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Effects of limited midwifery clinical education and practice standardisation of student preparedness

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ABSTRACT

Aim: To explore the perceptions of midwifery educators regarding effects of limited standardisation of midwifery clinical education and practice on clinical preparedness of midwifery students.
Background: Investigation of levels of clinical competency of students is a critical need in the current era. Such competency levels are especially important in midwifery practice in South Africa as there is a significant increase of maternal deaths and litigations in the country. Most of the deaths are in the primary healthcare level maternity units where the newly qualified midwives practise. These areas are mainly run by midwives only. The current article seeks to report the findings of the study that was conducted to investigate how midwifery educators prepare students adequately for clinical readiness.
Settings: The study was conducted amongst midwifery nurse educators on three campuses of the Nursing College in the Eastern Cape.
Design: A qualitative, explorative, descriptive and contextual research design was used for the study.
Data sources and methods: Seventeen purposively selected midwifery educators, with the researcher using set criteria, from a Nursing college in the Eastern Cape, were the participants in the study. Data was collected using focus-group interviews that were captured by means of an audio-voice recorder. Tesch's data-analysis method was used to develop themes and sub-themes. Trustworthiness of the study was ensured using the criteria of credibility, transferability, dependability and confirmability.
Results: Inconsistent clinical practice amongst midwifery educators in their clinical teaching and assessment were found to be the major factors resulting from limited standardisation. The inconsistent clinical practice and assessments of midwifery educators was found to lead to loss of the necessary skills required by the students which led them to perform poorly in their final clinical assessments.
Conclusion: There are some barriers in the current clinical teaching and education strategy used in this college that prohibit the production of confident, independent, and safe practitioners as planned. Midwifery educators need to be assisted in reviewing the current teaching strategy. Furthermore management should be involved if not the initiators of that reviewing and should put in-place new measures to support the teaching of the clinical module.

1. Introduction and Background

Globally in the past ten years clinical preparedness of students has become a central focus in improving standards of midwifery practice that could assist in the reduction of maternal deaths in the sub-Saharan African region (Tyler-Viola et al., 2012). Midwifery is a practice-based profession of which clinical teaching, learning and assessments are the core requirements (Tyler-Viola et al., 2012). As a preparatory stage clinical skills are taught as an initial background in simulation laboratories in the nursing and midwifery departments and schools followed by placement of the students in the different wards and units for practice. This is meant to protect the patients from avoidable clinical errors by the students while they are continuing with the clinical practice module (Kaddoura, 2010). Student preparation to move into independence starts in the classroom where the student is provided with a theoretical background while the mastering of clinical skills is done in the clinical areas (Mackenzie, 2009:395; Meyler and Trenoworth, 2007). Practical competency and independence of students is expected to be accelerated when students are well prepared so that they emerge confident with their clinical performance.

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Globally and in South Africa midwifery educators have been concerned about the poor performance of newly qualified midwives (Sandy, 2014; Douw, 2012; Simonelli and Paskausky, 2011; NDOH, 2013; Chetty and Gwele, 2001; Chokwe and Wright, 2013). Several studies concur that midwifery education and training programmes are not automatically producing competent and efficient practitioners (Sandy, 2014; Douw, 2012; Simonelli and Paskausky, 2011; Schytt and Waldenstroon, 2011).Reasons cited to be associated with the poor midwifery clinical results are the overcrowded classes against a limited number of clinical nurse educators and mentors. Noted also are the inconsistencies in clinical teaching as well as assessment tools that allow poor performers to pass through the programme (Sandy, 2014; Senti, 2013). Consequently, in South Africa the newly qualified midwives are mostly identified to be the ones that are poor performers and are thus at times vulnerable to litigations (NDOH, 2013; Chetty and Gwele, 2001; Chokwe and Wright, 2013; Waterson et al., 2006). The findings of poor performance are not unique to South Africa only as they are congruent with the findings of a similar study by Schytt and Waldenstroon (2011). In that study newly qualified midwives were concerned about their lack of knowledge in emergency care and proper assessment of women during intrapartum care. Nonetheless, such noted research findings are a concern to the midwifery nurse educators regardless of the demographic orientation of the study.

Midwifery educators have a legal responsibility to provide quality education to produce competent and confident clinical practitioners according to the standards set by international (see ICM, 2013) and respective national statutory bodies Confirmation of full delivery to that legal responsibility nurse educators are to conduct assessments of the presented education against the actual performance of the student. In this regard it is assumed that performance that is observed behaviour and which is achieved through assessments is the actual result (WHO, 2011). Furthermore assessment can tell us how to improve future programmes (Kirkpatrick and Kirkpatrick, 2009:19) and benefit students' performance; therefore midwifery educators have to be well oriented with the current care models and developments to equip students to meet the needs of the programme and clients (WHO, 2013). Standardised midwifery programmes and well-designed clinical assessment tools, based on legally and officially stipulated core competencies should validate the outcomes. Such qualities will help to promote authenticity and quality in the provision of any teaching and learning (Perry, 2015) but most importantly, for the purpose of this paper, that of effective midwifery clinical module and practice.

In South Africa midwifery education and training are under the control and regulation of the statutory body which stipulates set standards and the objectives for both theory and clinical requirements for competencies to be achieved (SANC R174:2013). To meet set standards midwifery students have to accumulate clinical experiences in different clinical settings in midwifery care units. Furthermore the practical assessments have to be passed by the student before he or she can be accorded the qualification and licence to practise (SANC, 2005) as accorded by ICM and WHO. In so doing SANC makes clinical competency a vital requirement for licensure to independent practice. As stated by Jeggels et al. (2010), a well-founded clinical background depends on knowledgeable support, adequate mentorship and efficient practice of students. Clinical laboratories could be of assistance in preparing the students for the required clinical practice and thus building the confidence needed for safe practice. Of importance also is the uniformity maintained in the preparing and implementation of the clinical module.

Clinical simulation laboratories are considered to be the environment conducive to skills learning and practice for undergraduate students (Jeggels et al., 2010; Douw, 2008, 2012; Tyler-Viola et al., 2012). Clinical simulation laboratories are used by many countries to prepare students for clinical competency and future practice (Simonelli and Paskausky (2011). In America, for example, clinical simulation laboratories are used as a safe environment to provide students, new graduates and practising staff with an opportunity to prepare and practise skills and bridge the gap where possible (Jeffries et al., 2009). Exploiting simulation to assist in bridging that gap is more than welcomed; but it has to be done correctly to be effective. Simulation laboratories have the potential to prepare confident practitioners in decision-making and acting promptly during emergency situations (Wurdinger and Carlson, 2010). Midwifery care like in any other healthcare situation is about appropriate decisions that are relevant and prompt to limit occurrence or extension of a complication, hence promoting the use of simulation laboratories.

A number of countries support the fact that clinical simulation laboratories are the ideal area for clinical skills teaching and learning (Jeggels et al., 2010; Douw, 2008, 2012; Tyler-Viola et al., 2012; Kaddoura, 2010); but there may be a need for additional strategies for continuous practice to enhance clinical preparedness for practising midwifery. In support of this view the South African National Department of Health has incorporated the revitalisation of simulation laboratories in nursing education institutions in the Department of Health strategies (NDOH, 2013).In so doing it is hoped that there will be uniformity in the clinical practice as the teaching methods and assessments will be known to everyone involved.

Nursing education in the UK approved a higher education system which is provided at universities and nursing colleges and concurrently the students attain supernumerary status in the clinical setting. The number of students joining the basic nursing programmes also increased, causing a challenge in clinical placement for them all, which created a gap between learning of theory and in practice. Therefore, other skills development strategies and methods, like curriculum arrangement were introduced. The increased student intake is, especially in the Eastern Cape, a response to replace those who left the healthcare services (see Muller, 2009).

The shortage of staff in clinical maternity units and nursing institutions prevents students from completing their clinical procedures as there is limited student accompaniment. Simulation could be a possible strategy to overcome mentoring shortages in midwifery as long as it is introduced correctly to ensure good results. In view of the aforementioned statement, Tyler-Viola et al., 2012) argue that simulation use, even in under-resourced countries, is an effective teaching and learning strategy. Clinical performance results could be enhanced if not increased as the students will be accorded reasonable time to practise under close supervision before being placed in the respective maternity units. The findings of the study by Licqurish et al. (2013) revealed that students felt it was unrealistic to be rated as independent for all midwifery competency standards used for their assessments, as they had prioritised achievement of minimum practice requirements for registration due to time constraints. When it happens it is inconsistent resulting in inconsistent assessment of students. Readiness for clinical placement needs are not always being met; therefore other skills-development strategies and methods had to be developed or adapted to improve student competence (Borneuf and Haigh, 2009). In this regard some assistance is needed to enhance current clinical education and practice so as to secure the required student clinical preparedness. The current challenges being experienced in the clinical practice in South Africa clearly indicate that additional measures are essential to achieve the clinical module outcomes stipulated by SANC and to achieve the competency needed for them to become safe practitioners.

According to the participants of the study being reported on, lack of standardisation in clinical midwifery teaching and practice impact negatively on student clinical preparedness. The study was conducted so as to identify how the nurse educators in a college in the Eastern Cape perceived the preparedness of their students before clinical placement.

2. Research Methodology

2.1. Design

A qualitative design using exploratory, descriptive and a contextual