonstrated Introductory Competence in the performance of a newborn examination. On completion of the **Fundamentals of Midwifery I** clinical placement, the student should have demonstrated Intermediate Competence in newborn examination. On completion of the **Complex Care II** clinical placement, the student should have demonstrated Entry to Practice Competence in the performance of a newborn examination.

The third section heading is TEACHING SUGGESTIONS. This section contains suggestions based on the experience of preceptors and students to help teach and learn most effectively, with the goal of helping students achieve confidence and competence in their clinical skills.

The final section, DESCRIBING LEVELS OF COMPETENCE shows the standards for demonstrated competence in each of the skills addressed. Competence will be described in three levels:

INTRODUCTORY COMPETENCE

INTERMEDIATE COMPETENCE

ENTRY TO PRACTICE COMPETENCE

Course abbreviations:

FUN I & II - Fundamental in Midwifery Care I (previously Normal Childbearing)

CC I – Complex Care I (previously Complications & Consultations)

CC II – Complex Care II (previously Maternal & Newborn Pathology)

TEACHING CLINICAL SKILLS

5. ABDOMINAL EXAMINATION

5.1 Learning Opportunities

Abdominal examination is introduced in the **Clinical Skills Course**. During the clinical placement, the student should be participating in an average of 15-20 client visits weekly. Most of these will be prenatal appointments. The student should practice abdominal examination skills at each prenatal visit attended, with the client's permission. The MEP expects that students will follow all of the clients of the midwife, even those whose births they will not attend, and that students will practice abdominal examination at each visit throughout all clinical placements.

The student should be directly supervised throughout the examination until an intermediate level of competence is consistently demonstrated. This often coincides with the final weeks of the **FUN I** placement, at the point the student has usually performed more than 100 abdominal examinations. After this point, the midwife must be on site to provide assistance if the student is uncertain about their findings, but does not need to directly supervise each abdominal examination. During the Clerkship when students are expected to conduct prenatal care independently, preceptors should confirm fetal position at critical points in pregnancy.

5.2 Program Competency Requirements

At midterm of the **FUN I** placement, the student should have achieved Introductory Competence.

On completion of the **FUN I** placement the student should have achieved Intermediate Competence.

On completion of the **CC I** placement the student should have achieved Entry to Practice Competence.

5.3 Teaching Suggestions

Ensure that the student has sufficient opportunity to practice this skill.

At the beginning of the **FUN I** placement, “walk through” the pattern and sequence of the abdominal examination components with the student. Have the student practice the sequence with a volunteer while you observe, before practising with a client. Suggest how much time is reasonable to spend on each part of the

examination, and what to say to a pregnant client throughout the examination. Present some questions commonly asked by clients to give the student a chance to be oriented before working with clients.

For many of the initial examinations the midwife will want to do their assessments first in order to be better able to guide the student about what to expect to feel, measure, and hear. Once the student begins to develop some comfort with the manoeuvres the midwife may want to do assessments after the student to provide a bit of independent opportunity and to use as a check.

Ensure that the student is sensitized to appropriate touch issues, especially how to palpate firmly enough to elicit information through finger pads, but not to cause pain for the client.

Review the student's theoretical knowledge early in each placement. Provide oral testing about uterine growth, observation, palpation and auscultation skills, concepts of lie, attitude, flexion, presentation, fetal positions, fetal head engagement, and amniotic fluid volume.

With students in **CC I** and **CC II** placements, actively teach and test abdominal examination skills for clinically challenging situations: multiple pregnancy, malpresentations, unstable lie, polyhydramnios, oligohydramnios, lack of engagement at term in primiparous clients, insufficient or excessive uterine growth, lack of fetal heart rate, and abnormal sounding fetal heart sounds. Only a few of these situations are likely to present clinically with your clients during a placement, so active teaching using mock scenarios is critical to help students develop competence in these areas.

5.4 Describing the Levels of Competence

a) Introductory Competence (FUN I midterm)

- Has demonstrated theoretical knowledge about the purpose and process of abdominal examination.
- Can describe and demonstrate observation, palpation and auscultation manoeuvres and their sequence.
- Addresses clients appropriately, ensures that they are comfortable and have emptied their bladder, asks clients to move clothing over abdomen or asks permission to move clothing.
- Warms their hands or if not possible to warm them, apologizes for cold hands.
- Can identify lie, presentation and fetal position with 50-75% accuracy in uncomplicated positions.

- Can auscultate the fetal heart rate with fetoscope with 75% accuracy.
- Understands the concept of engagement and can assess engagement with 50% accuracy.
- Can measure fundal height with 75% accuracy.

b) Intermediate Competence (FUN I final)

All skills demonstrated in Introductory Competence, and in addition:

- Can identify fetal position with 75-100% accuracy.
- Can auscultate the fetal heart rate with fetoscope with 90-100% - accuracy.
- Can assess engagement with 75-100% accuracy.
- Can provide a clinical assessment of amniotic fluid volume by palpation.
- Can assess flexion with 50% accuracy.
- Can identify multiple pregnancy, breech, transverse lie, oblique and mobile/unstable positions with 50% accuracy.
- Can converse easily with clients in normal situations, conveying information accurately and answering their questions.
- With normal fetal positions, is able to complete an abdominal examination in reasonable time and is confident of findings.

c) Entry to Practice Competence (CC I)

All skills demonstrated in Intermediate Competence, and in addition:

- Can identify fetal position, heart rate and engagement with near 100% accuracy.
- Can identify multiple pregnancy, malposition and malpresentation with near 100% accuracy.
- Demonstrates advanced palpation skills, e.g. ballot fetal head wherever located in uterus, identify and mobilize fetal breech to release legs and identify location of parts.
- Can cope with difficult abdominal examination situations, including conveying information and concerns appropriately to the client.

6. PHYSICAL ASSESSMENT OF THE WELL PREGNANT CLIENT

6.1 Learning Opportunities

Physical assessment is introduced in the **Clinical Skills Course**. During the **NC** clinical placement, the student should practice physical assessment approximately 18 times with clients under direct supervision. There should be the opportunity to perform physical assessment approximately 12 times per placement in **C&C and CC II**, with minimal supervision after **FUN I**.

6.2 Program Competency Requirements

On completion of the **FUN I** placement, the student should have achieved Introductory Competence.

On completion of the **FUN II** placement, the student should have achieved Intermediate Competence.

On completion of the **CC I** placement, the student should have achieved Entry to Practice Competence.

6.3 Teaching Suggestions

Discuss with students how they have been taught to perform a physical assessment. Watch the student demonstrate on a student or midwife. Show how you perform a physical assessment on a student or midwife, and if you have particular requests of the student, mention them before you are both with a client.

Have the student observe you perform a physical assessment with a client before participating.

With nervous students, or clients, ask the student initially to only perform parts of the physical assessment, and gradually build expectations within **FUN I** until the student can perform the whole assessment.

Role model for the student the way you would like the client to be included in the assessment and communicated with. Have the student practice this with you before trying with a client.

Walk and talk through appropriate touch issues before the student works with clients. Discuss documentation issues with the student: when and what to document of the physical assessment findings.

6.4 Describing the Levels of Competence

a) Introductory Competence (FUN I final)

- Demonstrates each segment of a physical examination appropriately with clients.
- Able to document findings of each segment of the exam using appropriate forms and language.
- Able to explain the purpose and process of the full physical examination and of each of the segments when performed with a client.

b) Intermediate Competence (FUN II final)

All skills demonstrated in Introductory Competence, and in addition:

- Has demonstrated theoretical knowledge about history taking and physical assessment.
- Can walk through a complete physical assessment in a simulated setting, giving appropriate direction and information.
- Approaches the client appropriately, communicates respectfully and demonstrates appropriate touch.
- Is able to gather information from the dialogue with the client at the same time as the student performs the physical assessment.
- With direct supervision, can perform a complete physical assessment with a client, sometimes without co-ordination of parts of the assessment or confident communication and documentation.
- Is familiar with physical assessment documentation forms and demonstrates competent documentation of full physical assessment.

c) Entry to Practice Competence (CC I)

All skills demonstrated in Intermediate Competence, and in addition:

- Without supervision or direction, can perform a complete physical assessment of the well client.

- Performs assessment with co-ordination of all parts and displays confidence and helps the client to feel comfortable with the process of a physical assessment.
- Provides health information appropriately to client.
- Documents physical assessment findings appropriately within the appointment.
- Appropriately responds to abnormal findings, in terms of providing information to the client, counseling, discussion with midwife and/or consultation.

7. VENIPUNCTURE

7.1 Learning Opportunities

Venipuncture for blood draws is introduced and first practiced in the **Clinical Skills Course**. During the **FUN I** Clinical Placement, the student should have the opportunity to perform venipuncture at least 18 times. The student should be directly supervised throughout the procedure until an introductory level of competence is consistently demonstrated. In most cases, this will coincide with 5 to 10 venipuncture experiences. After this point, the midwife must be on site, but does not need to supervise each venipuncture. During the **Complex Midwifery Care-I** Clinical Placement, the student should perform at least 12 venipunctures. In subsequent clinical placements, the student should perform enough venipunctures to maintain an entry to practice level competence.

7.2 Program Competency Requirements

At midterm of the **FUN I** placement, the student should have achieved Introductory Competence.

On completion of the **FUN II** placement, the student should have achieved Intermediate Competence.

On completion of the **(CC I)** placement, the student should have achieved Entry to Practice Competence.

7.3 Teaching Suggestions

Plan with the student at the beginning of the placement to make sure there are a number of chances to practice venipuncture during each week of the clinical placement.

Students can initially practice on each other, and volunteers can be used when opportunity with clients is lacking.

Identify students who have fear, anxiety and/or manual difficulty with this skill. Have them practice on a plastic arm model, a cloth doll, an orange, a towel, or a pillow. Plastic tubing hidden in a towel can be used for practice in identifying the vein.

Before students collect multiple tubes of venous blood from one site on a client's arm, have them practice withdrawing tubes and inserting new ones, without

moving the needle, using a model arm, pillow, doll or orange. Then, move to performing the skill on volunteers, and finally on clients.

Emphasize to the student that some clients experience nausea, fear, or fainting with blood draws. Teach and show the student how to reassure and comfort a pregnant client who is feeling nervous or unwell.

Walk through nausea and fainting scenarios with students before they practice this skill with clients. You can role-play the pregnant client and let the student practice assisting the client in a range of situations.

Protect the student by reviewing how to avoid accidental needle sticks, safe recapping of needles and how to dispose of needles.

Convey to the student how a venipuncture performed well, with smooth integrated movements and sensitivity to the client's experience helps the client feel confidence in the student in general as caregiver.

7.4 Describing the Levels of Competence

a) Introductory Competence (FUN I final)

- Approaches client appropriately, explains procedure, obtains permission, makes client comfortable.
- Collects and assembles equipment correctly, puts on gloves, attaches tourniquet correctly.
- Demonstrates how to visualize and palpate for veins.
- Swabs skin puncture area with alcohol swab, then waits a few seconds for it to dry.
- Inserts needle at 30-40 degree angle, bevel up/point down into vein.
- Attaches vacuum tube to syringe without moving needle, collects venous blood into tube (Introductory competence is associated with the student successfully obtaining blood about 75% of the time when veins are visible, and 50 to 75% of the time when veins are palpable but not visible).
- Releases tourniquet before withdrawing needle from arm. Gently presses cotton on puncture site while needle is being withdrawn without pressing on needle and causing discomfort
- Guides the client to compress the puncture site with cotton and elevate the arm slightly to prevent bruising.
- Ensures that the client is comfortable and not feeling nauseous or faint (If the client feels unwell, the student helps them to lie down on their left side, supported by pillows, and if helpful, gives them a glass of cool water or cold washcloths for their neck and wrists).

- Collects all equipment, disposes immediately of needle in sharps container, handles tube appropriately (e.g. gently rotating tubes as appropriate), then labels tubes and completes paper forms.
- Inspects puncture site and fixes bandage.
- Places blood tubes and paper forms in designated area for midwife to sign and lab to pick up.

b) Intermediate Competence (FUN II final)

All skills demonstrated in Introductory Competence, and in addition:

- Where veins are visible, student obtains venous blood in almost every attempt. Where veins are found by palpation only, obtains venous blood in at least 75% of attempts.
- Can take multiple tubes of blood from one puncture site confidently, and change tubes smoothly, not causing delay or discomfort for the client.
- Has integrated skill into practice for the student, and this competence is conveyed to the midwife and to clients.
- Is able to perform venipuncture quickly and smoothly
- Begins to competently perform venipuncture in more challenging situations, i.e. with clients who actively fear venipuncture, with children and others present and watching, with clients in advanced active labour who are in pain and need to move to cope with contractions.

c) Entry to Practice Competence (CC I)

All skills demonstrated in Intermediate Competence, and in addition:

- The student can consistently obtain multiple tubes of venous blood whether veins are visible, palpable or difficult to locate.
- The student is able to problem solve when venipuncture is difficult, i.e. anticipate a difficult venipuncture and have the client hold their arms low in relation to their body to accumulate blood in arm veins, hold a warm compress on the inner elbow to facilitate dilation of blood vessels.
- The student has integrated the skill well into the context of the prenatal visit, labour, or postpartum visit.

8. INTERNAL EXAMINATION

8.1 Learning Opportunities

Internal examination is introduced and first practiced in the **Clinical Skills course**. The students have an opportunity to practice bimanual and speculum exams with pelvic teaching assistants. **By the completion of FUN I** the student should have the opportunity to perform 8 or more internal examinations during prenatal care and in labour. In subsequent placements, the student should perform internal examinations in labour with all of the student's assigned clients. In most cases, the preceptor will want to be present for internal examinations during **all courses**, especially those done in labour. It is left to the judgment of the midwife to decide when it is appropriate for them to precede or follow the student in performing the exam, when it is not in the client's best interest to have the student perform an exam, and when the midwife does not need to check the student's findings. As a guideline, students' findings should be checked until they have consistently demonstrated intermediate competency. The midwife needs to be available on site throughout all clinical placements in the program when the student is performing a I exam.

8.2 Program Competency Requirements

On completion of the **FUN I** placement, the student should have achieved Introductory Competence.

On completion of the **CC I** placement, the student should have achieved Intermediate Competence.

On completion of the **CC II** placement, the student should have achieved Entry to Practice Competence.

8.3 Teaching Suggestions

In FUN I the preceptor will be introducing internal examinations for the first time. Before the student performs a internal examination with a client, describe to her what will do, and what will be trying to feel.

Try to arrange if possible for the student's first few internal examination experiences to be with relaxed and comfortable clients, preferably in late pregnancy or early labour. A client who has had a baby before and is pregnant or in early labour may feel comfortable enough to give feedback to the student during the exam.

When a student is first learning I exams, the preceptor usually assesses first, and then guides the student through what they are feeling. As the student gains comfort in doing I exams, it is useful to vary whether the preceptor precedes or follows the student in performing I exams. When proceeding, the preceptor can provide specific guidance to the student. When following, they can give the student the opportunity to test their skills and be assessed. It can be particularly helpful for the preceptor to assess first when the student is learning a new aspect of the skill, like finding landmarks on the fetal skull as this facilitates the preceptor's ability to actively teach. With senior students who have demonstrated competence at all aspects of I exams, preceptors may only reassess if the student is uncertain of their findings or the preceptor has clinical concerns.

Before you ask the client's permission (and usually outside of their presence) discuss with the student how you plan to perform the exam, i.e. if you plan to precede or follow in performing the I exam. If you don't want a student to perform a I exam with particular clients, tell the student ahead of time if possible, and explain why.

The preceptor or the student can describe to the client the learning level of the student, and encourage her not to be attached to the findings reported by an inexperienced student who examines before the midwife. Emphasize to the client that their input, both positive and critical, is welcome, and is valuable teaching for the student.

When first learning internal examination, the student should be directed to think about one or two findings, e.g. does the vulva look healthy, does the feel normal, where is the cervix. As the student becomes more comfortable with the process they can be encouraged to identify additional findings such as effacement, dilation, status of the membranes and so on.

As the student gains competence, help develop a system that works for the student to remember to identify all relevant findings. One system is to identify findings progressively from superficial to deep as the fingers are probing deeper into the vault, similarly to how findings are documented.

Beginning students tend to finish a I exam quickly and find they did not get enough information. If this occurs, you can plan ahead with the student to use a technique to assist in keeping the examining fingers inside long enough. Some preceptors have the student describe findings out loud until everything has been covered. Other preceptors keep their hand on the student's arm as a reminder to stay in long enough. In other situations where students are taking a long time to determine findings, preceptors may want to develop a signal to indicate that it is appropriate to end the exam.

It can also be helpful to discuss with the student (in advance of a I exam) what they expect to find. This can help preceptors to assess other skills such as evaluating progress from external signs, to assist the student in making a “plan” and in preparing to discuss findings with the parents. For example, with a senior student who is learning care management skills, have a discussion about what should be discussed with the client if had made good progress, slow progress or no progress from the last I exam.

8.4 Describing the Levels of Competence

a) Introductory Competence (FUN I final)

- Has demonstrated theoretical knowledge about the functions and process of internal examination.
- Addresses the client appropriately, ensures that they are comfortable and have emptied their bladder, shows respect for the client in labour by waiting until contractions have finished before talking about or performing a internal examination.
- Responds to the client’s individual needs about modesty and support by asking appropriate people to stay and leave, by draping with sheets or blankets if desired by client.
- Puts gloves on both hands, using sterile gloves as appropriate, separate labia with one hand before inserting gloved fingers with the other to minimize risk of infection and discomfort to the client.
- Touches the client’s thigh with the back of the student’s arm to prepare client for I exam, touches the client gently so as not to cause pain, but firmly enough to elicit information.
- Observes vulva to note any abnormalities.
- Can identify vaginal walls and can locate cervix 75% of the time*.

* *When assessing competence in clinical situations using these guidelines, preceptors should take into account whether it is possible for an experienced practitioner to make an accurate assessment in the particular case, for example, sometimes fetal position is not possible to determine even by a very experienced practitioner, occasionally a cervix is extremely hard to locate.*

b) Intermediate Competence:
(Section i by the end of **FUN II**) (Section ii by the end of **CC I**)

- i) All skills demonstrated in Introductory Competence, and in addition can:
- Identify cervix 90% of the time*.
 - Assess degree of effacement and amount of dilation with accuracy 75% of the time*.
 - Feel membranes and identify the presenting part nearly 100% of the time*.
 - Identify when the presenting part is higher than or lower than spines 75% of the time*.
 - Identify when caput and/or moulding are present 50% of the time*.
 - Report findings to the preceptor and the client.
 - Document findings.
- ii) All skills demonstrated in Introductory Competence and Section i Intermediate Competence, and in addition can:
- Assess degree of effacement and dilation with accuracy nearly 100% of the time*.
 - Identify sutures and fontanelles and determine position 50% of the time*.
 - Assesses station accurately 50% of the time*.

c) Entry to Practice Competence (by the end of **CC II**)

All skills demonstrated in Intermediate Competence, and in addition:

- Identifies presentation, position, and malpresentation accurately nearly 100% of the time*.
- Assesses effacement and dilation accurately nearly 100% of the time*.
- Can identify sutures and fontanelles and determine position nearly 100% of the time*.
- Assesses station of the presenting part accurately nearly 100% of the time*.
- Able to convey information to the labouring client accurately and in a supportive way to facilitate decision making, e.g. decision to change position, to be mobile, rupture membranes, to have an epidural or other pain relief, to consult.
- Can differentiate the development of caput and/or moulding from descent of the fetal skull when assessing progress in labour.

** When assessing competence in clinical situations using these guidelines, preceptors should take into account whether it is possible for an experienced practitioner to make an accurate assessment in the particular case, for example, sometimes fetal position is not possible to determine even by a very experienced practitioner, occasionally a cervix is extremely hard to locate.*

9. COMFORT AND SUPPORT IN LABOUR

9.1 Learning Opportunities

Support for clients in labour is first discussed and practiced in the Clinical Skills course. During their initial terms in the Program students learn about the importance of midwives having highly developed skills to provide comfort and support to clients in labour and study some of the popular midwifery literature about labour support. During the first year, students learn about labour support and observe at least one birth, in most cases developing a relationship with the client and providing support during their labour. During the **FUN I** clinical placement, the student should be present at approximately 18 births, and at each, there should be opportunity to learn about comfort and support measures. By **FUN I** midterm, students should begin to integrate labour support with other aspects of care. In subsequent placements, the student should demonstrate comfort and support skills at most labours **and** demonstrate the ability to integrate labour support skills with assessment and management of labour.

9.2 Program Competency Requirements

At midterm of the **FUN I** placement, the student should have achieved Introductory Competence.

On completion of the **FUN II** placement, the student should have achieved Intermediate Competence.

On completion of the **CC I** placement, the student should have achieved Entry to Practice Competence.

9.3 Teaching Suggestions

Ensure that the student's background reading on this area is broad and current. Ask the student to make presentations to your practice group about books, journal articles, videotapes, or conference presentations on comfort and support in labour. Encourage the student to explore information about different approaches to providing support in labour, including ones you may not agree with. Make clear to the student that your practice environment is a place where ideas about comfort and support in labour are introduced, debated and tried, and include the student in this process.

Walk through labour scenarios with students and ask them to describe the kind of comfort and support measures that could help the labouring client.

When a student is having difficulty with 'hands-on' support techniques such as massage of the lower back, talk to the student to check your assumptions about where the difficulty lies. Is it shyness or lack of confidence, or lack of skills? Have the student practice on you or a volunteer until they gain confidence. Have the student evaluate themselves.

After births, review with the student which comfort and support measures were helpful to the client and which were not. Help the student to understand why in each case.

Teach and demonstrate to the student the importance of pacing oneself through a long labour and sharing the responsibility for provision of support appropriately. Help the student learn when to take breaks and how to stay alert and properly nourished.

Talk with the student about how to best facilitate labour support: when to encourage the labouring client to cope independently, when to involve a partner and help them be more effective, and when to play an active role.

9.4 Describing the Levels of Competence

a) Introductory Competence (FUN I)

- Demonstrates knowledge of theories about support and comfort in labour, the role of the partner, family or friends, role of the midwife.
- Enters the environment of the labouring client without being disruptive, is comfortable with the labouring client, responsive to their needs, and respectful, able to initiate conversation in a way that is welcome to the client.
- Demonstrates appropriate personal boundary and touch awareness.
- Can use hands to provide back pressure, and back, abdominal, leg and foot massage.
- Understands use of applied heat and cold for comfort.
- Can encourage mobility, change of positions, use of food, drink, showers and baths and other comfort measures appropriately in normal labours.
- Can help the labouring client who has difficulty moving to shift positions or to walk assisted.
- Demonstrates ability to help clients use breathing to cope with labour.
- Provides appropriate verbal support and encouragement.
- Can provide adequate comfort and support measures acceptable to the labouring client in normal labour situations.

b) Intermediate Competence (by the end of **FUN II**)

All skills demonstrated for Introductory Competence, and in addition:

- Can discuss and teach comfort and support measures in an accurate, succinct and reassuring way to prenatal clients.
- Can identify effectiveness of comfort and support techniques, and recommend and initiate changes in approach.
- Recognizes limits to effectiveness in difficult labour situations and when pharmacologic pain relief may be beneficial.
- Responds appropriately to client requests for pain relief and/or to client's emotional distress.
- Can provide adequate comfort and support measures acceptable to the labouring client in abnormal labour situations.

c) Entry to Practice Competence (CC I)

All skills demonstrated in Intermediate Competence, and in addition:

- Can combine and integrate the management role of the midwife with the provision of support and comfort measures.
- Can combine clinical hands on monitoring and assessment, i.e. fetal heart auscultation, internal examination with support and comfort measures.
- Consistently demonstrates ability to facilitate comfort and support measures cooperatively with others at birth.
- Can provide effective comfort and support measures through long, complex and difficult labours.
- Demonstrates ongoing current awareness of trends and developments in labour support via conferences, peer review, practice meetings, journals, popular media and books.
- Demonstrates the ability to incorporate the documenting of support and care without interrupting the provision of care.

10. MANAGEMENT OF FIRST STATE OF LABOUR

10.1 Learning Opportunities

The management of first stage of labour is introduced in **Clinical Skills** along with non-pharmacologic methods of pain relief, comfort measures and learning to do I exams in labour. At that time, students begin to learn about monitoring the well-being of the labouring person and fetus during the intrapartum, including beginning level interpretation of electronic fetal monitor (EFM) tracings. In **Clinical Skills** they have a workshop on monitoring of fetal well-being. In the **Advanced Clinical Skills** intensives, they do more advanced workshops on fetal monitoring. They learn about normal labour and birth for occiput anterior and posterior presentations in **Clinical Skills**. In **CC I and CC II** they add abnormal presentations and their mechanisms of birth. They also study atypical and abnormal fetal heart rates. During the FUN I & II clinical placements, the student should participate in the management of at least 14 labours. Subsequently, the student should participate in managing at least 10 labours in **CC I**, at least 10 labours in **CC II**, and at least 10 labours in the **Clerkship**. Initially in **FUN I**, students are only expected to manage some aspects of intrapartum care, and they are mostly focused on learning skills. By the final evaluation in **FUN II** students will be able to manage complete normal labours. By **CC II** the student should be able to manage all types of labours.

10.2 Program Competency Requirements

On completion of the **FUN I** placement, the student should have achieved Introductory Competence.

On completion of the **CC I** placement, the student should have achieved Intermediate Competence.

On completion of the **Clerkship** placement, the student should have achieved Entry to Practice Competence.

10.3 Teaching Suggestions

Early in placements, have the student review the relevant chapters in their textbooks. Ask them to review with you the physiology of normal labour. In later placements, have them review for you variations of normal and the pathophysiological causes of abnormal labours

Help students to become confident with the mechanisms of labour by having them demonstrate mechanisms for a small group of midwives and students.

Review charts or tell stories of labours that you think are particularly instructive highlighting decisions made, and approaches to managing labour. Talk about how support and comfort measures are used strategically by midwives to facilitate progress. Ask the student to share the stories of labours they have participated in and ask what they learned about first stage management from these experiences.

Talk through and plan first stage management scenarios with the student if traveling to births or visits together. It can be helpful for a student to think through what management decisions they might face, before arriving at the labour. Depending on labour circumstances, have the student review and revise the plan as clinical circumstances warrant.

Have the student write or review protocols for management of first stage.

Ask the student to make 5 - 10 minute presentations to your practice group on meeting days about topics including: understanding the different management issues for primiparous and multiparous clients, a critique of their management at the last birth attended, strategies for helping the client cope when the baby is posterior.

Talk about the client's needs in relation to management of first stage. Talk about and/or role play appropriate ways of working through and communicating management issues with the client in labour. Initially the focus should be on normal, then later on difficult and complicated labours, and emergencies. Cover a wide range of scenarios with the student.

Have the student describe fetal heart tones in a systematic fashion including rate and rhythm, periodic changes, and whether reassuring or not. Have the student interpret EFM strips when used at a birth and report findings, including the likely cause of non-reassuring patterns, and suggested care plans. Use copies of EFM strips from births you have attended or from textbooks as practice sessions and extra opportunities for the student if few present in the labours which the student attend.

10.4 Describing the Competencies

a) Introductory Competence (FUN I)

- Has demonstrated theoretical knowledge about the physiology of normal first stage of labour, including understanding concepts of I effacement, I dilation, fetal descent, uterine function, beneficial fetal positions.

- Has demonstrated knowledge about the mechanisms of labour for normal fetal positions and presentations, occiput anterior and posterior.
- Has demonstrated theoretical knowledge of midwives' approaches to facilitating progress in labour.
- Approaches the client respectfully, communicates suggestions and plans clearly to the client with guidance from preceptor.
- Has demonstrated knowledge about reassuring fetal heart rate patterns and common non-reassuring patterns.
- Demonstrates ability to auscultate fetal heart during labour and to use EFM.
- Demonstrates a beginning ability to interpret EFM strips.
- Can confidently manage all aspects of normal first stage of labour.

b) Intermediate Competence (by the end of **CC I**)

All skills demonstrated for Introductory Competence, and in addition:

- Has a developing ability to recognize and manage abnormal first stage of labour in terms of initiating consultation and/or transfer of care to appropriate care provider.
- Has a developing ability to recognize and manage emergency situations in first stage of labour appropriate to home and hospital settings.
- Recognizes progress in labour or lack of progress with minimal assistance from preceptor, using both non-interventive observation and appropriate physical assessment (abdominal and internal examinations) when indicated.
- Recognizes non-reassuring fetal heart patterns and the need for intervention.
- Can describe and interpret an EFM strip in a systematic fashion.
- Can combine hands-on clinical skills with providing information, counseling and support for clients in most labour situations (e.g. (1) can combine provision of labour support with discussion of pain relief and initiation of changes to management plan when a client is distressed and discouraged; (2) can initiate conversation with a labouring client or respond to their queries about amniotomy, can simultaneously provide support and information, and can perform an amniotomy in normal circumstances).
- Can communicate management plans and discuss them or respond to those of other care providers (in consultation situations) accurately, in summary and with a calm, professional approach in non-emergency situations.
- Reports to and discusses with second midwife as appropriate.

c) Entry to Practice Competence (Clerkship)

All skills demonstrated in Intermediate Competence, and in addition:

- Can confidently manage normal first stage of labour and can manage both emergency and less urgent consultations and transfer of care in abnormal labour.
- Provides management in the context of client centered care, involving the client in decision-making, combining management with support appropriate to the labouring client's needs.
- Can manage first stage of labour in both home and hospital settings, conveys management options in each setting accurately to labouring clients.
- Requests assistance from second midwife when appropriate.
- Consults with second midwife when in doubt.

11. MANAGEMENT OF SECOND STAGE & SPONTANEOUS PHYSIOLOGIC BIRTH

11.1 Learning Opportunities

The management of second stage of labour is introduced in **Clinical Skills**. In **FUN I**, the student learns about the management of normal second stage labour and common variations, including OP and monitoring the fetal heart. In subsequent courses the student also studies atypical and abnormal fetal heart patterns, shoulder dystocia, and precipitous birth. The student should have the opportunity to participate in management of second stage by midterm with at least 4 four-handed “catches” and by final at least -4 additional births with the preceptor’s hands nearby. The student should have an opportunity to manage the second stage of labour and conduct a spontaneous physiological birth under direct supervision at least 10 additional times by the end of **FUN II**, at least 10 times in **CMC-I**, at least 10 times in **CC II** and at least 10 times during the **Clerkship**.

Throughout each placement, the student will be under direct supervision during the second stage of labour. During **FUN I & II**, the preceptor will attend with gloved hands, and initially be in close physical proximity, probably using their hands to guide the student’s hands. After the first several births, if the student is performing well, the physical involvement of the preceptor will decrease. The preceptor will always be close at hand when the birth is imminent, or if any clinical concerns are present. At any time, the preceptor may direct the student to stop or modify conducting a birth or step in to assist or to replace the student as needed.

11.2 Program Competency Requirements

On completion of the **FUN II** placement, the student should have achieved Introductory Competence.

On completion of the **CC I** placement, the student should have achieved Intermediate Competence.

On completion of the **Clerkship**, the student should have achieved Entry to Practice Competence.

11.3 Teaching Suggestions

Have the student focus (by observation) on the details of how the midwife conducts two deliveries.

Ask the student to review relevant chapters in their textbooks and discuss with you any areas not understood.

Talk to the student about your expectations for the way to talk with clients in second stage and how to approach and work with them physically. Describe for the student your approach to protecting the perineum, and supporting different birth positions.

Have the student practice the hand positions you use at a birth with a torso and fetal doll or a doll and pelvis.

Discuss with the student the fact that equally talented midwives with equally positive outcomes may have different approaches to the management of second stage. Be clear about your expectations and approach. Focus on the principles and purpose of techniques so that student understands the rationale.

Review charts or share birth stories about second stage with the student highlighting cases that were challenging, and listen to the student's experiences of second stages of labour.

Review birth equipment in home and in hospital prior to a birth to increase the student's familiarity and confidence in the birth set-up. Some practices provide a diagram of how they set-up.

Have the student set up the birth equipment in both places. If the student comes as the second midwife have the student review the set-up and check equipment on arrival at each birth.

Have the student watch birth videos, and discuss the second stage management seen in them.

Talk through a number of scenarios including recent births, using doll and torso or pelvis, beginning with learning to recognize differences between primiparous and multiparous second stages and implications for midwifery management. Discuss the management of precipitous birth. Demonstrate the difference between 'sticky shoulders' and shoulder dystocia, and discuss what that difference means for management approaches. Move to discussing nuchal cord, the range of compound presentations, atypical and abnormal fetal heart patterns, and gauging the stretching ability of perineums. Discuss client circumstances that lead to cesarean delivery or the use of forceps or vacuum delivery.

Include a practice session on receiving the baby with the client in lithotomy or positioned at the end of a bed that is set up as a birthing chair.

11.4 Describing the Levels of Competence

a) Introductory Competence (FUN II)

- Demonstrates understanding of the physiology of second stage.
- Can recognize signs of full dilation and pushing both through passive observation and internal examination.
- Approaches the labouring client sensitively and effectively in terms of appropriate touch, information provision, support and encouragement.
- Facilitates physiologic pushing, demonstrates skills to help guide pushing efforts safely and respectfully if needed by clients.
- Recognizes signs of descent, and when birth is imminent.
- Is able to set up appropriately for birth including checking all emergency equipment.
- Encourages client, if guidance is appropriate, to adopt positions which are acceptable to them and facilitate progress.
- Recognizes reassuring and non-reassuring fetal heart patterns
- Can perform appropriate hand manoeuvres at birth in normal situations.
- Handles newborn at birth competently and with respect for baby and parent(s).
- Demonstrates understanding of the roles of primary and second midwife.
- Suggests the appropriate time to call in the second midwife.

b) Intermediate Competence (by the end of CC I)

All skills demonstrated in Introductory Competence, and in addition:

- Is able to differentiate between normal and abnormal progress in second stage.
- Is able to competently assist the client to protect the perineum with a range of approaches during advanced second stage.
- Is able to recognize the need for midwifery intervention (e.g. direction provided for pushing, change of position, closer fetal heart monitoring, episiotomy).
- Can perform an episiotomy.
- Is able to recognize the need for obstetric intervention (e.g. delay in progress despite appropriate time and management, atypical and abnormal fetal heart patterns with birth not imminent).
- Is able to understand and convey to client management options in non-urgent and urgent situations both at home and in hospital.

- Demonstrates competent and confident hand manoeuvres at normal births with the client in a wide range of positions, including semi-squatting, squatting, hands and knees, and lithotomy.
- Can manage an increasing range of birth situations, (e.g. can recognize and manage 'sticky shoulders', but may still need assistance with shoulder dystocia).
- Knows when to call in the second midwife.
- Communicates effectively with the second midwife.

c) Entry to Practice Competence (Clerkship)

All skills demonstrated in Intermediate Competence, and in addition:

- Demonstrates advanced clinical judgment in assessing whether midwifery or obstetric intervention is required.
- Communicates clearly, respectfully and calmly with client throughout second stage, whether complicated or not.
- Can initiate appropriate intervention, including transfer of care and emergency management in the absence of this option.
- Is skilled in encouraging clients having difficulty coping with second stage and in facilitating changes that may be helpful.
- Can provide emergency management for shoulder dystocia, multiple pregnancy, prolapsed cord, breech and consult and transfer as needed within full scope of midwifery practice.

12. MANAGEMENT OF THE THIRD STAGE OF LABOUR

12.1 Learning Opportunities

Management of the third stage of labour is introduced in the **Clinical Skills Course**. Postpartum hemorrhage is included in the content of **FUN II, and in Advanced Clinical Skills**. The student should have the opportunity to participate in management of third stage by midterm of the **FUN I** placement with hands on for approximately 4 births and an additional 8-16 by completion of **FUN II**

. During the subsequent placements, students should manage the third stage of labour at each birth they attend as primary caregiver, which is at least 10 times in each of **CC I, CC II** and **Clerkship**. If the student's primary birth numbers are low and/or if third stage poses challenges to the student, the preceptor may allow the student to manage the third stage at births attended in the role of second midwife.

12.2 Program Competency Requirements

On completion of the **FUN II** placement, the student should have achieved Introductory Competence.

On completion of the **CC I** placement, the student should have achieved Intermediate Competence.

On completion of the **CC II** placement, the student should have achieved Entry to Practice Competence.

12.3 Teaching Suggestions

Suggest that students review relevant chapters in their textbooks. Have the student describe how they would recognize signs of placental separation, and how exactly, step-by-step, they would manage 3rd stage physiologically. Ensure that you and the student have a shared understanding of what should be done clinically while waiting for the placenta (e.g. observation, palpation, assess pelvic blood loss, assist a positional change for the client).

Review with the student the indications for active management of 3rd stage at births. Have the student describe, step by step, active management of 3rd stage. If you have particular practices relating to management of 3rd stage, make sure that the student is familiar with these before managing 3rd stage at a birth with you. Use a doll and pelvis or torso for scenario practice.

Have the student observe two occasions when you are handling the third stage. The student may find it useful to describe to you those observations. Initially, the student gently rest a hand on the fundus and do nothing else, in order to

concentrate on learning to wait for contractions and to be aware of and sensitive to what is happening to the uterus in the third stage.

Assist the student with '4 handed' handling of the placenta and cord the first couple of times, to help develop awareness of and skills in using appropriate tension when handling the cord and the placenta especially in assisting the delivery of membranes.

Review the subject of normal blood loss, how it looks, and the common patterns of initial blood loss after a birth. (e.g. different patterns of loss when standing or squatting compared with recumbent positions, appearance of blood when dispersed in the water of a tub or pool, how to assess 3rd stage when blood loss is concealed.)

Role model for the student how you would communicate with the client during 3rd stage and exactly what you would want to be done. (e.g. Do you quietly encourage the client to breastfeed, to be squatting, or do you ask them if they want the umbilical cord cut? Do you or your clients prefer to have lights down low and quiet at this time? Do you assess for perineal lacerations while waiting for the placenta?)

Walk through normal and then abnormal scenarios with the student to practice the range of management skills. Use a pelvis and model baby with cord, placenta and attached membranes to practice and evaluate advanced skills that do not happen during the placement (e.g. postpartum hemorrhage, manual removal of the placenta, bi-manual compression of the uterus).

12.4 Describing the Levels of Competence

a) Introductory Competence (FUN II)

- Understands principles of and has demonstrated both physiologic and active management of 3rd stage at births.
- Recognizes normal and abnormal 3rd stage blood loss.
- Assists in the management of postpartum hemorrhage with guidance.

b) Intermediate Competence (CC I)

- Participates calmly and competently in management of 3rd stage postpartum hemorrhage under direction of preceptor.
- Understands when to initiate midwifery interventions (administration of oxytocic drugs, active management, IV insertion and IV oxytocic administration), and when to call for obstetric intervention.

c) Entry to Practice Competence (CC II)

All skills demonstrated in Intermediate Competence, and in addition:

- Competently combines assessment of client well-being and management of 3rd stage with appropriate supportive communication with the client.
- Can initiate and complete physiologic and active management without assistance.
- Can initiate transfer from home or call for obstetrician in hospital without direction.
- Can initiate midwifery interventions and in emergency situations, can manually remove a placenta and initiate bi-manual compression of the uterus.
- Can recognize and manage postpartum hemorrhage appropriately.

13. INFILTRATION OF THE PERINEUM AND PERFORMING AN EPISIOTOMY

13.1 Learning Opportunities

Infiltration of the perineum and performing an episiotomy are discrete clinical skills introduced prior to **FUN I**. These skills are subsequently reviewed in Advanced Clinical Skills intensives.

Because the midwifery standard of care involves performing perineal infiltration and episiotomies only for a small number of clinical indications, most students will not have many opportunities to practice perineal infiltration and episiotomies within midwifery clinical placements.

Between **FUN I** and the **Clerkship** placements, whenever a situation requiring an episiotomy presents, the preceptor should involve the student as much as possible, as long as doing so does not compromise safety of client and baby. Students usually gain additional experience with infiltration and episiotomy during their placements with obstetricians.

13.2 Program Competency Requirements

On completion of **FUN II** placement, the student should have achieved Introductory Competence.

On completion of the **CC I** placement, the student should have achieved Intermediate Competence.

On completion of the **CC II** placement, the student should have achieved Entry to Practice competence.

13.3 Teaching Suggestions

Have students review with you the indications for episiotomy and describe how they would recognize them at the time of advanced second stage.

Ask the student to describe how to infiltrate the perineum, and to tell you the size of needle and syringe, dosage and type of local anesthesia to use. If needed, practicing infiltration into a piece of thin red meat stretched between two points can be useful and help build student confidence.

Have students model for you how to place their fingers to protect the head, how to shift the fetal head if necessary to access the perineum safely, and how to place the scissors on the perineum protecting the fetal head. A doll and cloth can be used for this purpose. The wide rubber bands (e.g. Thera-band) used for physiotherapy can also be used to mimic a stretched perineum.

Have the student explain to you the benefits and disadvantages of mid-line versus medio-lateral episiotomies. Discuss with the student the different sizes and types of episiotomies that can be required in different situations where there is fetal distress with a rigid, long perineum, failure to progress at the perineum with a large occipital posterior fetal head, potential damage threatening the rectum and anus, and friable perineal tissues.

Stress to the student that episiotomy is rarely required, but that it is critical for the well-being of client and baby for midwives to be highly skilled in performing this intervention for the few times it is needed.

Sensitivity and respect for clients may lead students to be disturbed by the trauma to clients' bodies, which is inherent in episiotomies. Take time to talk about your experience with episiotomies and listen to the student's perspective. Emphasize that you do not have to become de-sensitized to clients' feelings and experience to be competent in performing episiotomies when necessary. Discuss the importance of discussion of emergency procedures, like episiotomy, during prenatal discussions so that clients understand when and why midwives might recommend episiotomy.

Talk with the student about effective ways to communicate with the client and with the midwife in second stage if the student thinks an episiotomy is necessary. Walk through a range of scenarios, including answering the client's questions, dealing with their reluctance to give permission for an episiotomy, dealing with a frightened or angry partner.

13.4 Describing the Levels of Competence

a) Introductory Competence (FUN II)

- Recognizes or describes indications for episiotomy.
- Understands and describes the procedure for doing an episiotomy.

b) Intermediate Competence (CC I)

- Can infiltrate the perineum and perform a medial or medio-lateral episiotomy.

c) Entry to Practice Competence (CC II)

- Recognizes indications for episiotomy without direction.
- Can infiltrate the perineum and perform a medial and medio-lateral episiotomy without assistance.
- Can communicate with the client to explain why an episiotomy is necessary, obtain consent, and continue informing them and supporting them throughout the birth.

14. SUTURING PERINEAL LACERATIONS AND EPISOTOMIES

14.1 Learning Opportunities

As with episiotomies, it often happens that students lack learning opportunities in midwifery clinical placements because of the happy occurrence of many intact perineums or perineums that do not require suturing. Whenever suturing opportunities are available, the preceptor should involve the student in part or all of the suturing process to maximize learning. Generally, students obtain additional experience in suturing during their obstetric placements.

14.2 Program Competency Requirements

On completion of **FUN II**, the student should have achieved Introductory Competence.

On completion of **CC-I**, the student should have achieved Intermediate Competence.

On completion of the **CC II**, the student should have achieved Entry to Practice competence.

14.3 Teaching Suggestions

To maximize student practice and confidence, keep a cone of fine cotton string at the practice office, and have students practice finger ties whenever possible.

Have students in need of experience, practice handling needle drivers, suture material and suture scissors at home or in the practice office. They can practice suturing on wash cloths or sponge, on white or red meat, or on eggplant to gain experience.

If a student is nervous, have them just do one or two sutures in a repair initially, and integrate them gradually. Start with a simple laceration.

Draw a few examples of episiotomies and types of lacerations. Describe the damaged tissue in layers, and have the student draw and describe the repair. Have the student describe 1st, 2nd, 3rd, and 4th degree lacerations and identify which types can and cannot be repaired by midwives.

In a practice session, have the student practice setting up all the equipment they will use for suturing. Practice with the student how to use sterile technique when drawing up Lidocaine for infiltration for suturing.

Ask the client permission to let you and the student describe landmarks of the perineum when doing assessments with intact perineums, small tears and more complicated tears. It might be helpful to have the student do a practice assessment on a willing client during a Pap test or on a fellow student.

Use an instrument to point out exactly where the needle should be placed when assisting a student with their initial sutures.

When infiltration is being used, it will be better for the student to do an assessment and plan the repair after freezing takes effect.

14.4 Describing the Levels of Competence

a) Introductory Competence (FUN II)

- Recognizes a tear.
- Sets equipment up with assistance.
- Ensures the client's comfort with assistance.
- Infiltrates with assistance.
- Can place and tie sutures with assistance.

b) Intermediate Competence (CC I)

- Can accurately assess the degree of laceration or episiotomy to ensure that it is within a midwife's scope of practice to commence repairing the damage.
- Can provide information to the client that is accurate, and is provided calmly and respectfully.
- Can set up for suturing without assistance at home or in hospital, using appropriate equipment and suture material.
- Can infiltrate the perineum if necessary for pain relief.
- Ensures that the client is as comfortable as possible.
- Performs complete suturing job with assistance.
- Performs post-suturing assessment of the vulva and rectum as appropriate to ensure proper repair occurred.

c) Entry to Practice Competence (CC II)

- Can, within a reasonable period of time, complete a repair of an episiotomy or laceration.

15. NEWBORN EXAMINATION

15.1 Learning Opportunities

Newborn examination is first taught in the **Clinical Skills course**. During the **FUN I** clinical placement, the student should have the opportunity to observe at least 2 complete newborn examinations with gestational age assessment and practice the newborn examination at least 16 times. From the **NC** placement through the **Clerkship**, the student should have the opportunity to perform a newborn examination at every birth attended.

15.2 Program Competency Requirements

On completion of the **FUN I** placement, the student should have achieved Introductory Competence.

On completion of the **FUN II** placement, the student should have achieved Intermediate Competence.

On completion of the **CC II** placement, the student should have achieved Entry to Practice Competence

15.3 Teaching Suggestions

In **FUN I** watch the student practice a newborn examination on a model baby, and ask questions to elicit knowledge of anatomy and physiology. The student can also do a practice session with the preceptor acting as the pregnant person.

When the student is observing newborn examinations, involve the student by describing what you are doing, asking questions and welcoming questions from the student.

If a student initially lacks confidence in handling babies have the student hold a baby wrapped in a blanket before holding a naked one, and perform small parts of the newborn examination until more confident.

Students may benefit from other opportunities to hold and work with babies, perhaps by volunteering to spend time assisting on a postpartum ward or in a normal nursery.

Introduce early the importance of involving the client and appropriate others by performing the newborn examination where they can see everything you are doing, and by talking with them throughout.

Show students how to model confident, gentle handling of babies. Use language that parents can understand when talking about the baby. Help students to develop proficiency in using medical terminology as necessary in medical and academic settings, and be equally at ease using clear language for parents.

Encourage clients to give feedback to the student in the early postpartum period about their experience of the student conducting the newborn examination. Did they feel included? Did it affect their confidence with their baby? Did they learn useful information? Was their baby handled respectfully?

While eye prophylaxis and Vitamin K injection are not part of an examination, they usually occur together with the examination and so are included here. Students should be competent at an entry to practice level in giving intramuscular injections to newborns and in administering eye prophylaxis by the completion of **CC I**. The student may need an opportunity to practice on model babies and on adults in order to gain confidence giving injections to babies. When a student experiences difficulty with these skills, a brief placement in a hospital may offer opportunities to promote competence and confidence.

15.4 Describing the Levels of Competence

a) Introductory Competence (FUN I final)

- Approaches client appropriately to ask permission to perform newborn examination.
- Washes hands before examination.
- Approaches baby respectfully, and is confident and gentle in speaking to, holding and handling baby.
- Ensures that the baby does not get cold, comforts baby appropriately, or gives baby to client to comfort as necessary.
- Using MEP and AOM guidelines for content on newborn examination, is able to conduct the newborn examination with guidance from the preceptor.
- With guidance, can 'walk through' all of the components of the newborn examination, including gestational age assessment.

b) Intermediate Competence (FUN II final)

All skills demonstrated for Introductory Competence, and in addition:

- Can perform entire newborn examination under supervision.
- Is at ease with both client and baby and communicates well with client and others present throughout examination.
- Can recognize overt abnormal findings, and convey appropriate information to client about need for management by midwife.

- Able to incorporate eye prophylaxis and vitamin k injections smoothly while doing the newborn exam.
- Able to perform full exam in a timely fashion.

c) Entry to Practice Competence (CC II)

All skills demonstrated for Intermediate Competence, and in addition:

- Can perform entire newborn examination without supervision.
- Recognizes range of abnormal and questionable findings.
- Communicates well with client about both normal and abnormal findings.
- Understands appropriate management, including when to consult and transfer care, versus when they are able to enact management independently.

16. DOCUMENTATION

16.1 Learning Opportunities

Documentation skills are first introduced in the **Clinical Skills Course**. During the **FUN I & II** clinical placements, the student should have the opportunity to practice documentation skills on most days in clinic. The student should be directly supervised until an intermediate level of competence is consistently demonstrated. Usually, this will coincide with the completion of the **FUN I** placement. Throughout all clinical placements, including the **Clerkship**, the preceptor or another midwife must review, approve and sign all student entries in records, and review, approve and sign all consultation and transfer of care letters written by the student.

16.2 Program Competence Requirements

By **completion of FUN I** placement, the student should have achieved Introductory Competence.

On completion of the **FUN II** placement, the student should have achieved Intermediate Competence.

On completion of the **CC I** placement, the student should have achieved Entry to Practice Competence.

16.3 Teaching Suggestions

Have the student begin with filling in 'boxes' on the Ontario Perinatal Record (OPR), e.g. dates, weights, urine dipstick results, fetal heart rates, etc.

Some students benefit from "shadow" documenting where they use a blank OPR to practice and compare with what the preceptor has documented for the same client. (To save paper, the student could use the same practice OPR form to document the visits of several clients.)

Remember that students can be challenged with listening intently to clients and with demonstrating counseling and management skills in the second half of FUN I onward. The integration of being with clients in appointments and completing records at the same time can be difficult. Try role-playing with you as the client. Enact part of an appointment and then ask the student what documentation is needed.

Have students record only a part of the appointment at first. Provide immediate feedback with explanations of your suggestions.

Stress with students the importance of being accessible to and focused on the client in appointments, and not being hidden by a file. Have the student practice looking at a file, then putting it down and focusing in a clear and calm way on the client.

Request that the student be familiar with file contents, including lab results before a visit begins. The student can review the charts the night before clinic or arrive early the day of clinic. The student can make lists of what needs to be covered during the visits.

Role play with the student as the client and you as the student to demonstrate how the client might feel when the student does not make eye contact frequently enough during history taking. Role play a history taking that is interactive and exploratory, rather than very limited to reading questions directly from OPR.

Ask the student to compose all comments for notes on separate pieces of paper. Once reviewed, edited and approved by you, they can then be written into the client notes. Remember that you cannot erase the student's notes once they are written in the records but can add your own.

Have students review and critique their own charting and yours from time to time giving them the opportunity to point out good examples of documentation and see where a different note would have been preferable. Refer students to the CMO's Practice Management Standards and the Record Keeping Standard for Midwives,

16.4 Describing the Levels of Competence

a) Introductory Competence (FUN I final)

- Can consistently document normal findings on Ontario Perinatal Record, labour on postpartum record forms.
- Can consistently fill in standardized chart "boxes" in labour records.
- Produces legible recordings.
- Is familiar with the content of the Ontario Perinatal Record and labour and postpartum records.

b) Intermediate Competence (FUN II)

All findings for introductory competence, and in addition,

- Can consistently compose comments for the Ontario Perinatal Record, labour records, and postpartum records that report normal situations.
- Understands medical and midwifery terminology and uses these appropriately.
- Can write succinct and complete notes, having drafted them first on a separate piece of paper.
- Can compose letters for normal client situations under supervision of midwife.
- Can compose letters requesting consultation, under supervision of the midwife, when the circumstances are not complex.
- Spells accurately or if having difficulty, carries appropriate dictionaries or word lists and uses them without prompting.
- Uses abbreviations appropriately.
- Informs clients of their rights regarding access to their records and shares information from notes during and between appointments with clients appropriately.

c) Entry to Practice Competence (CC I)

All findings for intermediate competence, and in addition,

- Can consistently compose comments for the Ontario Perinatal Record and labour and postpartum records in reporting abnormal and/or complex situations.
- Can incorporate charting in a timely fashion while continuing to provide care to clients.
- Can write succinct and complete notes without pre-writing them on a separate piece of paper.
- Can compose letters for consultation or transfer or care for the full range of complex and/or abnormal situations.

17. COMMUNICATION SKILLS

17.1 Learning Opportunities

Communication skills are studied and practiced during the **Clinical Skills** course. Students study principles of active listening and counseling. Issues relating to communication with clients and with other health care providers form part of the discussion during tutorial sessions for all of the later courses when certain cases are presented. Respectful communication is considered part of good professional behaviour. Every interaction with clients, preceptors, midwives, and others provides an opportunity for clinical teaching about communication.

17.2 Program Competence Requirements

At midterm of the **FUN I** placement, the student should have achieved Introductory Competence.

On completion of the **FUN II** placement, the student should have achieved Intermediate Competence.

On completion of the **CC II** placement, the student should have achieved Entry to Practice Competence.

17.3 Teaching Suggestions

Ask the student who is new to your practice group to identify any learning needs regarding communication with clients and with professionals, in order to get an idea of how much assistance and teaching is needed. Students in early **FUN I** should be assigned a part of the visit to accomplish rather than the whole appointment, until they gain confidence.

At the end of certain client sessions or at the end of a clinic day, ask the student to identify examples observed or performed of various communication skills, including listening skills, body language, appropriate touch, appropriate eye contact, mirroring, and so on. Ask the student to point out behaviours that facilitate communication as well as those that do not. Ask the student to describe examples of communication that have a trans-cultural context. When planning for the next clinic day or the next visit, ask the student to describe any particular techniques or approaches that will be useful when communicating with clients about certain issues.

Some clients have difficulty communicating directly with the beginning or shy student. Allow the student some time to introduce themselves and talk with the client before you enter the room. It may be helpful to position the student in “the midwife’s chair” to encourage the client to communicate directly with the student. If the client directs questions to the midwife instead of the student, the midwife can look towards the student as a cue for the student to respond. The preceptor can gaze occasionally at the student during the visit rather than at the client assisting the client to direct their attention to the student and include the student in the conversation. Inviting clients to participate in teaching and valuing clients’ contributions to teaching can help support the development of positive relationships. Asking the client to provide feedback to a student directly encourages general communication between the client and the student.

Many students find it beneficial to be prepared for the kind of informed choice and teaching discussions that will take place at the next clinic day. By reviewing the charts and checking with the preceptor before the clinic day, the student can find out what discussions to prepare. A note about the topics to be discussed can be left as a reminder in the client chart.

Suggest to the student to practice informed choice presentations in front of a mirror or with a friend. Timid students will benefit from role playing with the preceptor as the client. More advanced students may benefit from role playing about consultation and about the use of appropriate advocacy. The student who remains hesitant or shy may wish to take an assertiveness training course.

Arrange for the student to observe the midwife doing phone calls using a speaker phone. Check the student’s telephone communication skills by listening during a conversation with a client, by using the speaker phone, or by arranging 3-way calling on occasion.

Take the opportunity to provide positive feedback, as appropriate, about communication in front of the client to bolster the client’s confidence in the student. If the feedback is not positive, reserve it for private sessions. When a student is having difficulty communicating with a client or a consultant, gently take over the communication and review the situation afterwards to gain an understanding of where the difficulty lies. Is it related to general communication skills, or to shyness, or to a lack of knowledge about that particular topic? Is it part of a pattern or an isolated event?

Feedback sessions form an important opportunity for demonstrating good communication or for learning appropriate methods of communication. If the student is uncomfortable or frightened in feedback sessions, ask the student to identify why and to suggest ways to approach the feedback sessions that would work for the preceptor and the student. For example, would it be easier to receive

written rather than verbal feedback or to begin with self-evaluation before the preceptor's observations?

If a conflict develops between preceptor and student, be sure to document what discussions have taken place and to involve the tutor earlier, rather than later, in a situation of conflict.

Communication behaviours should reflect appropriate professional behaviour. Refer also to other sections in the Guide that discuss professional behaviour and feedback. These include: "MEP Expectations of Students in Clinical Placements" and "Professional Role and Behaviour".

Be aware that the student who has excellent communication skills may inadvertently mask difficulties in clinical skills and knowledge.

17.4 Describing the Levels of Competence

a) Introductory Competence (FUN I)

- Has an understanding and awareness of basic communication skills such as active listening and the effects of body language and other non-verbal communication techniques.
- Recognizes the use of specific communication skills used by the midwife during interactions with clients and with colleagues.
- Uses appropriate touch, asks permission to touch, uses appropriate personal space.
- Recognizes how the midwife advocates for the client with consultants.
- Has the ability to communicate with increasing competence and confidence with assistance during initial interviews, pre- and post-natal visits, and while assisting clients in labour.
- Able to take a history with assistance in an organized fashion using the antenatal forms.
- Able to clearly explain procedures, routine care, and the physiology of normal labour and birth to clients (from the **FUN I** scope of knowledge).
- Able to organize and deliver informed choice discussions of common topics in the **FUN I** curriculum such as eye prophylaxis, vitamin K, nutrition, and breastfeeding. May require assistance.
- Able to report to the preceptor, with prompting, about care they have provided.
- Recognizes the need to manage time in appointments appropriately and strives to end appointments on time.
- Has developed ways of wrapping up a session without upsetting the client.
- Is respectful and diplomatic in interactions with others, clients,

midwives, consultants, etc.

- Uses appropriate language depending on the situation, whether medical or lay, culturally sensitive and inclusive.
- Able to self-evaluate regarding communication skills. Knows when to ask for assistance and does not hesitate to do so when needed.
- When in conflict, checks assumptions, and tries to resolve the conflict in a respectful manner, following MEP guidelines.
- Able to identify clients who may need a different approach for communication, e.g. those with special learning needs or interests, those of a different culture, different primary language, and different education background-may refer these clients to preceptor for care.

b) Intermediate Competence (FUN II)

All findings for introductory competence, and in addition,

- Able to adjust to clients who may need a different approach for communication, for example, those with special learning needs or interests, and when working across differences of culture, language, education, class, etc.
- Shows increasing competence in communicating (with assistance) in complex discussions such as those where emotions play a factor. Recognizes the responses of the client and has a beginning comfort with acknowledging emotion and responding. Recognizes the need (most of the time) to refer clients to other resources within the community when the client's emotional need is beyond the midwifery scope of practice.
- Able to communicate with clients most of the time in a relaxed fashion without displaying nervousness.
- Able to explain physiology, lab results, and medical problems to clients with the appropriate level of detail and yet enough simplicity to be understood by most clients.
- Able to take a health history, with minimal assistance from the preceptor, with a flexible approach.
- Able to include the partner or other family members in discussions as appropriate.
- Able to give a report to the preceptor about care provided and about the client situation with minimal prompting.
- Demonstrates a beginning level ability, with assistance, to consult with specialists.
- Able to write a consultation letter with assistance.
- Advocates for the client with consultants with the assistance of the midwife.
- Knows when to explore further for more information most of the time.
- Able to self-evaluate.

c) Entry to Practice Competence (CC II)

All findings for intermediate competence, and in addition,

- Communication is clear, appropriate, and respectful whether written or verbal, with clients and with professionals.
- Appears comfortable when communicating with clients and professionals.
- Able to communicate effectively and confidently in all levels of informed choice discussions and where the information and exchange is complex.
- Able to take a health history independently with comfort and ease.
- Recognizes when the client has a question or concern, even when it is not expressly stated by the client, and is able to respond.
- Knows when it is appropriate to listen rather than intervene and when to intervene as opposed to simply listening.
- Able to explain physiology, lab results, and medical problems to clients with enough detail and yet enough simplicity to be understood by all clients with a variety of cultural, social, and educational backgrounds.
- Able to recognize the client's level of understanding.
- Knows when and how to probe more deeply with questions to seek more information.
- Knows the limit of their scope of practice with regards to counselling and readily refers clients to appropriate resources in the client's community.
- Able to give a complete report to the preceptor about client care without prompting.
- Able to consult effectively with specialists when the situation is somewhat complex.
- Able to write consultation letters independently.
- Able to independently provide advocacy effectively and diplomatically.
- Able to present clearly and succinctly in a peer review or case presentation.
- Takes initiative about necessary communications.

18. PRIMARY CARE DECISION MAKING

18.1 Learning Opportunities

An understanding of the role of the primary care provider is introduced in **Clinical Skills**. Students observe and begin to participate in primary care decision making in **FUN I & II**.

Workshops in the **Advanced Clinical Skills** intensives focus on the primary care role and the regulatory framework for midwives as primary care providers, and also address consultation and transfer of care, including the primary care role in relation to other care providers. These issues are also addressed during other academic courses taken prior to **CC-I**.

During each clinical course, students learn decision-making in relation to the kind of care they are able to provide with their experience level. Each course builds on the level of responsibility that the student can take until the student is able to provide complete care and accept the responsibility as a primary care provider together with the preceptor. The **Clerkship** provides the student with the opportunity to act as a primary care decision-maker for complete care of a client, with preceptor supervision.

18.2 Program Competence Requirements

On completion of the **FUN II placement**, the student should have achieved Introductory Competence.

On completion of the **CC I** placement, the student should have achieved Intermediate Competence.

On completion of the **Clerkship** placement, the student should have achieved Entry to Practice Competence.

18.3 Teaching Suggestions

Talk about the role of a primary care provider, the health care professional who has the first and main responsibility for a client and their situation. Refer students to the Canadian Midwifery Regulators Council and the Canadian Competencies for Midwives, the CMO Professional Standards for Midwives, “Scope of Practice”, and “Consultation and Transfer of Care ” document (now rescinded but valuable as a reference), the drug and lab regulations and other CMO documents that define the primary care role. Students should refer to these documents regularly and feel more and more comfortable with using them in practice. They may also find the Public Hospitals Act and local hospital by-laws helpful in understanding

the responsibilities of a primary care giver in their community.

Gradually give the student more and more independence and responsibility as you see confidence and decision-making skills progress. Encourage students to take initiative in providing care within their capabilities. It can be a challenge as a preceptor to gradually allow the student more and more independence and responsibility. That is one of the main teaching roles in the skill of primary care decision-making.

Encourage reflective time for the student alone and with the preceptor to contemplate the decisions taken and the responsibility involved in providing primary care. Talk to the student about your feelings about being a primary care decision-maker, what it means to you.

Identify or have the student recognize the difference in roles between being a primary decision-maker and other health care functions, for example support and monitoring during labour versus being responsible for decision-making with regards to interventions. After a clinic day or a birth have the student identify examples of your role as a primary care decision-maker. Later, have students identify the primary care decisions they have made.

Discuss the full responsibility, “the big picture”, with the student, so that you can highlight all that is included in the role. You can use the chart in the Appendix D called “Primary Care and the Big Picture”, that shows the breadth of roles of the midwife.

18.4 Describing the Levels of Competence

a) Introductory Competence (FUN II)

- Understands the principles and the breadth of the role of a primary care decision-maker.
- Can identify most of the components of “the big picture”, the roles of the midwife.
- Able to communicate the principles and responsibilities of midwifery clearly to clients
- Recognizes the decision-making process
- Begins to recognize normal from abnormal in the pre- and post-natal period.
- Begins to take responsibility for care decisions in the pre- and post-natal period.
- Recognizes the difference between roles of support and primary care, for example the roles of labour support versus clinical decision-making in labour.

b) Intermediate Competence (CC I)

All findings for introductory competence, and in addition,

- Understands the regulatory framework for midwives as primary care providers
- Able to take responsibility for complete client care
- Is aware of own limitations; knows when to ask for assistance
- Has the ability to make judgments on the basis of information received
- Takes responsibility for own decisions and actions
- Understands the position played as part of the health care team, when the midwife is the leader and when not
- Knows when and how to facilitate a consultation
- Takes initiative in responding to clients, including client pages
- Makes appropriate decisions in response to urgent client calls and pages
- Able to make decisions in normal and common situations
- Able to make decisions about the care of clients in situations outside of normal where consultation is required (in most situations). Able to incorporate documentation as part of client care

c) Entry to Practice Competence (Clerkship)

All findings for intermediate competence, and in addition,

- Able to take complete charge of client care including prenatal care, labour and birth care, and postpartum care, including any necessary consultations or transfer decisions. (Consults with preceptor before taking a decision about intervention or when the client situation falls outside of normal.)
- Comfortable with the responsibility of being the decision-maker.
- Able to describe the extent and limitations of their own knowledge and abilities.
- Accepts responsibility for their decisions and care planning.
- Understands the full range of responsibility of the midwife as primary care provider.

19. CARE MANAGEMENT SKILLS

19.1 Learning Opportunities

The student will begin to observe midwives managing care throughout midwifery practice during the first clinical placement. During the **FUN I & II placements** the student begins to learn the general steps in care management and to discuss care plans with the preceptor. The student begins to develop and practice care management skills for prenatal and postnatal care during **FUN II**. The student develops the skills to plan and manage care in normal and common intrapartum situations in **FUN II**. In **CC I** the student develops an understanding of how to manage care with all clients, including when complications occur, and consultation is needed. By the end of **CC II**, the student should be competent in care management skills throughout midwifery care, including situations where transfer of care is needed.

19.2 Program Competency Requirements

On completion of the **FUN II** placement, the student should have achieved Introductory Competence.

On completion of the **CC I** placement, the student should have achieved Intermediate Competence.

On completion of the **CC II** placement, the student should have achieved Entry to Practice Competence.

19.3 Teaching Suggestions

In **FUN I**, the preceptor can demonstrate for the student how to plan pre- and post-natal visits for a clinic day, showing the student the charts, describing out loud what is being reviewed and what is being planned, as well as follow-up on any client issues. This period of observation and demonstration of how to plan care can be critical in developing care management skills. The next step is to have the student plan for the visits. Many preceptors have the student review the chart in advance and leave a post-it note on the chart with the student's suggestions for what to assess and discuss at that visit. The student should be prepared for informed choice discussions. Some students find preparing cue cards helpful.

Asking the student to self-evaluate after appointments is helpful in developing care management skills: What did the student find worked well (or not well) and what was the evidence for that evaluation? What suggestions will the student have for

the next time?

Senior students are expected to plan and conduct complete appointments. Students can describe what they intend to do and why, and how to determine if the plan has been successful. The student can think about what the next steps will be needed if the plan is not successful or if it needs further follow up. Other strategies include using layered scenarios or reviewing a case step by step to look at what the facts are and what could be done next. The student can compare, seeing if the student would have planned the care in the same way as the midwife who took care of the client. Discussing these cases or scenarios with the preceptor can be very helpful for the student in learning to organize care, to see different ways of providing care, and to problem solve.

Students can be asked to review cases in which they are involved for the practice group at a practice meeting or at a peer review. The student may need direction from the preceptor about how to organize the presentation, what information to present and what to leave out, and how to present the proposed plan of care for a client who is presently being cared for and how to critique the care for a client who has already been cared for. Observing case presentations done by members of the practice group will provide good role models.

Some difficult situations, especially those which include difficult informed choice discussions, are best learned by the use of role modeling, where the preceptor plays the role of the client.

Some students benefit from learning a systematic approach to care management such as the SOAP system, where they are guided to do full subjective and objective assessments before making a plan, and then evaluating the results.

19.4 Describing the Levels of Competence

a) Introductory Competence (FUN I)

- Shows initiative in planning certain aspects of care, especially for prenatal and postnatal care.
- Is systematic in the approach to problem-solving.
- Able to interpret and understand the implications of normal lab findings in the pre- and post-natal period.
- Able to organize equipment needed for clinical tasks such as PAP tests and blood draws.
- Able to fill out lab requisitions and to organize ultrasounds and other tests as needed.
- Understands the components of care management.
- Able to verbalize an understanding of care planned and managed by the preceptor.

- Able to complete most client discussions within the appropriate time period.
- Able to clearly communicate the principles of midwifery to clients.
- Knows when advocacy is needed.
- Demonstrates the ability to locate needed information, including recent research, required for planning care.
- Demonstrates a readiness (e.g. by having notes or cue cards) and ability to lead an informed choice discussion on topics related to **FUN I**.
- Able to create a care plan in normal and common situations.
- Able to interpret and understand the implications of lab findings and test results in normal and common situations

b) Intermediate Competence (by the end of **CC I**)

- Able to identify client needs.
- Able to create a care plan in normal and common situations
- Able to create a care plan where consultation is required
- Able to articulate the plan clearly to both client and midwives.
- Able to present a rationale for all decisions.
- Able to evaluate plan of care.
- Able to interpret and understand the implications of lab findings and test results in normal and common prenatal and postpartum situations (**FUN I**) and normal and common intrapartum and in situations that fall outside of normal (CC I).
- Plans and follows up when results are outside of normal
- Employs good time management skills for appointments.
- Understands all of the components of care and its planning and how care can be effectively shared by a team; e.g. understands the “big picture” (See Appendix D “Primary Care or the Big Picture”).
- Able to integrate evidence into planning care.
- Able to delegate tasks when appropriate and understands when tasks are being delegated to the student.
- Able to respond appropriately to client pages and phone calls.
- Knows when to call the second midwife to attend a birth in most situations.
- Able to decide when it is appropriate to leave a client and when midwives should remain in attendance.
- Able to respond to a change by revising a plan of care in most situations.
- Is knowledgeable about midwifery and hospital equipment (e.g. how long it takes to get an oxygen tank refilled, able to use the autoclave, safety measures relating to use of suction machines).
- Restocks birth bag.

c) Entry to Practice Competence (by the end of CC II)

- Works comfortably independently and as a team member.
- Coordinates client's care.
- Plans care in a thorough and systematic way, including gathering information about the client using appropriate resources, making relevant assessments, processing information, making appropriate suggestions and initiating appropriate actions, and evaluating and following up.
- Able to balance evidence, client choice and clinical findings in planning care.
- Communicates plans clearly and confidently to team members, including consultants.
- Prioritizes and reorganizes as appropriate.
- Knows when to call the second midwife to attend a birth.
- Takes initiative in planning care and carrying out the plan.
- Able to integrate new information.
- Able to evaluate the plan and change the plan based on the evaluation.
- Makes decisions based on "the big picture", keeping in mind all that the midwife is responsible for.
- Demonstrates a systematic approach to clinical skills – assessments are complete, done in a logical fashion, with a minimum of disruption to the client.
- Uses an organized approach to informed choice discussions.

20. PROFESSIONAL ROLE AND BEHAVIOUR

20.1 Learning Opportunities

Students enter the program with many interpersonal skills and life and work experiences that will be relevant to learning professional behaviour as a midwife. It is expected that students will enter **Fundamentals of Midwifery I with** at least a beginning understanding, having been introduced to the role of the midwife and appropriate behaviour for midwives in first year and in **Clinical Skills**. In each placement, preceptors will be continually modelling professional behaviour in their own relations with clients, students, and other health care practitioners. Some students will need more direct teaching than others to understand and incorporate some of the behaviour that is expected in health care and midwifery environments.

Preceptors should introduce students to specific expectations regarding their clinics and communities at the practice group and hospital orientation sessions. Every interaction with clients, preceptors, midwives, and other professionals and community members provides an opportunity for modelling and teaching and learning appropriate professional behaviours.

During MEP intensives and tutorials, appropriate professional behaviour will be discussed. A wide variety of topics are discussed under the umbrella of professional behaviour including what is expected of the student in a placement, confidentiality, the midwife-client relationship, interprofessional relations, the process of consultation, and how to conduct case reviews with other health care practitioners.

20.2 Program Competency Requirements

By the end of **Clinical Skills**, the student should have Beginning Competence on entry to the **FUN I** placement.

On completion of the **FUN I** placements, the student should have achieved Intermediate Competence.

On completion of the **CC II** placement, the student should have achieved Entry to Practice Competence.

20.3 Teaching Suggestions

The preceptor and student should spend time discussing the practice group's expectations about professional behaviour at the orientation session, which should be done on the student's first day at clinic. Make sure the student is aware of the practice group's guidelines about attire and appearance for the clinic and for attendance at births. Students may need to be helped to understand that inappropriate appearance can sometimes focus attention on the student rather than where it should be, on the client, and that acceptable appearance may vary depending on the particular community. It may also vary from clinic, to client home, to hospital. Understanding appropriate dress and appearance may assist students in being accepted by clients, especially as they take on a more primary role. (Refer to the document on practice group orientation for other suggestions.)

Preceptors need to be aware that any feedback to students about appearance and behaviour should be focused on professional issues and given in a socially and culturally sensitive manner, making students aware of norms and potential implications and avoiding personal comment or judgment. Preceptors should keep in mind the importance of avoiding any appearance of discrimination based on factors such as culture, religion, marital status, or sexual orientation. Each university has human rights officers who may be helpful if preceptors have questions.

Preceptors may want to review with the student a professional approach to communication with clients, midwives and other health care workers. Some students need help to structure their communications in a formal and deliberate manner.

Refer the student to the documents of the College of Midwives of Ontario that address issues of professional behaviour, including Professional Standards for Midwives, Good Conduct Guide, and sections in the Midwifery Act that refer to professional misconduct. Review the MEP Student Guide to Professionalism with the student.

Ask students if there are any issues relating to taking on a professional role that they would like to discuss. Review together the items on the evaluation form related to professional behaviour. Students are expected to participate professionally in review and evaluation sessions. Discuss various teaching and learning styles and your plans for reviewing progress so the student is aware of what to expect and how you give feedback. Being prepared for feedback and evaluation sessions may help students conduct themselves professionally during these sessions. Help students to understand that constructively critical self-evaluation and review of peers is an integral part of all health care practice. Preceptors and other practice members can role model constructive evaluation of care and integration of feedback during peer review sessions.

In day-to-day clinical practice the preceptor should be able to demonstrate the ability to acknowledge areas for improvement in care and discuss how to respond to them.

There may be specific issues about confidentiality and about interprofessional relations that the preceptor will address during the orientation session. When orienting the student to the hospital it can be helpful to point out to the student which locations nursing and medical staff prefer to keep “private” and which areas are reasonable for the student to use. (Refer to the document on hospital orientation for other suggestions.)

Interactions with clients, midwives and other health caregivers can be used as learning opportunities about professional behaviour. Sometimes the preceptor will model professional behaviour and discuss with the student what was important in the interaction, for example respect for the role, knowledge and skills of other practitioners, and an approach to clients that is open but not overly casual. At other times the preceptor may discuss with the student ahead of time how to approach a given situation.

Some students have difficulty receiving feedback from preceptors and other health care providers, such as nurses and consultant physicians. Some students have difficulty giving feedback to the preceptor. Ask the student to self-evaluate about giving and receiving feedback. Help the student to understand that being able to accept feedback and react as gracefully as possible as a student can be considered a dress rehearsal for the on-going feedback that midwives receive throughout their careers, from other midwives, from students, clients, and other health care providers. As experienced midwives we expect to continue to be learners and to accept feedback. An inability to accept feedback gracefully should be identified as a “learning issue”.

Refer to other sections in the “Guide...” about professional behaviour and about feedback, including “MEP Expectations of Students in Clinical Placements” and “Communication”. Also refer to the section on “teaching suggestions” in the chapter on communication. If students are uncomfortable or frightened or tearful in feedback sessions, ask them to identify why and how they are uncomfortable and to suggest ways to approach the feedback sessions that would work for the preceptor and the student. Be clear about the realities of giving feedback in clinical situations; feedback may need to be direct and the student’s response may need to be prompt. Discussion and teaching may need to take place later.

If a student demonstrates behaviour that you find is not professional, be sure to discuss it as soon as is reasonable but not in front of clients or other professionals. Explore whether the student understands that the behaviour was unprofessional. Some issues that may arise include confidentiality, appropriate disclosure, and the nature of the relationship with clients. Ask the student how the situation might have been handled differently. Invite the student to ask you to “model” how to react to challenging situations. This can be particularly helpful in demonstrating an appropriate level of disclosure of the midwife’s or student’s personal life if the student is having trouble focusing on the client instead of on personal experiences. Simulations can also be useful for pointing out when it is appropriate and when it is not appropriate for midwives and students to have “casual” conversations.

Preceptors will regularly model confidentiality and can point out to the student when they have demonstrated confidentiality in more difficult circumstances.

Appropriate professional behaviour facilitates care for clients. Inappropriate behaviour can be a barrier to care for clients. If the student has received feedback and continues to demonstrate behaviour that the preceptor considers is unprofessional, the student and preceptor should meet with the tutor in order to work together on a learning plan. Preceptors may consider a mark of “unsatisfactory” on the student’s evaluation form when a repeated lack of professional behaviour interferes with care provided to clients.

20.4 Describing the Levels of Competence

a) Beginning Competence (Clinical Skills, entry to FUN I)

- Aware of the need to be sensitive to practice group norms with regards to professional attire and appearance.
- Displays respect for clients, staff, and midwives.
- Able to distinguish between personal and professional issues.
- Demonstrates an interest in learning about the clients, the practice group and the skills required for the course.
- Has an understanding of the ‘professional role’ and the importance of appropriate professional behaviour.
- Is familiar with the content of the MEP Student Guide to Professionalism; the CMO Professional Standards and Good Character Guide and the codes of conduct of the student’s university.
- Identifies any lack of knowledge or ability that could interfere with learning and with client safety.
- Treats all clients with respect; is aware and respectful of clients from diverse backgrounds.

- Able to listen to clients respectfully even when the client expresses views and opinions that are different from the student's opinion.
- Demonstrates an understanding of confidentiality.
- Uses appropriate touch, asks permission to touch, uses appropriate personal space.

b) Intermediate Competence (FUN I)

- Is able to identify and acknowledge own strengths and weaknesses.
- Knows when to ask for assistance and does not hesitate to do so when needed.
- Is familiar and fits in with practice group requirements with regards to behaviour, including attire and appearance and any other circumstances which may be particular to the practice group.
- Is ready and available when on-call, e.g. competently uses pager, refrains from the use of alcohol or other substances that might pose safety concerns and plans schedule to get adequate sleep when appropriate in preparation for a labour.
- Able to arrive early for appointments; when lateness is unavoidable, provides an appropriate explanation or apology.
- Is ready and prepared for the clinic day and for each client appointment.
- Comes promptly when called to attend at non-scheduled client assessments.
- Is respectful in interactions with others, clients, midwives, consultants, etc.
- Is diplomatic in interactions with others most of the time.
- Understands how to be responsive to clients and others in a professional manner, even when their behaviour appears inappropriate.
- Uses appropriate language and terminology depending on the situation, whether medical or plain language, that is culturally sensitive and inclusive.
- Able to deal with evaluation and feedback as a professional activity.
- Able to listen to, understand, and accept feedback respectfully (not defensively) from clients, preceptor, and others.
- Understands feedback as positive and constructive.
- Is able to provide feedback, honestly and tactfully, to preceptors, other midwives, and students.
- Is aware of own learning issues most of the time and identifies them for the preceptor.
- Demonstrates a willingness to take responsibility for own learning.
- Participates in peer review with preceptor assistance.
- Refrains from demonstrating personal "neediness" most of the time.
- Able to refrain from being student centered most of the time in interactions with clients and other health care providers; able to

- focus on the client even when the student is stressed.
- Uses appropriate coping skills during stressful situations most of the time.
- When in a conflict situation, checks assumptions, and tries to resolve the conflict in a respectful manner, following MEP guidelines.
- Maintains confidentiality of clients as well as midwives' personal information and practice group business information.
- Refrains from talking about other practitioners with clients and other health care providers.
- Is aware of situations that could result in a conflict of interest and declares them.

c) Entry to Practice Competence (CC II)

- All findings for intermediate competence, and in addition,
- Able to maintain composure even in difficult situations
- Appears comfortable in interactions with other practitioners.
- Is diplomatic in interactions with others.
- Knows when and when not to ask questions and give opinions with clients, other midwives and consultants.
- Able to refrain from inappropriate focus on self
- Able to establish a trusting relationship with clients, even when clients are from different backgrounds or have different values and able to establish comfortable boundaries with clients
- Consistently respects the dignity of clients.
- Knows when and how to advocate for clients with consultants in a sensitive fashion without antagonizing consultants.
- Demonstrates responsibility by following up in a timely fashion in responding to client concerns and clinical needs.
- Refrains from demonstrating an inappropriate degree of personal "neediness".
- Able to refrain from being student centered with clients and health care providers; able to focus on the client even when the student is stressed.
- Consistently uses appropriate coping skills during stressful situations.
- Participates without defensiveness in feedback sessions evaluation, and peer review.
- Offers self-reflection on own initiative.
- Is able to provide feedback, honestly and tactfully.
- Demonstrates ability to integrate feedback into practice.
- Knows the limit of scope of practice with regards to counseling and readily refers clients to appropriate community resources.

APPENDICES

APPENDIX A CONFLICT OF INTEREST

CONFLICT OF INTEREST (COI)

Conflict of interest may be described as ‘any situation in which a person has one or more loyalties or obligations, when personal interests are placed ahead of professional obligations, and/or where there is the potential to interfere with the exercise of professional discretion and impartial judgement’.

There are situations within the MEP in which faculty, students, and preceptors may have an actual or potential conflict of interest. Awareness, appropriate planning, and intervention can prevent problems from developing. The midwifery community in Ontario is still relatively small. It is important that pre-existing relationships do not unduly advantage or disadvantage the admission, teaching or evaluation of a student. Examples of conflict of interest situations include those that may impede the ability of a preceptor or faculty member to provide an unbiased opinion or judgement, such as having been a care provider to the student. Other examples include conflicts for either student or preceptor due to recent student employment at a practice or health care setting or due to a personal relationship.

COI can be practice wide or with individual midwives. For example, in a large practice there may be a midwife or small number of midwives who know the student and declare a conflict, but many others who do not. In this case, only the individual midwives should declare a conflict. Normally faculty members do not act as the primary preceptor for MEP students and whenever possible are not assigned as the clinical course tutor for students placed in their practices.

PROCESS FOR DECLARATION OF CONFLICT OF INTEREST IN CLINICAL PLACEMENTS

The MEP contacts students and midwifery practices prior to each placement allocation process to provide an opportunity to identify conflicts of interest. When a student or practice identifies a potential conflict of interest, placement staff consider the conflict in the final allocation of placements. Information about potential conflict of interest is confidential and is not disclosed or discussed with any party unless the integrity of the allocation process is impacted. Despite this there may be situations where students or practices can assume that conflicts have been declared. Declarations of conflict should be considered carefully and are subject to the norms of ethical professional conduct and provisions of the Human Rights Code. Conflicts cannot be declared based on any human rights protected grounds. The protected grounds are: “age, ancestry, colour, race, citizenship, ethnic origin, place of origin, creed, disability, family status, marital status, gender identity, gender expression, sex (including pregnancy and breastfeeding), sexual orientation and record of offences”. If placement staff become aware of potential human rights concerns with respect to declarations of conflicts of interest, they may be required to disclose such issues to the university to review whether further investigation or intervention may be required under applicable human rights policies and/or the Human Rights Code. Practices and students are accountable for the appropriate use of this policy and should ensure that the process is free from discrimination as prohibited by the Human Rights Code.

It is important that students and practices are aware of the appropriate process to declare a conflict. The goal is to identify potential conflicts prior to the placement allocation process. Conflicts declared after the practice or student know the identity of the student or preceptor may raise concerns about actual or perceived discrimination in the process in violation of the Human Rights Code.

MIDWIFERY RELATED STUDENT EMPLOYMENT DURING THE PROGRAM

It may not be appropriate to continue employment within midwifery practices or related agencies once enrolled in the program. This is particularly the case when clinical placements begin. There are potential conflicts of interest that can arise from employment, especially when it is closely associated with midwifery care, e.g., being a doula, being a second attendant in a midwifery practice, providing childbirth education classes, working as a labour or postpartum nurse. If employment is undertaken, the student must make clear that employment activities are separate and distinct from the clinical activities of a midwifery student and may not represent themselves unfairly as a midwifery student, e.g., using their student status in advertising materials, wearing a name tag issued by the university or affiliated hospital.

THE MIDWIFERY ACT(1994)

The Midwifery Act (1994) sets out the Scope of Practice and the Controlled Acts for Midwives. Under the law, a student may only perform the controlled acts for midwifery when working as a student midwife in a clinical placement authorized by the program. The university’s liability insurance coverage extends only to those placements. When employed outside of the program, the student is not legally permitted to perform any of the controlled acts authorized for midwives unless permitted by law to do so as a health care professional under legislation governing that profession, e.g., medicine, nursing. If a student violates the Midwifery Act, their actions shall constitute grounds for dismissal from the program.

Approved as amended by Management Committee – September 19, 2018

APPENDIX B

Precepting Styles

It is important for preceptors to recognize these four main styles for precepting. When to use which style depends upon the needs and development of the student's professional skills. The following section, "Elements of Precepting Styles" is included with the permission of the Frontier School of Midwifery and Family Nursing's Community-Based Nurse-Midwifery Education Program.

Adapted from SL II: A Situational Approach to Managing People, by Kenneth H. Blanchard.

1. ELEMENTS OF PRECEPTING STYLES

1.1 Directing

In **Directing** the preceptor:

- Identifies the tasks for the session.
- Sets goals for the student.
- Initiates decision-making.
- Takes responsibility for decision-making.
- Provides specific instructions as needed.
- Closely supervises work.
- Recognizes and praises good performance.

1.2 Coaching

In **Coaching** the preceptor:

- Identifies the goals for the clinical session.
- Develops a plan for the session and consults the student.
- Solicits input from the student on plans and decisions.
- Takes responsibility for decision-making.
- Directs the work of the student.
- Evaluates the work at the end of the session.
- Recognizes and praises progress.

1.3 Supporting

In **Supporting** the preceptor:

- Sets goals with the student.
- Lets the student take the lead in planning client care and solving clinical problems.
- Listens to and facilitates problem solving and decision making by the student.
- Shares responsibility with the student for problem solving.
- Evaluates the student's work with the student.
- Recognizes and praises the student for successful planning.

1.4 Delegating

In **Delegating** the preceptor:

- Jointly defines a care plan or clinical problem with the student.
- Lets the student develop a plan of action and control decision-making.
- Accepts the student's decisions within safety guidelines.
- Allows the student to be responsible for their own interventions.
- Allows the student to evaluate their own performance.
- Recognizes and praises the student's ability to complete specific goals.

2. WHEN TO USE THE DIFFERENT PRECEPTING STYLES

Adapted from the Community-Based Nurse-Midwifery Education Program's *Preceptor Training Manual*.

2.1 Directive Style

2.1.1 Guidelines

- Communicate frequently. Give clear, concise directions when necessary.
- Check for understanding.
- Praise good performance of beginners' skills.

2.1.2 A Directive Style Is Appropriate

- With the beginning student.
- When an Intermediate student is undertaking a new task.
- In an emergency.
- When there is a shift in the client's condition that requires intervention beyond the student's skill.
- When an intermediate student has performed a skill unsatisfactorily.
- To correct unsafe behaviour.

2.1.3 A Directive Style Is Not Appropriate

- When you have an intermediate or advanced student.
- When you are doing something the student could do.
- When you use it constantly, not giving the student a chance to demonstrate emerging competency.
- When you use it punitively.
- When you do not check for understanding.

2.2 Coaching

2.2.1 Coaching Is Appropriate

- With a beginner, intermediate or advanced student who may be having a problem with motivation or who may be disillusioned.
- With the student who has performed well as a beginning student.
- When you want to build on the student's beginning skills and foster progress in assessing responsibility for management.
- With an intermediate student who needs extra encouragement or who continues to be unsure of them self in a few areas.
- In an emergency with an intermediate or advanced student.

2.2.2 Coaching Is Not Appropriate

- When there is too much encouragement and consulting with the beginning student.
- When there is too much direction with the advanced student.
- When used too frequently. It is over praising or back seat driving.

2.3 Supporting

2.3.1 Supporting Is Appropriate

- With intermediate and advanced students who have the skills, but are a little insecure, lack confidence, or lack motivation.
- With the advanced student trying a new skill.
- With the advanced student who is regressing because of attitude or a personal problem.
- With someone who needs recognition and support.
- With an advanced student in an emergency.

2.3.2 Supporting Is Not Appropriate

- With beginning students - they need more direction.
- If it is rescuing and you cannot stay out even if the student has advanced skills.
- If it is overly friendly or supportive.
- When the praise is global, not specific.

2.4 Delegating

2.4.1 Delegating Is Appropriate

- With an advanced student.
- With an intermediate student where the tasks are low risk.

2.4.2 Delegating Is Not Appropriate

- With unmotivated, insecure, or apathetic students.
- With students who do not have all the skills recommended for the task.
- With an advanced student who is regressing.
- With the advanced student when the task is new and the skill involves risk.
- When it is an excuse for not monitoring students.

APPENDIX C

Human Rights and Equity – A Summary for MEP Preceptors

Definitions

Discrimination: differential treatment of an individual or group of individuals which is based in whole or in part on one or more of the prohibited grounds (see below) and which has an adverse impact (imposes unequal burdens/denies benefits) on the individual or group of individuals.

Harassment: a comment or conduct that is known or ought reasonably to be known to be unwelcome and that demeans, or humiliates a person. Harassment can be verbal, psychological, emotional, physical, sexual, or electronic.

Duty to Accommodate: a means of preventing and removing barriers that impede individuals from participating fully in an employment, academic or service environment. It is the modification of rules, practices, conditions and/or requirements that are specific to the needs of an individual or group. It is based on one or more of the prohibited grounds and is a legal duty enshrined in human rights legislation.

Human rights and equity policies can apply to:

- Any academic or work-related activity, travel, social function, placement or assignment
- Any behaviours that impact on the work or study environment even if they occur off-site or outside of normal working or school hours.

Prohibited Grounds according to the Ontario Human Rights Code (may not discriminate based on the following):

- Race
- Ancestry
- Place of origin
- Ethnic origin
- Colour
- Citizenship
- Creed (religion)
- Sex
- Sexual orientation
- Age
- Marital status
- Same-sex partnership status
- Family status
- Disability

- Record of offences*
*Protection for Record of Offences” applies in area of employment only

Preceptor Responsibilities

- Model appropriate behaviour.
- Use inclusive and respectful language.
- Establish and communicate clear expectations in order to prevent discrimination and harassment.
- Take action on any behaviour and/or language that is inappropriate (known or apparent) – even if no one complains.
- Document any action taken to deal with human rights related issues.
- Know your rights and responsibilities under human rights related policies and codes.
- Seek support and information as needed.
- Note that a person in a supervisory role who knows of an incident of discrimination or harassment and does not take action to stop the behaviour may be subject to penalties under this policy and under the law

Examples

Quid pro quo – A supervisor suggests that an evaluation may be improved in exchange for sexual favours.

Discriminatory comments – “This work involves manual labour so would be done better by a man.”

Reprisal – A benefit or advancement denied for refusing advances or objecting to discriminatory behaviour

For support and more information contact the equity office at your home university:

McMaster University 1280 Main St W, MUSC Room 212
905-525-9140 ext 27581
hres@mcmaster.ca

Toronto Metropolitan University
Equity and Community Inclusion (OVPECI)
Office of Discrimination and Harassment Prevention
Services
350 Victoria St POD 254A
416-979-5379
equity@torontomu.ca

APPENDIX D

Teaching Primary Care

TEACHING + LEARNING MIDWIFERY

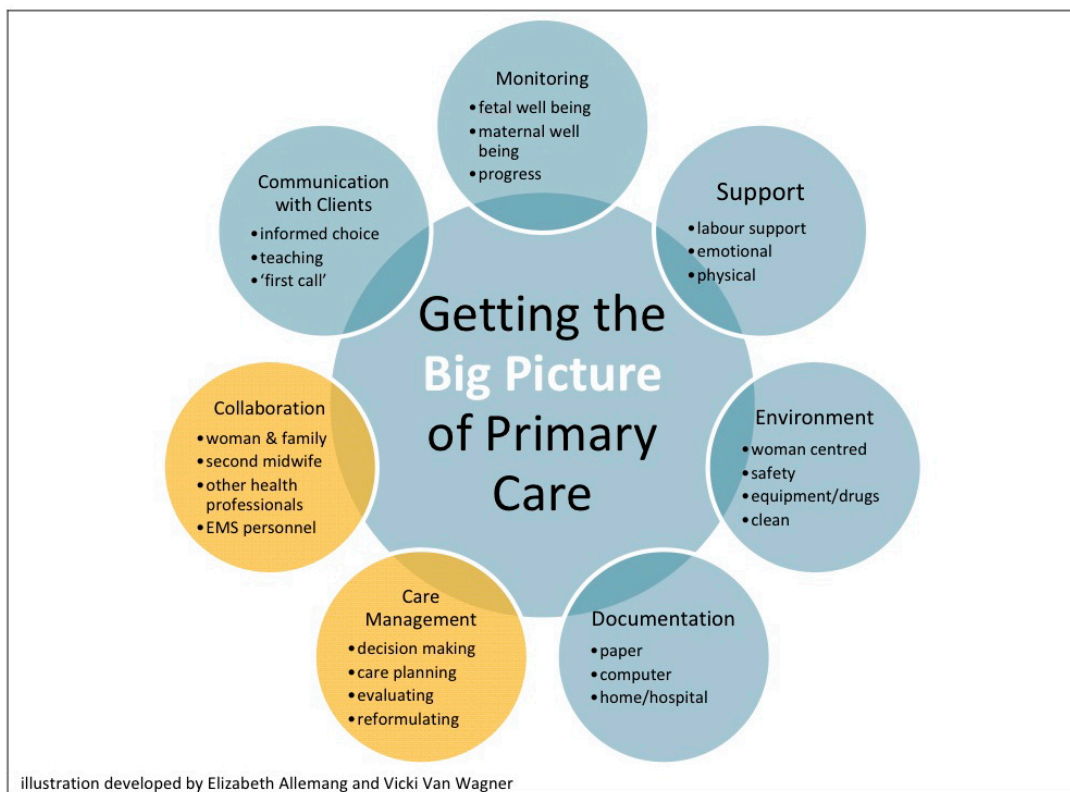
Seeing the Big Picture

May 2011

Students are engaged in learning the **BIG PICTURE** of primary midwifery care throughout their clinical education in the Midwifery Education Program. Care management competencies for students in Normal Childbearing focus on normal pregnancy, labour, birth and postpartum. Students take increasing responsibility for care outside of normal as they progress through the three senior clinical courses in the final year of their program. The diagram below breaks down the concept of primary midwifery care into discrete components. The areas in yellow are those that are mastered in the senior clinical year. This diagram is designed to assist preceptors and tutors in teaching and students in learning primary midwifery care management.

Here are some suggestions for how to utilize this tool to teach and learn primary midwifery management:

- assist the student to identify and learn the discrete components of primary midwifery care
- develop a multistep and gradual process for the student to multitask all components
- set discrete goals with a long term plan for the student to be fully responsible for all areas
- have the student be responsible for those components where she is skilled and add one new or challenging component at a time until that one is mastered and integrated
- make time for student self reflection and provide feedback re: her progress
- reformulate goals and expectations with the student until all areas are mastered



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APPENDIX E

Student Performance / Learning at a Birth

(Form provided by Community Midwives of Toronto)

- Student Copy
 Midwife Copy

Name of Student: _____ Date: _____ Primary
 Second
Name of Preceptor: _____ Client Initials: _____ Place of Birth: _____
Primary Midwife: _____ Second Midwife: _____

KEY: **S** = *Satisfactory*, **NI** = *Needs Improvement*

	Primary Midwife's Comments
1. Assessment of Early Labour and Phone Counseling <hr/> <i>Overall:</i> S <input type="checkbox"/> NI <input type="checkbox"/>	
2. Arrival at Home/Hospital <hr/> <i>Overall:</i> S <input type="checkbox"/> NI <input type="checkbox"/>	
3. Set Up and Preparation for Birth <hr/> <i>Overall:</i> S <input type="checkbox"/> NI <input type="checkbox"/>	
4. Monitoring of First Stage <hr/> <i>Overall:</i> S <input type="checkbox"/> NI <input type="checkbox"/>	

	Primary Midwife's Comments	Second Midwife's Comments
5. Labour Support and Comfort Measures in First Stage <hr/> <i>Overall:</i>	S <input type="checkbox"/> NI <input type="checkbox"/>	S <input type="checkbox"/> NI <input type="checkbox"/>
6. Assessment of Progress in First Stage <hr/> <i>Overall:</i> S <input type="checkbox"/> NI <input type="checkbox"/>		
7. Monitoring of Second Stage <hr/> <i>Overall:</i>	S <input type="checkbox"/> NI <input type="checkbox"/>	S <input type="checkbox"/> NI <input type="checkbox"/>
8. Timing of Call to Second Midwife <hr/> <i>Overall:</i> S <input type="checkbox"/> NI <input type="checkbox"/>		
9. Assessment of Progress in Second Stage <hr/> <i>Overall:</i>	S <input type="checkbox"/> NI <input type="checkbox"/>	S <input type="checkbox"/> NI <input type="checkbox"/>
10. Labour Support and Comfort Measures in Second Stage <hr/> <i>Overall:</i>	S <input type="checkbox"/> NI <input type="checkbox"/>	S <input type="checkbox"/> NI <input type="checkbox"/>

11. Birth		
<hr/> <i>Overall:</i>	S <input type="checkbox"/> NI <input type="checkbox"/>	S <input type="checkbox"/> NI <input type="checkbox"/>
12. Immediate Postpartum Care - <i>Parturient</i>		
<hr/> <i>Overall:</i>	S <input type="checkbox"/> NI <input type="checkbox"/>	S <input type="checkbox"/> NI <input type="checkbox"/>
13. Immediate Postpartum Care - <i>Infant</i>		
<hr/> <i>Overall:</i>	S <input type="checkbox"/> NI <input type="checkbox"/>	S <input type="checkbox"/> NI <input type="checkbox"/>
14. Third Stage		
<hr/> <i>Overall:</i>	S <input type="checkbox"/> NI <input type="checkbox"/>	S <input type="checkbox"/> NI <input type="checkbox"/>
15. Assessment of Perineum/Repair		
<hr/> <i>Overall:</i>	S <input type="checkbox"/> NI <input type="checkbox"/>	S <input type="checkbox"/> NI <input type="checkbox"/>
16. Newborn Exam		
<hr/> <i>Overall:</i> S <input type="checkbox"/> NI <input type="checkbox"/>		
17. Communication with Parents / Informed Choice		

<hr/> <i>Overall:</i>	S <input type="checkbox"/> NI <input type="checkbox"/>	S <input type="checkbox"/> NI <input type="checkbox"/>
18. Documentation		
<hr/> <i>Overall:</i>	S <input type="checkbox"/> NI <input type="checkbox"/>	S <input type="checkbox"/> NI <input type="checkbox"/>
19. Management / Decision Making		
<hr/> <i>Overall:</i>	S <input type="checkbox"/> NI <input type="checkbox"/>	S <input type="checkbox"/> NI <input type="checkbox"/>
20. Consult/Transfer		
<hr/> <i>Overall:</i>	S <input type="checkbox"/> NI <input type="checkbox"/>	S <input type="checkbox"/> NI <input type="checkbox"/>
21. Postpartum Instructions		
<hr/> <i>Overall:</i>	S <input type="checkbox"/> NI <input type="checkbox"/>	S <input type="checkbox"/> NI <input type="checkbox"/>
22. Supply Awareness		
<hr/> <i>Overall:</i>	S <input type="checkbox"/> NI <input type="checkbox"/>	S <input type="checkbox"/> NI <input type="checkbox"/>

Comments: _____

_____ Signature of Preceptor: _____